[LB330 LB406 LB481 LB630]

The Committee on Health and Human Services met at 1:30 p.m. on Friday, March 4, 2011, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB630, LB330, LB406, and LB481. 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: Good afternoon and welcome to the public hearings of the Health and Human Services Committee. I am Senator Kathy Campbell and I represent the 25th Legislative District, and it's my honor to Chair this committee. We'll start on my far right.

SENATOR BLOOMFIELD: Dave Bloomfield, District 17, northeast Nebraska.

SENATOR COOK: I'm Tanya Cook. I'm from Legislative District 13, which is northeast Douglas County and the city of Omaha.

SENATOR WALLMAN: Norm Wallman, District 30, south of here.

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

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

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

SENATOR CAMPBELL: To my far left is Diane Johnson, and Diane is the committee clerk, and we have one page today. Crystal is with us. Senator Gloor is presenting in another committee and I expect it will be quite late this afternoon before we see him. A few housekeeping items before we start. Please silence your cell phones so you don't bother your neighbor as they are listening to the testimony. If you have a handout, we would like 12 copies of that handout. If you did not bring 12 copies, posted outside is the location of where you can obtain extra copies. As you testify, if you are testifying today you need to complete one of the orange sheets that are on either side of the room. If you want to just enter a position on any of the bills, you can jot your name on the white sheet and say I am in favor or opposed and give us the bill number. We do go by the light system here. And so when you sit down, it will be green and you'll have about four minutes, and then it will go yellow and you'll have another minute, and red...you'll look up and it will be red and I'll be the person going "time, time, time, time." We try to be very close to that five minutes because we want to ensure that the last hearing of the afternoon has a much attention given to it as the first. So that's why we're sticklers on the time. I don't think there's anything else. When you come forward, just give all the materials to the clerk or the page and they'll take care of it for you. With that...oh, and

when you sit down to testify, do give us your full name and spell it so that the transcription is correct. With that, we'll open LB630 with Senator McGill.

SENATOR McGILL: Hello.

SENATOR CAMPBELL: Hello. And the bill is to adopt the Applied Behavior Analysis Practice Act. Senator McGill has been with us before. Welcome.

SENATOR McGILL: Yes, not that long ago.

SENATOR CAMPBELL: Yes.

SENATOR McGILL: (Exhibit 1) Thank you, Senator Campbell, and members of the committee. I'm Senator Amanda McGill. That's A-m-a-n-d-a M-c-G-i-l-l. I'm here today to offer LB630, also known as the Applied Behavior Analysis Practice Act. It would permit master's- and doctorate-level educated applied behavior analysts to be eligible for healthcare professional licensure as licensed behavior analysis practitioners and licensed behavior analysts, respectively. It's a mouthful. (Laugh) This bill was introduced on behalf of the University of Nebraska Medical Center who employs these professionals in programs that are very familiar to many of you through the Munroe-Meyer Institute. Some of you may recall that this committee advanced and the Legislature passed a bill a few years ago to direct the Department of Health and Human Services to seek a Medicaid waiver to treat autistic children using applied behavior analysis at UNMC. Last year, this committee advanced and the Legislature passed a bill to direct the Department of Health and Human Services to change the state Medicaid plan in order to cover services provided by applied behavior analysts and other professionals in treating young children with feeding disorders. This committee has reviewed in depth the clinical successes that this program has achieved with these master's- and doctorate-level trained applied behavior analysts. These individuals are certified by a national accrediting body called the Behavior Analyst Certification Board. They follow an empirically derived process to assess behaviors and methods to change the behaviors. The director of MMI is here to present you detailed information about their training and work. I bring this licensing bill because, while the Legislature believes that these services are extremely successful, without state licensure these professionals have an almost impossible time billing any third party for their services, with a couple of notable exceptions. The military insurance coverage TRICARE has contracted with MMI to provide these applied behavior analysis services for autistic children of military families under a pilot program, even though there is no licensure yet, because it is so effective and cost-effective as a treatment. Licensure does not ensure reimbursement. The coverage of any such service is still up to individual insurance carriers, but without licensure, such discussions are almost impossible. And as you will hear later, these are expensive services since they are so labor intensive. Several other states have already adopted laws to permit licensure, and others are currently considering such. The bill

before you is not just a model bill; it's a bill tailored for Nebraska and taking into consideration the suggested changes throughout the LB407 review process. For example, LB630 calls for these professionals to be under the purview of the Board of Psychology as opposed to a stand-alone board. This was requested by the technical panel. Another example of this is Section 25, which states that insurers must reimburse psychologists who work in their scope of practice if they provide applied behavior analysis services. This was added at the request of the State Board of Health. However, I understand that the insurance industry opposes that section. You may wonder what the difference is between behavior analysis and psychology. You may hear disagreement on that topic today. Psychologists contend that this is a treatment modality that they are licensed to perform, and I don't dispute that. On the other hand, I do not believe many licensed psychologists have been trained to conduct the incredibly complex functional assessment, data recording, and behavioral modification that occurs at MMI by their applied behavior analysts. LB630 clearly states what is not within the scope of practice of behavior analysts that is within the scope of psychologists, including psychological testing, neuropsychology, psychotherapy, cognitive therapy, marriage counseling, psychoanalysis, and diagnosis or treatment of a major mental health disorder, unless in consultation with a qualified physician or licensed psychologist. However, even if with these restrictions, we hear the Nebraska Psychological Association opposes the bill on the grounds that these individuals might not recognize additional issues while treating a patient, since they are not so trained. Therefore, I'm offering an amendment that goes even further. It requires that both master's- and doctorate-level professionals must work under the supervision of a licensed psychologist in order to ensure the client's safety. In addition, the amendment strikes Section 23 and also contains a technical correction requested by the national certifying board, BCBA (sic--BACB), concerning the required coursework. I understand that more discussions and possibly amendments may be necessary to get LB630 in its final form, and I look forward to working with the committee and other interested parties to accomplish that. We have some great experts following us. I can try to answer any questions if you have any, but they probably are in better shape to answer many. [LB630]

SENATOR CAMPBELL: Questions for Senator McGill? Thank you very much for providing us with a copy of the amendment... [LB630]

SENATOR McGILL: Um-hum. No problem. [LB630]

SENATOR CAMPBELL: ...and covering that in your testimony so that everyone knows what you are proposing. Will you be staying to close, Senator McGill? [LB630]

SENATOR McGILL: I will be. [LB630]

SENATOR CAMPBELL: Okay. [LB630]

SENATOR McGILL: All right, thanks. [LB630]

SENATOR CAMPBELL: Excellent. With that, how many people in the room wish to testify on LB630? Okay. How many in favor? How many opposed? Anyone in a neutral position? All right. We'll start with the proponents this afternoon. So, the first testifier. Good afternoon. [LB630]

MICHAEL LEIBOWITZ: (Exhibit 2) Good afternoon. Chairperson Campbell, members of the Health and Human Services Committee, my name is Michael Leibowitz, M-i-c-h-a-e-l L-e-i-b-o-w-i-t-z, and I'm the director of the Munroe-Meyer Institute at the University of Nebraska Medical Center. I'm here to testify in support of LB630. Many of you know that MMI is the state's federally designated University Center of Excellence in Developmental Disabilities Education, research and service. One of our major goals is the translation of basic and applied research to provide services that will have a significant impact upon the lives of Nebraska's children, youth, and adults with developmental disabilities. Over the past five years, we have hired over 45 faculty and staff just to meet the needs of children on the autism spectrum and children with severe feeding disorders. These individuals are all exceptionally well trained in applied behavior analysis. The interventions used, as you've heard, require extensive data collection which drives therapeutic decisions. Our severe behavior program works with children with aggressive, destructive, and self-injurious behavior. Our early intervention program teaches very young children initial language and social skills, and our feeding disorders program works with children who, due to early experience, find oral feeding so unpleasant as to cause food refusal, tantrums, other behaviors leading to failure to thrive. The common therapeutic approach across all of those programs is applied behavior analysis. These intensive, many times daily interventions have been shown to be highly effective, in many cases preventing institutionalization for children with severe behavioral issues and preventing more intrusive medical procedures in our feeding disorders program. Likewise, these programs, while costly in the short run, have shown to be very cost-effective and saving states thousands of dollars per child over the long run. The Nebraska Office of Rural Health and the federal Health Resources and Services Administration has identified 88 of the 93 counties in Nebraska as mental health profession shortage areas. Data published shows that there are approximately 51 psychologists practicing in rural Nebraska outside of a 25-mile radius of Omaha and Lincoln. This represents the provision of services to over 850,000 Nebraskans by a very small number of practitioners. Further exacerbating the need for behavioral health professionals in rural areas is the fact that those psychologists who are in rural practice primarily work with adults, although some do work with children. With the dramatic increase in the incidence of children diagnosed or suspected of having an autism spectrum disorder, the lack of services has been exacerbated. In 2006, this Legislature passed LB994, creating the Rural Behavioral Health Training and Placement Program Act. The intention of that act was to expand the provision of services in rural parts of

Nebraska. MMI was funded for this task and we have so far created 13 rural behavioral health clinics embedded within the practice of pediatricians and family practitioners in rural communities. In 2008, we initiated a master's degree program with an emphasis on applied behavior analysis in collaboration with UNO's School of Psychology program, and at the same time we have introduced a Ph.D. program in applied behavior analysis at UNMC. The specific focus of the UNMC program is on autism and pediatric behavior disorders. Both sets of students from these programs can sit for the Behavior Analyst Certification Board examination. That would allow them with their coursework to practice within the scope of practice of LB630. At the present time, reimbursement for any behavioral health service requires licensure. You have heard TRICARE has a highly successful pilot program. They just announced that they would make that program permanent. Magellan at the national level likewise is looking into the BCBA certification as being the required credential for reimbursement. LB630 has been introduced by Senator McGill at the university's request. The field of psychology considers applied behavior analysis to be a subspecialty. But over the last 40 years, the area of applied behavior analysis has grown such that over 13,000 members of the Behavior Analysis International group are in ABAI, and only 700 members are members of the American Psychological Association. There is a large group of individuals who have to practice and train this way. We do not wish to start a turf war. MMI trains both psychologists and behavior analysts from all the university's campuses. We see the need for distinctive training programs and licensure. We believe, as Senator McGill said, that we have met all the issues that both the Nebraska Psychological Association and our colleagues at the University of Nebraska-Lincoln's clinical psychology program have set. Our goal is to produce the best trained and most effective behavioral health practitioners to meet the state's needs while providing a work force that can provide impactful services. In an era of increasing concerns over the rising cost of healthcare and the lack of accessibility, the status quo can't really be maintained. Practitioners of innovative, proven, and cost-effective therapies should be given an opportunity to benefit the citizens of Nebraska. Thank you for this opportunity to speak. [LB630]

SENATOR CAMPBELL: Thank you, Doctor. [LB630]

MICHAEL LEIBOWITZ: I'd be happy to answer questions if someone has them. [LB630]

SENATOR CAMPBELL: Thank you. Are there questions from the senators? Thank you very much, and I appreciate that you had to... [LB630]

MICHAEL LEIBOWITZ: (Inaudible) really (inaudible). [LB630]

SENATOR CAMPBELL: ...sort of condense. But we have everything here, so. [LB630]

MICHAEL LEIBOWITZ: Thank you. [LB630]

SENATOR CAMPBELL: Next proponent. Good afternoon. [LB630]

BRIAN FAHEY: (Exhibit 3) Good afternoon. Thank you. Good afternoon, Chairman Campbell and members of the Health and Human Services Committee. My name is Brian Fahey, B-r-i-a-n F-a-h-e-y, and it is my privilege to appear before you today in support of LB630. Let me also express my deep appreciation to Senator McGill for her introduction of this legislation that is important to many families across this state, some of whom are here, some of whom cannot be here. In order to put this bill into some perspective, please allow me to tell you the story of my wife Amber and I, and the birth of our twins. My wife gave birth to our twins, Michael and Gabrielle, 12 weeks premature. Their weights were 1 pound 5 ounces and 2 pounds 1 ounce, respectively. When born, among other things, the twins suffered from severe acid reflux and would vomit anything they would put in. This condition persisted for a few months, which resulted in no weight gain, enormous stress on me, my wife, and our families. With no other alternative, we placed an NG or naso-gastrostomy tube in my son. This did not help him very much. In fact, the tube acted as an accelerator for his vomiting. He was diagnosed with failure to thrive. The fear that his physicians, along with my wife and I, were that if he got sick he would not have the ability to fight off an illness or survive. After extensive consultations, our GI doctor and pediatrician suggested the Pediatric Feeding Disorders Clinic at Munroe-Meyer. Because of my son's emergency condition, we were immediately accepted and placed in an intensive day-treatment program. When my wife and I met Dr. Cathleen Piazza, our son was nine months old and would not take a bottle or anything orally. He had an NG tube in place and a pump that would run continuous drips 24 hours a day in order to ensure that he received the proper nutrients. She asked that we set some goals with our son, which we did. The goals were twofold: one, to remove the NG tube, and second, for us to be able to feed our son orally during the day. We met the goals we set out for my son. My daughter also went through the program and we were able to meet our goals for her. After being discharged from the intensive program, both children received follow-up services in the outpatient clinic and they made clear progress. One limitation of this approach was that the children sometimes displayed problems in the home that were not observed in the clinic setting. It can be highly stressful when a child displays a problem almost exclusively in the home and there is no one there to help you. In addition, because these problems were not often seen in the clinic setting, it made it difficult for Dr. Piazza and her team to develop solutions to these problems. It is analogous to when you take your car into the mechanic and it runs perfectly, but only for a short time, and it's back in the shop. If you think about it, young children do most of their eating in home settings. And therefore, it is most appropriate to provide treatment in the setting in which a behavior occurs. Although Dr. Piazza was able to come out to our home from time to time, her busy clinic schedules prevented her from coming as often as we would have liked. If Dr. Piazza could have sent a master's-level behavior analyst to our home, who could bill for these services, we would have had many more opportunities for the therapist to observe, diagnose, and treat the problems that we were experiencing in our home. With such

in-home services, our children's progress would have been more rapid. Many families in Nebraska struggle with feeding problems. It is important to note that behavioral approaches represent the only empirically supported intervention for pediatric feeding disorders. Because Nebraska currently does not credential individuals specifically trained in applied behavior analysis, most Nebraska families do not have access to professionals who are appropriately trained to deliver this empirically supported intervention. Although Nebraska allows psychologists to practice and bill for behavior analytic services, there are very few licensed psychologists like Dr. Piazza who have the training and expertise in behavior that approaches the treatment of pediatric feeding disorders. LB630 will help to facilitate increased access to professionals who have specialized training in behavior analysis that can deliver these effective interventions for a broad range of pediatric feeding disorders. This legislation will make it more likely for third-party payors who will cover this effective treatment approach. And finally, this legislation will help to protect vulnerable families from unprofessional and unqualified individuals who may falsely claim expertise in behavior analytic treatment of pediatric feeding disorders. Thank you for the time and consideration of LB630. I will be happy to answer questions. [LB630]

SENATOR CAMPBELL: How are the twins doing? [LB630]

BRIAN FAHEY: I've said this before. They're doing much better thanks to Munroe-Meyer. On the feeding, we still have feeding issues that have taken a long time because they do a lot of different things in the home than they do at their feeding clinic. It certainly would help, and when Dr. Piazza is available she does come to our house to observe. But besides that, intellectually--besides me being their father, they're going to be fine. (Laughter) [LB630]

SENATOR CAMPBELL: (Laugh) Well, we're glad to hear that. Questions from the senators? Mr. Fahey, I always appreciate your testimony and your story. I know you've been here for several different occasions and I just appreciate your commitment to helping and I know you're with the March of Dimes board also, are you not? [LB630]

BRIAN FAHEY: Yes. I'm board chair. Yeah. Thank you. [LB630]

SENATOR CAMPBELL: So thank you for coming. [LB630]

BRIAN FAHEY: Yes. [LB630]

SENATOR CAMPBELL: Next proponent. Good afternoon. [LB630]

CHRISSY McNAIR: Good afternoon. My name is Chrissy McNair, C-h-r-i-s-s-y M-c-N-a-i-r. Thank you for the opportunity to testify in front of you today on behalf of LB630. I'm testifying in support. This isn't the first time I've sat in front of this committee,

not all the same senators but a couple familiar faces, on behalf of children and families with autism. I'm the parent of three young boys, ages 13, 11, and almost 6. My 11-year-old was diagnosed with autism slightly after his second birthday, so a little over nine years ago. And allow me if you will to tell you a little bit about his story and then tell you kind of what I know about applied behavior analysis and, more specifically, about working with BCBAs. Our son Luke, soon after he was diagnosed, I dove in, head first, stayed up till 2, 3 in the morning, like many, many parents do when their children are first diagnosed with a disorder, to find out anything and everything that I could about treatment, what it is, how different it is from one child to another. You name it, I was trying to learn about it. And over and over I kept hearing applied behavior analysis, applied behavior analysis. And I thought: I have to find out about applied behavior analysis. This seems to be the treatment that every Web site was talking about. So I set out to find what that is and how is it available to me. And what I found out was that there was a program at Munroe-Meyer Institute where the clinicians there specialized in applied behavior analysis. And the problem was, insurance wouldn't pay for it, and when I talked to my insurance they said one of the reasons was "not licensed." BCBAs were not licensed in the state of Nebraska. So what that said to me was, so this is the treatment that the Surgeon General, the American Academy of Pediatrics, the...several other national boards and the scientific community has adopted as the treatment for kids with autism, but I don't get to have it in Nebraska because nobody will pay for it. So we ended up finding out a way to get it serviced, and we took our son, when he was very little, to Munroe-Meyer Institute and he worked with a BCBA there. And literally, within three days, my nonverbal child was saying his first words. And by the end of a few weeks, he had a vocabulary of about ten. And it sounds miraculous and kind of, too, you know, hard to believe, but it's not and it's just very systematic in their approach. So we decided that ABA was pretty good and we wanted to learn more about it and we explored doing it as much as we could and got him into some skills training. And I can certainly answer questions about that, but in the interest of time I'll move on. Our son's biggest challenge has always been his behavior. He had severe, severe behavior problems, and to the point where in 2008 we had to take him back to Munroe-Meyer to the severe behavior clinic. Once again, insurance wouldn't pay for it, but we were literally desperate at that point. Our son was hurting himself, hurting his siblings, and it was a real serious issue. He had broken windows with his head, things like that. So all of our commonsense parenting that we had always used on our other kids was out the window. We just didn't know what to do. Munroe-Meyer was just fabulous and instrumental in getting him to a good place. And the problem was, he wasn't able to go there as much as he needed because insurance wouldn't pay for it. So, unfortunately, about a year later, he significantly regressed. And what we had to do was send him to Baltimore to Kennedy Krieger Institute. They are affiliated with Johns Hopkins University. Our insurance did pay for that after we fought and fought and fought for it, and he was there for five months. It was the worst experience of my life and it was the best experience of my life, because at the end of...I got to see ABA and BCBAs, between Munroe-Meyer and Kennedy Krieger, at their best. It was absolutely

life-changing, the results. And our son came back to us and we are a different family. We can go to movies, we can go to restaurants. He is at a new school where he's thriving. I think I'm the poster child and I think he's the poster child for an ABA success story. So I kind of liken it to the equivalent of I was a registered dietician out of school, and I talked to people about weight management and treated some eating disorders. And I could talk to people about sports nutrition too, but I didn't specialize in sports nutrition. So I could help people with sports nutrition but it really wasn't my speciality and I had...if somebody really wanted a lot of help with that, I had to refer them. And I kind of think of BCBAs in the same category. They are the specialists of applied behavior analysis and how to work with kids with autism. In my experience, there's just the amount of expertise that they have is unsurpassed and it's been absolutely life-changing for us. And I'm happy to answer any questions. [LB630]

SENATOR CAMPBELL: Thank you, Ms. McNair. Questions from the senators? Senator Wallman. [LB630]

SENATOR WALLMAN: Thank you, Chairman. Yeah, thanks for coming. This is a routine or something that helped with this autism? I have...I know a family member that has this. But does that really help then or...? [LB630]

CHRISSY McNAIR: It depends on the child. Some children really need routine and everything has to be the same, and I think my son isn't really like that as much. He just needs to be taught in a certain way. And (inaudible) taking...you know, if you want to..for example, we tried to teach him how to...we tried to potty train him, and...but he was scared to death of the sound of a toilet. So he wouldn't even look at a toilet because he knew it had the potential of making that sound. So our BCBAs taught us how to potty train him by, first, literally praising him and rewarding him for just walking into the bathroom. So every child is very different. Some need the routine. But the breaking down of the tasks is what for us really worked. [LB630]

SENATOR WALLMAN: Thank you. [LB630]

SENATOR CAMPBELL: Good question. Any other questions? Thank you very much for sharing your story with us. [LB630]

CHRISSY McNAIR: My pleasure. [LB630]

SENATOR CAMPBELL: Next proponent. Good afternoon. [LB630]

STEPHANIE PARKS: Hi. My name is Stephanie, S-t-e-p-h-a-n-i-e, my last name is Parks, P-a-r-k-s. I'd like to thank you for the opportunity to talk about my little boy today. Any opportunity to talk about Dell is pretty great, so. I am the mother of Dell Parks, who I'd like to introduce you to. I've brought you his kindergarten picture. He's six years old

next week. And if you can see this picture, my little boy is smiling. And Dell has autism and it took us a couple years to get this kiddo to smile, so this picture is very, very important to our family. I'm also the wife of a United States Air Force member. My husband is a jet engine mechanic, so we have the blessing of having TRICARE insurance. Dell was diagnosed with autism at the age of three, and we...it was awful when he was diagnosed. He was nonverbal, not potty trained, not sleeping, tantruming multiple times a day. And to complicate things, my husband was at war, so I was home alone with a family member directly in harm's way and a child who had just been diagnosed with autism. And it was Christmas, so it was probably the worst time in my life by far. We were so blessed to be in Omaha, Nebraska, at Offutt Air Force Base, where we could get to Munroe-Meyer Institute. I just can't tell you, when I took my son to them he couldn't say one word, and they taught him...they found out that he really loves jelly beans...Jelly Bellys. So they taught him to say the word "bean." And every time he did something great, he got a jelly bean. And a couple weeks later, my kid was saying "I bean," and then by the time he was, you know, four or so, he finally got to call me "Mommy." It's the best memory I have of my entire life to watch that little boy go from, you know, meltdowns on the floor, to being able to look at me and say Mommy; to know that I was his mommy. Dell not only was nonverbal, but he had many tantrums, as you know I've said. He did have to go through the behavioral clinic at Munroe-Meyer; actually twice we have visited that behavioral clinic. But he was tantruming and hurting himself and running away and we couldn't go to a grocery store. And as a mom with my husband overseas, not being able to go to the grocery store, it's pretty important. So you know, hours, every day, we go to...we go to therapy for hours every day, for 4-5 hours every day, including the behavioral clinic. And every day our BCBA therapist would follow us through Walmart or Walgreens or Hy-Vee, or whatever store we felt like driving to that day, to teach Dell how to walk through the store next to mom and not be scared of the lights or the people or the sounds or the things in the aisles, and how to behave himself. And now he's the best kid in the store--better than some of the parents in the store. (Laughter) So, you know, he's a pretty great little guy. Dell also attends the early intervention clinic with Dr. Kodak, and they're working on his social skills and his educational needs, and they have been able to do astounding things with my son. You know, when you get a child with autism and they're diagnosed with this, it feels like every dream and hope is ripped from you; that your child won't be able to succeed and won't have any choices in their life for what they want to be or who they're going to be. And working with these BCBA therapists and watching Dell go from not saying a word to learning how to read and understand sight words and, you know, talking about his baby sister and understanding who Santa Claus is--and smiling at a camera, my kiddo is going to succeed in this world and he's going to be a productive, happy citizen. And that's 100 percent in part to the services we've received with Munroe. It's been astounding and miraculous to watch. And it's a hard road to walk but I couldn't do it without them, and they've put our family back together and given us our child back. [LB630]

SENATOR CAMPBELL: Thank you very much for your story. Questions for Ms. Parks? Oh. [LB630]

SENATOR BLOOMFIELD: Just a brief one. You said your husband was in the service. [LB630]

STEPHANIE PARKS: Yes. [LB630]

SENATOR BLOOMFIELD: Is he back now or? [LB630]

STEPHANIE PARKS: He is currently back. He's enlisted so he kind of cycles through there every couple months. But right now he is home, thank goodness. [LB630]

SENATOR BLOOMFIELD: Thank you. [LB630]

SENATOR CAMPBELL: We just appreciate the courage of all parents to tell their story, so thank you for coming today. [LB630]

STEPHANIE PARKS: Thank you for allowing me. [LB630]

SENATOR CAMPBELL: Next proponent. All right. We will move to the opponents for the bill. First testifier. [LB630]

ANNE BUETTNER: (Exhibit 4) Anne Buettner, A-n-n-e, Buettner, B-u-e-t-t-n-e-r. I represent the Nebraska Association for Marriage and Family Therapy. I know ABA does not do marriage and family therapy so there is no suspicion of turf war here. We maintain we always have a concern of the point of entry of ABA credentialing, and the point of entry means that there is no requirement of a clinical degree in mental health diagnostic and treatment with a mental health focus. A mental health focus actually has been spelled out in our regulations and so on. In all the mental health professions in Nebraska, be it from psychologists to social workers to marriage and family therapists and professional counselors, we all are grounded with a degree in mental health. So I must admit that, you know, listening to the amendment introduced by Senator McGill that there would be supervision...and I understand it is permanent supervision? Yes, that somewhat relaxes our concern. But still you are thinking that supervision without knowing the specific parameters--it can be once a week and so on--it is just still that particular ABA therapist who eyeballs the client, relates with the client, and so on, is like asking a college administrator or a nursing home administrator or a college instructor, and so on, who is certified with ABA, to do therapy. I mean can they...are they able to recognize the mental illness symptoms, you know, to be able to triage or even able to recognize it and then make a referral? I mean those are the questions. I think the best metaphor is like this, I mean like the specialty of ABA, and I believe that...we believe, our association believes that it is valuable; whether it's a profession, a modality, it is

very valuable. And just like we have oncologists, we have radiologists, we have, you know, pathologists, and so on, but they all have to be first licensed physicians. They all have to be grounded with a medical degree because a medical degree guarantees that they have the broad-based knowledge of medicine--the holistic person, you know. So this is our concern. And perhaps, you know...perhaps some kind of credentialing is deserving. We don't know. But first, if it is grounded in licensed psychology or grounded in licensed mental health practice then it will be the safest for the public. [LB630]

SENATOR CAMPBELL: Questions from the senators? Senator Krist. [LB630]

SENATOR KRIST: I should have asked the question before, but...and maybe someone who is coming up after you can tell us. But I have a special needs daughter and I've been around special needs kids for my whole life since my daughter's birth, and I'm aware that autism, although it may have existed, the science and the therapy and the treatment of autism has come light-years in the last decade and maybe even more so in terms of diagnosis. I think the number I heard at an autism fund-raiser one time is that, you know, we now have a diagnosis of over hundreds of thousands that we really didn't tie. And in some cases, special needs have traits of autism embedded. Is your concern...? I mean this is...so I guess what I'm getting at here is we have...now we have a diagnosis. We have things that we're looking at. And essentially, it is...it's new. It's not...it hasn't been around since...yeah, so... [LB630]

ANNE BUETTNER: Relatively speaking. [LB630]

SENATOR KRIST: Yeah. It is evolving. It's a dynamic science. Is your concern that we're not diagnosing it properly? Because you made the reference to the medical profession. And I guess my other concern, and that would be, or that if it's not in the diagnosis, that those people would not be trained properly, even under supervision, to assist in the therapy? [LB630]

ANNE BUETTNER: It's more of the latter. Thank you for your question. This is our concern. Yes, the autism. Granted, the ABA, be it an analyst or a practitioner, master or doctoral level, is an expert in diagnosing and treating autism and also maybe other developmental disabilities and so on. But they are not problems couched...I mean they do not stand alone. They couch in multiple problems. It can be depression, can be anxiety, can be panic disorder, OCD--obsessive compulsive disorder, and so on. You do need somebody who has a degree in mental health, and in order to recognize those symptoms. And it may not work with them. But at least you have to recognize, first, in order to refer--and that is our concern. [LB630]

SENATOR KRIST: Okay. Thank you. Thank you, Chair. [LB630]

SENATOR CAMPBELL: Uh-huh. Any other questions? Next testifier. Welcome. [LB630]

WILL SPAULDING: Thank you. [LB630]

SENATOR CAMPBELL: Do we need to distribute something for you, sir? [LB630]

WILL SPAULDING: (Exhibit 5) Yes. [LB630]

SENATOR CAMPBELL: Do you have an orange...? Do we have an orange sheet for you, sir? [LB630]

WILL SPAULDING: I think someone has an orange sheet for me. [LB630]

SENATOR CAMPBELL: I think they'll bring it up. We'll get it...we'll have one of the pages (inaudible). Why don't you go ahead and give your name for the record, sir. We'll take the testimony. And then we'll have you fill out. [LB630]

WILL SPAULDING: Fine. I'm Dr. Will Spaulding. I'm the president of the Nebraska Psychological Association. You're going to hear a lot of testimony this afternoon regarding the technical complexities of regulating the practice of applied behavioral analysis. It is indeed a complex set of issues. We have a process for dealing with these complexities as they relate to professional credentialing in healthcare. It's the 407 process. The bill before you is an even more flawed version of a proposal that has already been through the 407 process, and failed to make it. Its presence here before the committee, in my view, constitutes an attempt to circumvent the legitimate 407 process. We need to let the 407 process work. This bill needs to be returned to that forum where these technical complexities can be adequately assessed. All that said, I also want to say that behavioral analysis is already explicitly listed in Nebraska psychology licensing statute as part of the scope of practice of licensed psychologists. Most psychology training programs include basic training in behavior analysis and many psychologists obtain further training needed to apply behavioral analysis with specialized populations or clinical problems. In contrast, the programs that provide training exclusively in behavior analysis, even at the doctoral level, do not meet criteria for accreditation by the American Psychological Association, and the graduates of these programs are not eligible to be licensed as psychologists. Individuals with degrees in applied behavior analysis do not have sufficient training to recognize or treat mental illness. Regarding the question of the diagnosis of autism, I should mention at this point that applied behavioral analysis, it ideologically eschews diagnosis. I also was trained in this tradition and I can tell you that the entire philosophy and scientific principle of applied behavioral analysis is anathema to psychiatric diagnosis. It's not a question of diagnosing a category of autism. It's a question of having the technological expertise to identify very particular behavioral problems and create an environmentally based response to those problems. So I don't agree with the idea that the need for applied behavior analysis to be separately certified has anything to do with scientific progress.

As a matter of fact, applied behavioral analysis for autism began in the 1950s, comparing...depending on how you count among historians, and has been solidly understood to be part of the clinical psychology armamentarium ever since that time. The existing regulatory structure governing the various mental health disciplines can accommodate a new group of practitioners, such as specifically trained applied behavior analysts. Individuals qualified in the day-to-day application of applied behavioral principles can already practice as behavioral technicians under the supervision of a licensed psychologist. These would be comparable to the psychology technicians who now assist licensed psychologists in assessment procedures under the auspices and control of the Board of Psychology. Individuals who have enough training to practice more independently but who do not qualify for licensure as psychologists, could be accommodated as mental health practitioners. A license that was specifically designed to be broad enough to avoid creating new licenses for small groups of practitioners who might still meet minimal requirements for delivering mental health services. Our mental health funding system already provides for services provided by psychology technicians and mental health practitioners. LB630 will not create funding channels that don't already exist. I and my colleagues are all frustrated by the limitations of funding opportunities for autism and other kinds of problems, and NPA strongly supports any efforts to make those services more available to the people who need them. However, credentialing separately, applied behavioral analysts, will not forward that cause. Thank you. [LB630]

SENATOR CAMPBELL: Questions? Senator Krist. [LB630]

SENATOR KRIST: Thanks for coming, and I hear what you're saying. So let me ask you directly: If the problem is TRICARE is recognizing this as a valid charge and our other insurances are not, you express the same frustration in not being able to pay for services that are needed within the behavioral health area. Is that correct? [LB630]

WILL SPAULDING: Yes, we're all frustrated by that. Yes. [LB630]

SENATOR KRIST: Okay. So how do we fix it? [LB630]

WILL SPAULDING: We change policy regarding funding of mental health services. We don't create new licenses. We develop a political and a social consensus that these kinds of problems are worthy of support through our healthcare underwriting mechanisms, and we develop a consensus that we need to fund these kinds of services. [LB630]

SENATOR KRIST: Okay. [LB630]

WILL SPAULDING: It's very similar, Senator, to the problem with mental health parity of just a few years ago. We now have federal laws that require that mental health services

be funded comparably to other healthcare services. That was not the result of scientific developments or the new profession. That was the result of a new consensus that we as a society need to provide these services. [LB630]

SENATOR KRIST: So have you ever been a part of the 407 process? [LB630]

WILL SPAULDING: Yes, I have. I participated in this 407 process myself because I, in fact, practice applied behavioral analysis in my practice. Although I don't see autistic kids, I see adults with other kinds of severe disorders. But part of the point is, this is a technology that transcends the problems associated with autism. [LB630]

SENATOR KRIST: I guess then my question is, why don't we see that in the 407? 407 says one side of it. The technical review committee recommended in favor. The State Board of Health recommended against. The director of the Division of Public Health also recommended against. But in no place--and I read this and I've read it a couple times in different places--do we suggest what the fix for the problem will be. You've just identified what you think technically a fix could be. [LB630]

WILL SPAULDING: Yes. [LB630]

SENATOR KRIST: Does that not have a place in a 407 process? [LB630]

WILL SPAULDING: It didn't happen this time. [LB630]

SENATOR KRIST: Okay. Thank you. [LB630]

WILL SPAULDING: The 407 process, the initial committee, failed to reach agreement about what the fix needs to be. And we need to expect that the 407 process should continue, rather than go before this committee, until those fixes are identified and agreed upon. [LB630]

SENATOR KRIST: Thank you. [LB630]

SENATOR CAMPBELL: Other questions? Thank you, Dr. Spaulding. Good afternoon. [LB630]

STACY BLISS FUDGE: (Exhibits 6-9) Good afternoon. I have a stack of stuff for you. [LB630]

SENATOR CAMPBELL: Ayisha will help you there. Welcome. [LB630]

STACY BLISS FUDGE: Well, thank you. My name is Dr. Stacy Bliss Fudge, S-t-a-c-y B-l-i-s-s F-u-d-g-e. I am a licensed psychologist. I work in Omaha, Nebraska. I am the

clinical director of developmental disability services at OMNI Behavioral Health. It is a mouthful. I'm also a family member and guardian of an individual with developmental disabilities. My purpose today is to discuss with you the application of applied behavior analysis and those people in the state of Nebraska who receive those current services. As stated before, it's really easy with applied behavior analysis to get caught up in this "it's autism, it's autism, it's autism." But applied behavior analysis is a set of techniques that have been around for more than 50 years. And as Dr. Spaulding has said, he works with adults with major mental illness. I work with kids through adults who are developmentally delayed but then also have major mental illness. We use the techniques of applied behavior analysis on a daily basis. So this is not just a set of techniques that is restricted solely to children or solely to the diagnosis of autism. In the state of Nebraska, there's currently 5,000 individuals who are receiving developmental disability services. The state regulates those services and requires that each one of those individuals receives applied behavior analysis services on a regular basis. So we have people all over the state who are getting services of applied behavior analysis by licensed psychologists, licensed mental health practitioners, social workers, etcetera, etcetera--people who have been trained in this particular area. I attached to my testimony page, if you want to flip to the second page if you don't mind, you're going to see a map on here. If...for LB630 to say that to practice applied behavior analysis you have to be a board certified behavior analyst, the map will show you where all of the board certified behavior analysts in the state are. There are currently 33 for the entire state. Of those, 25 live in Omaha and only 4 live in Lincoln. That leaves four behavior analysts for the rest of the state. If you would notice, Senator Wallman, people in your district would have to drive 45 minutes to receive the services in applied behavior analysis, although they have qualified practitioners who are much closer but don't have the degree. Maybe have the training; don't have the degree though, so then they can't do those particular services. I know Senator Gloor is not here but people who live in Grand Island, which is our fourth largest city, would have to drive more than two hours to receive services from a board certified behavior analyst, although they have very qualified licensed psychologists and mental health practitioners right there in their hometown. So for this bill to require you to go to a board certified behavior analyst to receive applied behavior analysis services is going to place a huge burden on families who are outside of the Omaha area. To ask a family member who has somebody...you know, we had heard from families who are saying, you know, how difficult that is to have a child with a disability or have a child with autism or even just developmental disabilities, that's very hard on families. But to expect them to then also have to drive two hours to receive any sort of services seems unreasonable, especially when we have local qualified practitioners. The last thing...oh, I had the letters that I needed to introduce. Do I need to introduce those? I brought with me several letters. One of them is a letter from Dr. Lori Wall who is a psychologist. She was previously trained at Munroe-Meyer and she is a psychologist and she uses applied behavior analysis in her practice. I also brought a letter from the University of Nebraska-Lincoln clinical psychology training program, and then also from Dr. Mark Hald who is a licensed

psychologist in Scottsbluff, Nebraska. The last thing...I realize I'm starting to run out of time. The last thing that I wanted to say was the Behavior Analyst Certification Board, which is the national certification board for the group who is sponsoring this particular bill, was so concerned about the restriction of services that this bill would provide, that they actually put out a memo saying that this was a bad bill and that this bill should not be passed. So if...we're looking at completely eliminating applied behavior analysis services for people outside of the Lincoln area, and their own certification board does not want them to pass this bill because they say that there are so many flaws in it, so I would just urge you to vote it down. Do you guys have any questions? [LB630]

SENATOR CAMPBELL: Questions? Thank you for bringing all the materials to us this afternoon. Next testifier. [LB630]

JOHN LINDSAY: Thank you, Senator Campbell, members of the committee. My name is John Lindsay, L-i-n-d-s-a-y, appearing on behalf of Blue Cross Blue Shield of Nebraska in opposition to LB630. And our opposition stems from, as Senator McGill mentioned, stems from the Section 25 which is, as we read it, a very broad mandated benefit provision, and that is the basis of our objection. The provision requires that no third-party payor, of course which would be an insurer, could exclude a licensed psychologist from payments for authorized or mandated behavior analysis services. Anything authorized to be done by a behavior analyst would be required under this provision to be paid for by insurance regardless of other standard contractual restrictions that might appear in an insurance contract. It's very broad in the sense that I don't believe there's another healthcare provider who has that kind of a broad requirement of coverage. When we talk about what kind of services would be covered, we have to look to the definition. And when we look to the definition of applied behavior analysis...well, actually there is no definition of applied behavior analysis. There's a definition of the practice of applied behavior analysis. And when we look at that definition, it is a broad definition of a description of a very broad categorical type of services, and within that it is not limited even to a group of persons. It talks about services provided to any person or individual...group of persons or individuals, and it's not even limited to...Senator Krist, you mentioned diagnoses. It's not limited to a person with a disease or deficiency or a person who has a diagnosis even. It's flawed in that respect. So we have a great deal of concern with just how broad this language is, and including, for example, we would be required to cover investigative treatments that are kind of a standard exclusion. And no other health provider is a beneficiary of that...or excuse me, health practitioner is a beneficiary of that kind of language. The...a couple of things that we have reminded...primarily the industry has reminded the Banking, Commerce, and Insurance Committee, since where most mandated coverages would appear in committee hearing, that under federal law, starting in 2014, that any benefit mandated by the state and not included in the essential benefits package as defined by the United States HHS must be paid for by the state starting in 2014. And so a reminder that to be careful so that the state is not exposing itself at some point in the future to

picking up the costs of these mandated benefits, in a...from the very fundamental position of opposition to mandated benefits, we have to remember exactly to whom it applies and what the net effect of that is. Remember that ERISA plans the state has no jurisdiction over. So at the outset...and the ERISA plans, of course, are those that are going to be provided by primarily large employers or mid-sized employers. So 60 percent of...60 percent-plus of people are covered by ERISA plans. So already we've whittled that down to who this type of coverage would include, down to 40 percent. If you include that there's also 12 percent of insured, we whittle it down further. And then the portion of that that's left is going to be split between...or is going primarily to be small employer groups and individual plans. So as we increase the cost of what has to be paid out, you are necessarily going to increase the cost of what has to be paid in, thus driving up the cost to small employers and to individuals who have insurance. And typically, mandated coverages will drive people off of the insurance rolls and into the uninsured category. We believe our concerns could be addressed a couple of ways. One is to delete Section 25 or the second is to delete the language "or third-party payor" within Section 25. And Senator Campbell, I'd be happy to answer any questions. [LB630]

SENATOR CAMPBELL: Thank you, Mr. Lindsay. Senator Krist. [LB630]

SENATOR KRIST: Thank you, Mr. Lindsay. This is a situation where a diagnosis is obtained, testing is performed. The child has autism, it has a reflux disease, whatever it might be. The fix in terms of the doctor's course of action and prognosis depends upon the therapy that would be given for the illness, right? [LB630]

JOHN LINDSAY: Um-hum. [LB630]

SENATOR KRIST: So I go to a doctor and I pay a lot of money for a diagnosis and then I go to therapy for...that he has authorized, ten trips, to lift my knee in a certain way. How does that differ from a diagnosis of your child has autism and he's not speaking, he is not talking, he is not acting; I prescribe that you go to a therapy that will let him laugh and talk and adjust. And it's that specialty that we're talking about here, which by the way, we all know TRICARE, which is usually ten steps behind everybody, recognizes as the therapy that gets people back to where they need to get to. Just...and I'm asking, I guess, in terms of the legal definition, do we need to step up to the plate and fund some of these things? We're probably going to do that anyway, but how does that differ from my knee and my doctor and my diagnosis of my therapy? [LB630]

JOHN LINDSAY: Because the doctor never has to diagnose the knee. You could go straight to the physical therapist without ever having a diagnosis. That would be the comparator to what could occur under this bill. [LB630]

SENATOR KRIST: I don't want to disagree with you but I went in and I had my doctor's

visit, and before I could go to my therapy, a separate clinic, I had to have a prescription from the doctor telling me to go to that. That's the only way my insurance company would pay for it. [LB630]

JOHN LINDSAY: Right. [LB630]

SENATOR KRIST: Is that what you're saying? [LB630]

JOHN LINDSAY: Yeah, it's correct. And what I'm saying, this LB630 would bypass that step, that there...because it requires...the language requires all authorized or mandated applied behavior analysis services must be paid for. That's the language in Section 25. If you flip back to the definitional section, it refers to services...in the definition of the practice of applied behavior analysis, it refers to...describes the services...and I may be over in this other...refers to the services provided to individuals or...I believe individuals or groups, and...but it doesn't say groups or individuals who have a particular diagnosis or... [LB630]

SENATOR KRIST: So that goes to your suggestion on the elimination of part 25, which... [LB630]

JOHN LINDSAY: Right. [LB630]

SENATOR KRIST: Okay. I understand. [LB630]

JOHN LINDSAY: And...or, and I think it also goes maybe to some of the definitional things you've heard in prior testimony about what exactly is included. [LB630]

SENATOR KRIST: Good. Thank you, sir. [LB630]

SENATOR CAMPBELL: Senator Wallman. [LB630]

SENATOR WALLMAN: Thank you, Chairman Council (sic--Campbell). Yes, thank you for being here, John. Does your Big Blue cover people in other states if they're licensed in this area? [LB630]

JOHN LINDSAY: Frankly, I don't know that. I will check on that and I will get an answer to you and to Senator Campbell for the committee. [LB630]

SENATOR WALLMAN: Okay. Thank you. [LB630]

SENATOR CAMPBELL: Okay. Thank you, Senator Wallman. Thank you, Mr. Lindsay. Next testifier. [LB630]

JUDITH BOTHERN: (Exhibit 10) Hello. [LB630]

SENATOR CAMPBELL: Pretty soon we're going to require a cart for all of this. (Laughter) [LB630]

JUDITH BOTHERN: I'm sorry. My name is Judith Bothern, J-u-d-i-t-h, Bothern B-o-t-h-e-r-n. I'm a clinical psychologist in Lincoln. I have worked in private practice with children and adolescents for over 19 years and I do treat children with autism. My training involves...actually they have 25 credit hours on their licensed people; I have 35. They require one year of BCBA-D supervision; I have two. I would not qualify for this license the way it's written. I'm going to try to move quick; I have a lot of stuff. The BCBA first developed or was first established in 1998. They began test administrations for their certification in 2006. In 2007, they did a self-study on offering a specialty in autism. I'm going to read that to you. It's in number 3: "...the BCBA Content Task List, that represents the additional knowledge and skills that BCBAs who work with people with autism should possess. In developing this list, the panel found that the skills and knowledge required beyond the BACB were not fundamentally behavior analytic but, rather, information specific to autism. The list includes skills such as expertise in communicating the history and culture surrounding autism to others, extracting relevant information from data provided by others...explaining diagnostic procedures, educating others about nonbehavior analytic interventions, and implementing safe emergency procedures, among others." Based upon this, "the BCBA (sic--BACB) decided not to continue a development of a specialty" in autism. Eighteen months later, they introduced a Model Licensing Act. The curriculum hadn't changed, they themselves say they can't do it, but they introduced a Model Licensing Act. In 2008, they introduced a credential for a doctoral level BCBA-D. The original deadline was June 2010. It was extended to December 2010, then it was extended to December 2011. The requirements for that: They have to be actively certified as a BCBA; they have earned a doctorate degree in applied behavior analysis, other human services, education, science, medicine, or other field approved by the BACB and strongly related to applied behavior analysis; they use graduate-level university coursework or they have taught courses. And then they pay a $35 fee and they are at the doctoral level with the same training as the master's level. One of the things that is in this particular legislation is the requirement for accreditation. To my knowledge, I know that BCBA does not offer accreditation, ABA International does. They began offering it in 1993. However, they are not recognized under the Commission of Higher Education Accreditation nor are they under the United States Department of Education. There are 17 accredited programs in the United States, none of which are in Nebraska. All of that's in here, too: Restriction of Services. One of the things that has come out from members of their own board, and that's under section 5, it's an article by two of their BCBAs who, oh boy, said that it doesn't make sense to try to license in a province or in a state where the number available would not be able to meet the need. Pennsylvania turned it down because they had 300. We have 33. Also, the seven states that have approved--and there's only

seven--a licensing agreement, only three have title protection. One of them that is working on it, which is Massachusetts, has been shot down three times; and the last one that came out did not make it through their consumer protection. It was written according to the model licensing law. I'm excited; I'm trying to hurry. Oh, and there's also a newsletter in here--I'm sorry--there's also a newsletter in here from...that quotes the proponents as saying that...and I think it's a direct statement against our whole process that, "It is our plan to put forth legislation for licensing behavior analysts in the state of Nebraska regardless of the opinions expressed by the Board of Health and medical director." And that's on section 8, the last page. I would have more to say but I'm out of time. [LB630]

SENATOR CAMPBELL: You did pretty well for the time. [LB630]

JUDITH BOTHERN: Oh, I worked hard. I'm out of breath. [LB630]

SENATOR CAMPBELL: And we have a lot...and you've provided a lot of material for us. Questions from the senators on the material that you have? I'm sure we will have a chance to take a look at it. [LB630]

JUDITH BOTHERN: Great. [LB630]

SENATOR CAMPBELL: And thank you for putting it together. [LB630]

JUDITH BOTHERN: You're welcome. And thank you for listening. [LB630]

SENATOR CAMPBELL: Next testifier. Any other testifiers? Good afternoon. [LB630]

KAREN DERR: (Exhibit 11) Hi. I'm Karen Derr, D-e-r-r, and I'm here to talk about my son. I'm sorry. [LB630]

SENATOR CAMPBELL: You're fine. Just take your time. [LB630]

KAREN DERR: My son Korey is presently...(emotional). Sorry. [LB630]

SENATOR CAMPBELL: Would you like a glass of water? [LB630]

KAREN DERR: I'm okay. Sorry. He's presently ten years old. My husband and I adopted him from foster care when he was two and a half years old. He began having behavioral issues--thank you--and to where, you know, he was violent, hitting, kicking, or refusing to do what he was told. In January 2008, my son was diagnosed with Asperger's in error. His behaviors continued to escalate with violence, and in 2009 I changed psychologists and he was diagnosed with oppositional defiant disorder. Again, his violence just continued; I mean he was just pretty out of control. From October 2009

to April 2010, my son was hospitalized seven times, and on the top of the paper I turned in it specifies hospital dates and the amount of days that he was hospitalized. He saw six different psychiatrists, which (inaudible) put in applications to Magellan, stating that my son needed residential care and the fact that he did not have Asperger's or pervasive developmental disorder. Magellan continually turned down all applications and appeals, stating that my son did have a pervasive developmental disorder. At this point I just didn't know what I was going to do to get him help. He was out of control. I asked Magellan for a conference call to include the current physicians on the call. I was told on that conference call that Magellan said that they would only approve a reevaluation for my son from Munroe-Meyer because they were the experts on Asperger's and pervasive developmental disorders. So that was in February 2010, and I called around the beginning of March, so we got the appointment for April. In between that time period, my son was formally arrested for violence at school; again, put back in the hospital; another application to Magellan which was denied again. I got a call from the Attorney General's Office, since he was arrested, asking what I was doing, you know, to try to get care for my son. I just cried to them. I was explaining everything I tried to do and I didn't know, you know, what else to do. And I did explain to them about the appointment that I had at Munroe-Meyer. They agreed to put my son's case on hold until I was able to go to the appointment to find out what the outcome was. I went to Munroe-Meyer. They did a great job with us. They did agree that my son did not have Asperger's; he did not have a pervasive developmental disorder. They did expedite their process to be able to get me documentation which I am very grateful for. We did...that information was turned in to Magellan with the next residential care application and my son was approved for residential care. Magellan did accept from Munroe-Meyer that he did not have a pervasive developmental disorder. It took about ten months for me to get, you know, help for my son from the first hospitalization in October 2009 to May 2010. My son did spend a little over four months in the residential treatment and he is now on Boys Town campus. You know, my hope now is that Magellan will continue to pay for the care he needs until Boys Town specifies, you know, that he has completed their program. That's about all I have. [LB630]

SENATOR CAMPBELL: Questions from the senators? It's a very difficult story to tell and thank you very much for coming. [LB630]

KAREN DERR: Sorry. [LB630]

SENATOR CAMPBELL: You're fine. You did just a great job. Oh, I'm sorry, Senator Howard. [LB630]

SENATOR HOWARD: No, I took her by surprise. She didn't know I had my hand up. I just wanted to thank you for being an adoptive parent. I worked as a social worker doing adoptions. And it's not always easy. You love them so much, and when you need help for them, then you need to have that help provided for you. So I'm really glad you got

that. [LB630]

KAREN DERR: I did. It's just that I think I went through...I had to go through too much to get it and I think I should have... [LB630]

SENATOR HOWARD: You had to go through too much to get it. It's wonderful... [LB630]

KAREN DERR: I think I should have gotten it from the beginning. It was just... [LB630]

SENATOR HOWARD: It's wonderful that you hung in there but you shouldn't have had to leap through that many hoops and for him to wait that long. [LB630]

SENATOR CAMPBELL: Thank you very much. [LB630]

KAREN DERR: Thank you. [LB630]

SENATOR CAMPBELL: Next testifier. Good afternoon. [LB630]

LEE ZLOMKE: Good afternoon. My name is Dr. Lee Zlomke, L-e-e Z-l-o-m-k-e, and I'm a licensed clinical psychologist and have specialized in applied behavior analytic training for persons with developmental disabilities, families and children, for more than 25 years. I had received my initial training at Munroe-Meyer with Dr. Leibowitz as my supervisor a long time ago, and so since that time I've been providing services. So I just wanted to talk a little bit of being careful in this law. If you have to be BCBA certified by the national organization, I couldn't...I can't practice. I mean I would have to go back, take some classes, pass a test, do a bunch of things. And I've been doing this work...in fact, I've been teaching applied behavior analysis at the university on and off for the last 15 years or so. So the restriction of practices in that can be difficult if we're not real careful how we put that together. Another huge problem would be if this law requires that only behavior analysts, or even only behavior analysts and mental health practice persons, can do applied behavior analysis, it's a huge impact on developmental disabilities providers all over the state. They do...their treatments are primarily behavior analytic in nature in Ord and Scotia and, you know, every little town--Oxford, and every little town all across the state. How will we provide those behavior analytic services with three or four behavior analysts or even the 50 psychologists that are all over the state? Right now, those persons are receiving services through persons who have some amount of training. They do some calls; I provide some outreach services; the state provides some technical assistance to help them with that. Schools are excluded from this requirement. Developmental disabilities providers may also need to be able to be excluded from that. Not that they can't use the service. It's a wonderful service, a great service. That's what I rely on almost entirely in my therapies--but it is a service. It's not necessarily a license. And so, Senator Krist, in answer to your question: An

independent provider of mental health services, the physician, the psychologist, the independent mental health provider, can do a differential diagnosis, a preview treatment assessment to determine, this is autism, this is an oppositional defiant behavior problem, this is a disease or disorder or set of symptoms that can respond to this treatment. And then they could order that treatment. They can talk about who is best to do that. But you don't order the person...I don't want to have to say, but only a behavior analyst can do that. Behavior analysts will not do that differential diagnosis. They're not capable nor would they want to do a diagnosis to say: Is this oppositional defiant problems or is this autism? They're not capable of doing that and don't want to do that. Somebody else has to do that. Well, if somebody else has to do that, how can the person...how can an applied behavior analyst be an independent practitioner when they have to rely very much on someone else to make decisions? And not only can they not initially diagnose this, if that set of signs and symptoms changes over time during the treatment and now it becomes more of a mental health issue, they can't make that determination. And so we just have to be careful about handing out independent licenses to practice in a very limited scope and not be able to meet the total challenges a person may present. And how is supervision? If they were practicing under the direct supervision of a psychologist, I'd feel much better about that. I haven't seen the amendment. I have no idea of what's in it. But how that works out is very tough. There was a licensed mental health practitioner law that was passed a few decades ago that said they must receive consult from a licensed psychologist. Personally, I never got anyone to ask me for a consult. I don't know very many psychologists that ever were asked for a consult. There was not a...there was a...it was written in the law somewhere but it was never really enforced and nobody followed it, and so...and no insurance company or third party will pay for that supervision. How's that going to happen? So there's just a lot of problems that would need to be worked out. That can work, but it's got to be a lot of steps about how that would take place, and that might be better done in committees such as the 407 process or other processes rather than a legislative bill process. Thanks very much for this time. [LB630]

SENATOR CAMPBELL: Questions from the senators? Thank you for coming today, sir. [LB630]

LEE ZLOMKE: Thanks. [LB630]

SENATOR CAMPBELL: Next testifier? Anyone wishing to testify in a neutral position? Senator McGill, would you like to close on your bill? [LB630]

SENATOR McGILL: I told you there would be opposition. (Laugh) Thanks for inviting me back up here to close. You know, introducing this bill, I knew it was the beginning of a conversation and the beginning of a negotiation process, and that's why we brought an amendment here today to try to meet some of the needs at least with having someone overseeing these behavioral analysts. It is not our intention to stop any psychologist

who is using this from being able to use it now. They won't have to get this license...they won't need to become licensed. They can't just then say that they are licensed. But it isn't our intention and if we need to clarify that in here to a greater extent, because we realize it is part of the bigger picture what psychologists do. We're just trying to serve that population like Brian Fahey's where they want to be able to send out billable hours so somebody can go reach them in the home and being able to use that for hopefully reimbursement in the long run. As far as the 407 review process is concerned, you know, they went through the process. One was approved, two weren't. But they did give suggestions or recommendations coming out of that process of things they'd like to see, and those things they'd like to see are in this bill: the statutory definition of applied behavioral analysts, education requirements--there are pages of education requirements on here for this specialty; other clarifications. I mean we can go through those as we sit down and talk after this meeting, and that includes that Section 25 was actually something recommended by the Department of Health and isn't in a lot of the other forms that have been in other states. So that's something we can discuss. It's something that was recommended coming out of 407 but perhaps it would be the will of the body to do otherwise with that particular part. But I look forward to working with the committee and everyone to...I don't know if there will ever be total consensus, but I think that there's something very important and special going on at Munroe-Meyer Institute, and with the evolving...well, just the increased education and evolving techniques. You know, they are doing something there that isn't being done elsewhere and they need that ability to treat people in their entirety and hopefully (inaudible) be able to allow families to afford to treat these kids or others to their entirety. [LB630]

SENATOR CAMPBELL: Questions or comments from the senators? Senator Howard. [LB630]

SENATOR HOWARD: Thank you, Madam Chairperson. If it makes you feel any better, I remember hearing this in 2006 and it was just as contentious. But it sounds like when you boil it all down, it's really a matter of payment and trying to get paid for...it sounds like an in-home service that right now is not billable. [LB630]

SENATOR McGILL: Um-hum. [LB630]

SENATOR HOWARD: Okay. Well, thanks for that clarification. [LB630]

SENATOR McGILL: Or certainly part of it. I can't say overall, but yeah, that's part of it, for sure. [LB630]

SENATOR HOWARD: Yeah, right. Right. And then you incorporated the recommendations that were previously made then. [LB630]

SENATOR McGILL: Um-hum. [LB630]

SENATOR HOWARD: Okay. Thank you [LB630]

SENATOR CAMPBELL: Thank you, Senator McGill. With that we will close the hearing on LB630 and ask that all guests that are here for that hearing leave as quietly as possible because we're going to move directly onward, so. If you would like a conversation, please have it outside. We're not being very quiet. Senator Cook. (Exhibits 12-16) [LB630]

SENATOR COOK: Thank you. Thank you, Madam Chair and members of the committee. I'm Tanya Cook, T-a-n-y-a C-o-o-k. I appear before you as the Nebraska State Senator representing Legislative District 13. LB330 increases access to basic, preventative dental care for Nebraskans by allowing dental hygienists to practice without the direct supervision of the dentist in public health clinics and institutional healthcare settings regardless of the age of the patient. Additionally, LB330 removes a burdensome regulatory barrier to dental hygienists beginning their careers serving in public health. That current regulation is that dental hygienists must have accumulated 3,000 hours of experience in at least four of the last five calendar years. This legislation eliminates that requirement. These statutory changes aim to address the current and increasing need for the dental hygiene services in public health and healthcare facilities. The bill allows basic, preventative dental care to be delivered to our underserved constituents. Dental hygienists perform dental exams, dental cleanings, and the application of sealants. This care increases the quality of life, ability to learn, and decreases the risk of more costly complications from neglected dental health. Nebraska has made great investments in establishing a fine public health network. LB330 utilizes this investment by the state to its fullest allowing all Nebraskans regardless of age to receive dental hygiene care by highly trained individuals. The law currently allows for a hygienist to practice without the direct supervision of a dentist in a public health clinic, but only on children. LB330 changes this to allow for Nebraskans of all ages to receive this care. LB330 will allow dental hygienists to provide basic, preventative dental care to our state's elderly population in nursing homes. Our state's growing elderly population deserves this care that can be provided by dental hygienists. I appreciate the committee's consideration of LB330 and ask for its advancement to General File. Thank you. [LB330]

SENATOR CAMPBELL: And Senator Cook, I know you'll be around for closing if you choose. [LB330]

SENATOR COOK: I was going to be here anyway. Thank you. [LB330]

SENATOR CAMPBELL: All right, how many wish to testify in favor of this bill? Okay. And how many in opposition? Okay. And in a neutral position? All right. All right. Well, we'll start with the proponents first. So if you're here to testify in favor, please come

forward. Good afternoon. [LB330]

ROXANNE DENNY-MICKEY: Good afternoon. Guess I'm all settled here. It's my first time doing this so hello everybody. My name is Roxanne Denny-Mickey, R-o-x-a-n-n-e M-i-c-k-e-y. I am a registered dental hygienist with my public health authorization. I am also currently the president-elect for the Nebraska Dental Hygienists Association and I also wear the hat that I'm the coordinator of a pilot program in Nebraska called Young Children-Priority One. And I'm here today, obviously, to hopefully sway you to support LB330. LB330, I think, addresses ability, need and opportunity and where do I go from there. Ability is of little use to encounter need without opportunity. So this, I think, will release a little bit of the handcuffs of what we can do and do what we need to do. The need is great in many of our communities. I get to see it firsthand all of the time. Dental decay is one of the greatest unmet chronic healthcare diseases in many of our child populations. There's at least 80 percent of the population that we see in our adults that are dealing with gum disease to one form or another. Both of these situations have such a potential detrimental effect on the whole systemic welfare of our populations with this that it has become on the radar of many other health organizations and associations that they want to incorporate oral health into that. We also are not seeing a decrease in oral cancer cure rates because we still need some more screenings. We need things to perk up. In my program in particular, it is a relatively new program; it's within...it's two years, has been in existence and I have had over...within the program over 9,000 encounters providing our prevention services and I am nowhere near making this well go dry. I have people beating down the doors; our seams are bursting; people want our services. And daily I hear from mothers and whatnot that are saying, I wish I would have known. And its a great comfort to know that we're making a difference, but it is also despairing to see that there is such a need out there. Young Children-Priority One, like I said, it offers prevention services to children that are ages 8 and under, their caregivers and also pregnant women and we offer them various, you know, I could get into lots of details there, but we offer various prevention services that are very basic in what our education can provide. So hence the need, it's out there, many in our communities need us. Ability, the dental hygienist, it's been proven time and time again that we are the good fit for filling this gap here. Prevention, as we know, is really the cheapest, easiest, and best way to tackle any disease and problem. And we're out there, you know, in the trenches trying to do that. It's been proven time and time again. The standards of what we have to go through with our education, we have to graduate from an accredited program, pass boards, maintain our...get a license, maintain it with 30 continuing education credits every two years and it's an ongoing thing. And I'm glad for that. I'm glad that we have high educational standards. We need to expand, because like I said, we're bursting at the seams and we added recently another hygienist, but we've had to utilize her with generalized supervision because she is a relatively new graduate, stellar employee. I'm a very, very particular person and only those who are, you know, ready to be on the bus and do a good job are going to come on board with me and she's great. It's in her college career she has had many exposures to public health: Dental Day;

Mission of Mercy; Sonrisa Program, and the list goes on. And that is kind of what is going on and that will be addressed here later in further testimony. But we have that situation where I really feel it would have been beneficial if we had been able to utilize Sam with her public health permit and not have to find a dentist to do the generalized supervision. We have Terry Krohn who is a public health department director. She would love to get hers; she's a registered dental hygienist, but because she hasn't been in the clinical setting in the recent years, she's been directing the health department and is ineligible with current language of this authorization to get hers. So there's ability, opportunity. With this program YCPO, it has shown such promise that the Department of Health and Human Services, with the Department of Oral Health and Dentistry has decided to mimic this program and we have created Program in a Box. Fifteen public health departments have been awarded funding to start these programs throughout the state, great opportunity. Many senior centers, nursing homes are asking for Mohammed to come to the mountain and so we're having strategic partners all over. Again, opportunities. They're all over the place, but what I guess I want to leave you with is before any of us look at taking action, I guess we need to address the issue of what happens if we do nothing. And we have much needless suffering in our communities and that will continue on and also the costs will be quite costly in our communities and with Medicaid cuts and with the economy that is not probably a good idea. So I just say that action is probably the antidote to this problem and I urge you to support LB330. Thank you very much. Can I answer any questions? [LB330]

SENATOR CAMPBELL: Questions that you'd like to ask? Senator Krist. [LB330]

SENATOR KRIST: Thank you, Chair. Just very quickly, thanks for coming. We went from 3,000 hours of clinical experience to nothing? [LB330]

ROXANNE DENNY-MICKEY: Sounds extreme, doesn't it. To be frank, that was one of those bones that was thrown out there to get this bill passed. It has been very unnecessary. We really thought that that was something we could live with. We thought that that was something that wouldn't be the hurdle that it is. And there's a lot of old school of thought that went into that as well. Back in, I won't...you know, way back in, say, 10, 20 years ago, the amount of public health exposure that a hygienist going through a college program was very limited. I mean they had it in college, exposure, but now they are going out in the trenches. They are spending a good deal of their educational time out there in the trenches. They come out of their college experience already, sometimes much more experienced, or at least having the exposure to public health, than many of us that have been out there. So that 3,000 hours is just blatantly unnecessary. It does not make for a more qualified hygienist. [LB330]

SENATOR KRIST: But nothing? [LB330]

ROXANNE DENNY-MICKEY: Yeah. And you know I... [LB330]

SENATOR KRIST: Can't we specify that in the case of the people that you're talking about that you have to have 20 credit hours of being out in the field? I mean this basically says... [LB330]

ROXANNE DENNY-MICKEY: Obviously, you know, whether...you know, there's wanting to have something like that, I'm sure, you know, to address it in the future, but as far as to say and to tell you that I feel, with my experience, which has been 20 years, to say that I feel that a hygienist is not qualified once...upon graduation to go out there and do this, no. The services that we're providing with the public health authorization are the basic skimming of what we, in our scope of practice is. I mean, we do so much more than what this is. This is your basic education, sealant applications, prophys and it's very basic to what we have been educated to do. So it's not like we are testing the limits of what we are able to do and do in other settings. This is pretty basic. [LB330]

SENATOR KRIST: Okay. Thank you. [LB330]

ROXANNE DENNY-MICKEY: You bet. Anybody else. [LB330]

SENATOR CAMPBELL: Senator Howard. [LB330]

SENATOR HOWARD: Well, I caught the same thing that Senator Krist did, and how long ago was this agreed to? [LB330]

ROXANNE DENNY-MICKEY: The 3,000 hours? [LB330]

SENATOR HOWARD: Yeah. [LB330]

ROXANNE DENNY-MICKEY: I would say it was 2001, 2006? [LB330]

SENATOR HOWARD: I'm sorry, 2006? [LB330]

ROXANNE DENNY-MICKEY: 2006 was when it was. [LB330]

SENATOR HOWARD: So barely four, a little more than four years ago. [LB330]

ROXANNE DENNY-MICKEY: It's not been very long, no. And we didn't really...like I said, to..and state we didn't realize that it would probably be this hurdle. It's really kept some... [LB330]

SENATOR HOWARD: Three thousand hours, I would think you'd think, that's a lot of hours. [LB330]

ROXANNE DENNY-MICKEY: It's a lot; it's a lot. [LB330]

SENATOR HOWARD: But you agreed to it, with the dental hygienists agreed to it. [LB330]

ROXANNE DENNY-MICKEY: Absolutely, and you know how it goes with negotiations unfortunately sometimes, we knew that there was a need and a need for us out there in these public healthcare settings and we wanted to get our people out there. It's just... [LB330]

SENATOR HOWARD: Sometimes you agree to things and then you end up living with them. [LB330]

ROXANNE DENNY-MICKEY: Absolutely, absolutely. We're hoping we don't... [LB330]

SENATOR HOWARD: What can you say. [LB330]

ROXANNE DENNY-MICKEY: But it's not just affecting us; it's affecting our communities. I have children that come before me with two teeth in their mouth and it's all because...it's not because of bad parenting, it's because a parent didn't know I shouldn't be putting my child to bed with a bottle; I shouldn't be putting my child to bed with a sippy cup. It's something very simple, oral healthcare education, we're changing behaviors and that's not something that 3,000 hours is necessary to do. [LB330]

SENATOR HOWARD: Well, I think baby bottle mouth has unfortunately been around for a long, long time, and it should have been eradicated a long, long time ago. [LB330]

ROXANNE DENNY-MICKEY: A long time ago and hopefully we can do that. Anybody else like to ask any questions for us? [LB330]

SENATOR CAMPBELL: I have a question. How many people in the association have met the 3,000 hours to follow-up on Senator Krist. [LB330]

ROXANNE DENNY-MICKEY: We have currently, I think, there's 51 authorized dental hygienists and that is predicted to increase because of the new opportunities that are laid out there. Like I said, I have worked with Department of Health and Human Services and we're seeing Program in a Box, where there is, again, this offer of prevention services too. And we're partnering up with WIC clinics, Head Start schools with high populations of children that need and so I only see that progressing. But we do have those situations where we've got people that, and I will be testifying here again soon. But I could have been in that boat. I had a element of time as a single parent where I was working and in the process of needing to move and because of jobs being scarce in certain areas, there was a time lapse, and I kind of by the hair of my chinny

chin chin had the required hours to go and get mine. Yet I had been working in public healthcare settings. I was the liaison with the Sonrisa Program which is a Hispanic program that serves Hispanic populations and offers them some dental care. I had worked with Dental Day organizing it with UNMC in certain communities. I had extensive experience in the public health arena and yet that could have negatively affected me because of how it is worded. It is an unnecessary restriction. [LB330]

SENATOR CAMPBELL: And so the 51 would be out of approximately how many? And just approximate, members would you have? Because you...the 51 are members of the association. [LB330]

ROXANNE DENNY-MICKEY: Not necessarily. They're registered dental hygienists and... [LB330]

SENATOR CAMPBELL: Okay. Okay. So we're looking statewide. [LB330]

ROXANNE DENNY-MICKEY: Yes, we're looking statewide at any registered dental hygienist. Membership is not necessary. [LB330]

SENATOR CAMPBELL: So. [LB330]

AUDIENCE MEMBER: Seven hundred and twenty dental hygienists. [LB330]

ROXANNE DENNY-MICKEY: Seven hundred and twenty. [LB330]

SENATOR CAMPBELL: Thank you, from the audience. [LB330]

ROXANNE DENNY-MICKEY: Thank you. We apologize for not knowing that one. [LB330]

SENATOR CAMPBELL: We'll hope the clerk got that on the record. Hopefully you repeated it. Any other questions from the senators? Thank you very much for coming today. [LB330]

ROXANNE DENNY-MICKEY: Thank you very much, appreciate it. [LB330]

SENATOR CAMPBELL: Next proponent. [LB330]

GWEN HLAVA: My name is Gwen Hlava, G-w-e-n H-l-a-v-a. I'm professor and chair of the Department of Dental Hygiene at the UNMC College of Dentistry and I've been at the College of Dentistry for 35 years. When the public health permit was conceived, Nebraska hygienists, in an attempt to protect the public, wrote the qualification of 3,000 clinical hours prior to application for the permit. In retrospect, dental hygiene eliminated

the group of hygienists who are best trained to work in public health settings. When I was a student in the seventies, I never learned how to place an occlusal sealant. Fluoride varnish wasn't available. Lab exams didn't occur. Outreach programs were nonexistent and no one had portable equipment. In the eighties and nineties, we required our students to place six occlusal sealants each semester, only six. In the past decade, UNMC students have placed over 2,000 sealants per year or more than 100 per student. The point is, today's graduate is better prepared than ever before. Our own public health curriculum in the college has expanded from one semester to the entire senior year. Outreach programs now involve a quarter of their curricular time. Diversity to our students is second nature due to the population trends here in the state and their own global perspective. I think dental hygiene students embrace the responsibility they hold by virtue of their education and that is to give back. Students are prepared today to treat patients across the entire life cycle. The UNMC College of Dentistry, dental patient population is predominantly elderly with increasingly complex medical histories. Accreditation today requires all dental hygiene programs to teach to clinical competency all treatment procedures to all age groups in any healthcare setting. Students no longer view dentistry as something that takes place only in a dental office with state-of-the-art equipment. I think it's time to fix a fallacy; our graduates are ready today to assume positions in public health settings and I hope we won't hold them back. And I think that speaks to some of the issues that you had. [LB330]

SENATOR CAMPBELL: Senator Krist has a question. [LB330]

SENATOR KRIST: I'm only concerned that it falls to the department then to say that they're qualified with a diploma. What you're telling me though is that they're qualified not just because they had the diploma, but because they already have clinical experience and they've done the sealants; they've done those kinds of things. [LB330]

GWEN HLAVA: Oh my God. [LB330]

SENATOR KRIST: So do you think we can make this more sellable on the floor if we said...whose diploma or certificate would include a basic minimum package which is consistent with what you would feel a hygienist would have to have to go out there and do something? Do you understand what I'm...do you understand the question? [LB330]

GWEN HLAVA: I think that's already part of every dental hygiene program curriculum. [LB330]

SENATOR KRIST: Okay, then I think in order to sell this on the floor, we're going to have to be able to say understandably that this is part of the curriculum; this is part of the certification; this is part of what we think is required and that's already part of that diploma. Now, second question, is it part of everybody's diploma? If they come here from Wyoming, are they going to have the same credentials? [LB330]

GWEN HLAVA: Well, I think that's why I wanted to bring to... [LB330]

SENATOR KRIST: I don't want to pick on Wyoming, but. [LB330]

GWEN HLAVA: ...to talk about that accreditation standards of any dental hygiene program requires that we teach to clinical competency every one of our clinical procedures and to all age groups in all healthcare settings. [LB330]

SENATOR KRIST: Thanks, Doctor. [LB330]

SENATOR CAMPBELL: Senator Howard. [LB330]

SENATOR HOWARD: Thank you, Madam Chairperson. Well, how would this fit for people that graduated...well, let me ask you, are there people that graduated ten years ago that are still working and practicing? [LB330]

GWEN HLAVA: Sure. [LB330]

SENATOR HOWARD: Well, then how would this fit? I mean, I know that sounds ludicrous, but how would that fit? You were talking about the recent graduates have to do all that, and yet the graduates from your era didn't get that same exposure. So now what would happen to people from your era that would have to fall into this classification? [LB330]

GWEN HLAVA: Well, I think that's why... [LB330]

SENATOR HOWARD: Not to say your era is...it's my era too. [LB330]

GWEN HLAVA: I know, my era was more than 3,000 hours. I think that's why the profession requires 30 hours of continuing education in a two-year period so that people do keep current with the... [LB330]

SENATOR HOWARD: Is that enough? Thirty hours, that's 15 hours a year. [LB330]

GWEN HLAVA: It's the same as dentistry. [LB330]

SENATOR HOWARD: And you feel that that would bring them up to the same standards as new graduates. Excluding the experience, which I value too, but we're talking about training right now. Would that put them on the same level of training? [LB330]

GWEN HLAVA: Well, there's nothing wrong with providing continuing education

programs for those people that want to come back and go over how to place a fluoride varnish, or how to place an occlusal sealant or those kinds of things. I don't think any program would be opposed to that. But I think hygienists today are prepared to do those things. [LB330]

SENATOR HOWARD: Okay. Thank you. [LB330]

SENATOR CAMPBELL: Any further questions? Thank you, Ms. Hlava. [LB330]

GWEN HLAVA: Thank you. [LB330]

SENATOR CAMPBELL: Good afternoon. [LB330]

ANNETTE BYMAN: Good afternoon, Chairman Campbell and members of the Health and Human Services Committee. My name is Annette, A-n-n-e-t-t-e Byman, B-y-m-a-n. I'm a dental hygienist from Omaha and I'm providing testimony on behalf of the Nebraska Dental Hygienists Association in support of this bill. As you are well aware by hearing the previous testifiers, this bill's intent is going to make two changes to existing statute. The first change would eliminate the 3,000-hour requirement. In Gwen Hlava's testimony she identified a group of hygienists being the students that would benefit from the removal of this requirement, but there is also another group of hygienists that would also benefit and that is hygienists such as myself who are working part-time. Now there is a multitude of reasons as to why dental hygienists may be working part-time. For many of us, we did work full-time at one point in our careers. Many of us worked 10, 15, 20, 25-plus years in a full-time position, but now are working part-time. We do feel that we are educated, knowledgeable, and proficient to practice underneath this public health permit. And I say, probably, there are three main reasons as to why. The duties that are listed underneath this public health permit are a very small portion of our overall scope of practice. We're able to provide a prophylaxis, pulp vitality testing, and preventive measures which is your sealants and your fluoride applications. These procedures are procedures that we do day in and day out; we've become very proficient at performing those duties. The second reason, to become licensed, and you heard this from the other testifiers, you have to graduate from an accredited dental hygiene program. You have to pass a national written examination. You have to pass a regional clinical examination and then you have to continue to obtain 30 hours of continuing education every biennium. I wanted to just quote our current Nebraska administrative code that defines what that continuing education means; it means it's an offering of instruction or information to licensees for the purpose of maintaining skills necessary to the safe and competent practice of dentistry and dental hygiene. In order for a continuing education course to meet those requirements, they do have to meet specific criteria that have been accepted by our Board of Dentistry. And those topics have to directly relate to the theory or the clinical application theory of dentistry. The last reason we feel we are quite competent is the language contained in the current public health

permit clearly identifies the Department of Health and Human Services as the entity who has the authority to determine whether or not a dental hygienist is eligible. We feel that is quite a safeguard. The second change would allow us to see patients of all ages. I don't think it's a secret anymore that communities across our state are struggling with widespread disparities in all aspects of healthcare. Currently, out of the 93 counties in our state, 62 of them either meet or exceed the definition of a federal dental shortage area. And what that means is, there is less than one dentist for every 4,000 people. Statistics clearly state that our most vulnerable groups are our minority groups, children, the elderly, and those individuals that have special needs. It's well documented that there is a direct link between periodontal disease and systemic health problems: cardiovascular disease, Alzheimer's disease, stroke, lung disease, diabetes, oral cancer, the list goes on. Of interest is the fact that out of all of the disease categories that fall underneath Medicaid, dental disease has ranked at the top. Five years ago we were at about $26 million; for fiscal year 2010 we're at $38,000 million. So, is there a solution? We do feel that the passage of LB330 would help create a solution. We'll see an increase in the awareness or oral health; see a reduction in dental disease; we'll see an increase in the collaboration of healthcare professionals which will directly benefit dentists. And most importantly, is a savings of important state dollars, especially our Medicaid dollars. I'd like to thank you for allowing me to provide my testimony and ask if there are any questions I could answer. [LB330]

SENATOR CAMPBELL: Any questions? Ms. Byman, it's good to see you again. [LB330]

ANNETTE BYMAN: Good to see you too. [LB330]

SENATOR CAMPBELL: From a personal question, how's your back? [LB330]

ANNETTE BYMAN: Much better. I've had a great year, so thank you. [LB330]

SENATOR CAMPBELL: Good. We shared a couple of experiences together a couple years ago and you were having a lot of back problems. [LB330]

ANNETTE BYMAN: We did. I can't believe you remembered that. But thank you. [LB330]

SENATOR CAMPBELL: I do, because I don't like standing in the Rotunda on that floor and you were having to stand there quite a bit which is very hard on your back. I do have a question though. Did you say that you test for the pulp vitality? [LB330]

ANNETTE BYMAN: Oh, the pulp vitality testing, uh-huh. [LB330]

SENATOR CAMPBELL: Do you still do that with a current or something? [LB330]

ANNETTE BYMAN: Uh-huh, absolutely. Have you had that done? Are you remembering that? [LB330]

SENATOR CAMPBELL: Yes, I have. And I perked up when you said that. I probably would deny that service again if I had a chance. (Laughter) Enough said for a Friday afternoon let's put it that way. Thank you for your testimony today. [LB330]

ANNETTE BYMAN: You're welcome. Thank you. [LB330]

SENATOR CAMPBELL: Next testifier. Welcome. [LB330]

JANE FORD WITTHOFF: (Exhibits 17, 18) Yes, good afternoon. Friday is my favorite day. Senator Campbell, members of the committee, I'm Jane Ford Witthoff and I'm health director with Public Health Solutions, District Health Department. My name is...spell my name is Ford, F-o-r-d, Witthoff, W-i-t-t-h-o-f-f. I'm here testifying on behalf of our Board of Health. I think most of you know a little bit about health departments; we're responsible by law for promoting and protecting the health of citizens in the areas that we serve. We happen to serve 58,000 people in five rural counties in Nebraska. In doing our responsibilities, the board has to do an assessment or determines what the needs are and the strategic plan to determine what are the best use of our time and the best allocation of resources to address needs. Well, the board has identified the need...identified problems with children's dental health and elder dental health. They see these as significant problems. Good dental health is the foundation to good health overall. And while with...you know, we're starting to see some programs developing for children, there's really nothing for elders. Against that, I wanted to...you've probably seen this before, but this was passed out to you too. There are 49 counties all of which...or part of which are critical shortage areas for dentists. We happen to have three counties that are full or part critical shortage areas. There are, roughly, 240,000 elders in Nebraska, 18,000 that are on Medicaid; 24,000 that are poor. And I was going through some statistics to just give you a sense of what the needs are. I mean I see the needs every day; the public health nurse is telling me about the needs every day because they're the ones seeing clients and they're the ones trying to get them into care. And incidentally, I didn't mention of our shortage areas, you know we're short on dentists, but there are only two dentists in our district that will see Medicaid clients and that's a significant problem. So it's one thing to be aware of the problem, another thing to provide preventative services, but then we still have the problem with treatment. Nonetheless, with elders, many of them have no opportunity for prevention either. According to...and I have this on the back of my letter, 7 percent of elders report tooth pain at least twice in the past six months. Thirty-three percent of elders have untreated dental caries. And incidentally, the state just reported that, I think it's only 17 percent of third graders have untreated dental caries. But elders have 33 percent; and 41 percent have periodontal disease. And I think that this, you know, this points to the fact that there are many elders without good dental care. And that includes people in nursing

homes and otherwise. In the designation of shortage areas, they say that as long as you're within 30 miles of dental care then that's...you're not in a shortage area. And the fact is, we have counties that are closer where it's very difficult for elders to get care because they are poor. And it's a myth to say that medications were the first thing to go out the door when there was a lack of money, the fact is, dental care went out the door long before that. And I think it's probably one of the largest problems that's unspoken and very much needs to have attention. I think that right now there are 51 public health dental hygienists and we see a tremendous need in our district. I would like to see more. And you know, I didn't particularly prepare myself to comment on the preparation, but I do want to add that when we hire a dental hygienist, or a public health dental hygienist, we hire them and we supervise them. Not that I'm a dentist, but the fact is that any good program has quality control and that kind of thing. So it's not like...I don't think it's a significant problem. That's all I have to say. [LB330]

SENATOR CAMPBELL: Questions from the senators? Senator Bloomfield. [LB330]

SENATOR BLOOMFIELD: Thank you. On this map you gave us. [LB330]

JANE FORD WITTHOFF: Yes. [LB330]

SENATOR BLOOMFIELD: I have learned over the last little while here to be a little suspect of some of these maps. [LB330]

JANE FORD WITTHOFF: Oh, I know. [LB330]

SENATOR BLOOMFIELD: Well, not because of anything you would have done. [LB330]

JANE FORD WITTHOFF: No, I know; no, I know. It's not my map, so I can say that. (Laughter) [LB330]

SENATOR BLOOMFIELD: Okay. But because of the proximity of my district, which is up there clear in the northeast. [LB330]

JANE FORD WITTHOFF: Yes. [LB330]

SENATOR BLOOMFIELD: Well, just across the river is Sioux City. [LB330]

JANE FORD WITTHOFF: Yes, I know. [LB330]

SENATOR BLOOMFIELD: And there's a...you know, so I'm curious how many of these areas around the state are served by somebody just outside the state, if you know that. [LB330]

JANE FORD WITTHOFF: I think...that is a good point and I would say that the area around Sioux City certainly would be one. But I think that there aren't really any significant major towns within 30 miles. [LB330]

SENATOR BLOOMFIELD: Well, Yankton would be up there at Cedar County, I would think. [LB330]

JANE FORD WITTHOFF: Yeah, I don't know the distance to Yankton. I'm sorry. [LB330]

SENATOR BLOOMFIELD: Okay. Just across the river, just like Sioux City. [LB330]

JANE FORD WITTHOFF: I guess...regardless, you know, as I even speak for my own counties. [LB330]

SENATOR BLOOMFIELD: Okay. [LB330]

JANE FORD WITTHOFF: I see the need and it's quite tragic, I think. Elders deserve more. [LB330]

SENATOR BLOOMFIELD: I just kind of wanted it on the record that there might be a dentist pretty close that don't show up on your map. [LB330]

JANE FORD WITTHOFF: Oh, I know. No, if I were doing the map, I would have done that. [LB330]

SENATOR BLOOMFIELD: Thank you. [LB330]

SENATOR CAMPBELL: Ms. Ford Witthoff, I have to say that in a lot of the maps that we have had on medical care, not very often is it noted that the Lincoln Correctional Facility and the penitentiary is on it. [LB330]

SENATOR HOWARD: As a dental service. [LB330]

SENATOR CAMPBELL: As a dental service. [LB330]

SENATOR HOWARD: I hadn't caught that. [LB330]

JANE FORD WITTHOFF: Yeah. They have teeth too. [LB330]

SENATOR CAMPBELL: Any comment on that? [LB330]

JANE FORD WITTHOFF: They have teeth too. [LB330]

SENATOR HOWARD: Are there restrictions? [LB330]

SENATOR CAMPBELL: But they don't serve any outside people, I'm assuming. [LB330]

JANE FORD WITTHOFF: Oh, no, no, no. But I think that they are commenting that that is a population that they have to serve. [LB330]

SENATOR CAMPBELL: Don't get ahead of me out there in the audience. (Laughter) [LB330]

SENATOR HOWARD: Do you...is there a requirement to getting...? [LB330]

SENATOR CAMPBELL: I think there is a requirement to get an appointment there. [LB330]

SENATOR HOWARD: That's good. [LB330]

SENATOR CAMPBELL: Any other questions or comments? Thank you very much for coming today. [LB330]

JANE FORD WITTHOFF: Thank you for your time. [LB330]

SENATOR CAMPBELL: Next proponent. Good afternoon. [LB330]

BRENDON POLT: Good afternoon. My name is Brendon Polt, that's B-r-e-n-d-o-n P-o-l-t. I'm appearing in support of LB330 on behalf of Nebraska Health Care Association and its membership of about 200 nursing homes and over 200 assisted-living facilities both proprietary and nonproprietary all of which as I read this bill would be affected by the bill. I have to be honest with you, when I first read the bill, I looked at it and not knowing a lot about dental care it would seem to me it would allow more prophylactics in nursing homes. (Laughter) We're all adults. Sounds okay to me. [LB330]

SENATOR CAMPBELL: It must be Friday. [LB330]

BRENDON POLT: It must be Friday, correct, end of day. A little levity is always good. But so I couldn't appreciate what the impact would be to have people without this clinical experience performing services in nursing homes so I sent it out to our membership. What I got back was overwhelming support, primarily in the rural areas, and I just over and over and over I got the same thing that the testifiers before me have said, is it is an access issue. I do want...now I haven't seen the map that was just discussed, however I'm curious, because what I heard oftentimes is there may be dentists in the community, but they might not accept Medicaid. So there might be, whatever, 40 dentists, but two

accept Medicaid. So for example in Gothenburg, got immediate response and there's only one dentist in the area and that dentist doesn't visit the nursing home, they have to go out. So if you're in an urban area...I still got the same response, it's difficult to get the services with the frequency that's needed. But nevertheless, in the rural areas it was the biggest issue. I wondered at first when I read this if it was a cost issue. Now for our facilities itself, it's not, because it would be a separately billed service. However, for a private pay nursing home resident it would definitely be a savings. So with that I'll close to not take anymore of your time. [LB330]

SENATOR CAMPBELL: Any questions? We always appreciate levity here. [LB330]

BRENDON POLT: Thank you. [LB330]

SENATOR KRIST: Even bad levity. [LB330]

SENATOR CAMPBELL: Next testifier. Okay. We'll move to the opponents to LB330 and take the first testifier. Any in opposition? Okay. Are there neutral testifiers? Good afternoon. [LB330]

DAVID O'DOHERTY: (Exhibit 19) Good afternoon, Senators. My name is David O'Doherty, O-'-D-o-h-e-r-t-y. I'm the executive director with the Nebraska Dental Association appearing in a neutral capacity. Just wanted to pass out a few items that are going around now. One issue that was talked earlier was about the 3,000 hours. The first item is from the 2005 407 Application from the Hygienists Association on page 18. The question asks: what is the necessary experience required? And they listed 3,000 hours within the first four to five years. So the 3,000 hours was not a bone or a negotiated point, it was a starting point back in 2005. One thing that I wanted to throw out that I noticed even in the sentence, I think because it says approximately 75 percent of currently practicing hygienists have five years of experience. I think that's...people are reading that statute that you have to have at least four years experience, not the 3,000 hours within the four years or the five. So you could accomplish that 3,000 hours if you're working 30-hour weeks in the first two years. And so if using their number, 75 percent have the five years of clinical experience if you're getting that 3,000 hours within the first two years, that would raise that number to, probably, closer to 90 percent of the hygienists in the state would be able to do this. The HHS lists 1,098 licensed hygienists in the state and Doctor Sorensen sent out a survey last fall, September I believe, and at that time there were 32 that held the permit and of those 32 only 16 were using the permit. And I've heard a lot of comments about a dentist in the area that doesn't take Medicaid; I believe that hygienists have been able to bill Medicaid for a couple years now and after that length of time there are only 8 hygienists out of 1,098 that have the Medicaid ability to bill; and 6 of those 8 are in Omaha. The second document I'm going to...passed out, one of the issues we had are...with the bill is that there is a reporting requirement. It says that the procedures that are performed are to be reported to the

department. To my knowledge there has never been any reporting at any year, because I've been asking every year. What I passed out is Washington also...the state of Washington also has a reporting requirement and I attached their reporting sheet that is required to be filled out by the hygienist and turned in quarterly. And behind that I just took kind of as a model from what Washington does and turned it into a form that Nebraska could use and the second page basically is formatted just as the procedures that appear in our statutes. So I would propose that the statute be modified with the procedures that are reported on a form approved by the Board of Dentistry because the department believes that a survey sent out to all hygienists was satisfying the reporting requirement. And I know back in 2005 we did not have a survey in mind as a report; it was something along this line. But the department never created a form to report on, so we created one as an idea to be used and hopefully approved for use. Finally, I just wanted to show, this is our...the last page, this is our page on our own Web site that just details the statute and what it does and it has a link, the top highlighted line is a link to the application that a hygienist can fill out. The bottom highlighted line would be my proposal of the link that would actually open up the reporting form so it would be easy to find and turn in. [LB330]

SENATOR CAMPBELL: Questions for Mr. O'Doherty? I just have a quick one, because I was trying to take notes while you were talking and I didn't see the figures here, maybe I missed them again. Mr. O'Doherty, you said there were 1,098 licensed hygienists in the state, 32 held the permit. [LB330]

DAVID O'DOHERTY: This is...I didn't print this out to pass out because I believe you have it personally. [LB330]

SENATOR CAMPBELL: Oh, okay. [LB330]

DAVID O'DOHERTY: But when Doctor Sorensen sent out the survey, it says on the top there, 1,098 licensed hygienists and further down in the survey it says, how many of you have the permit? And it said 32; and then how many of you are using the permit? And there's 16. So 16 out of the 32 who had it are actually using it. One of the things that is interesting in the survey results is that the big issue is payment. Sure we're interested, but how are we going to get paid? Well, fortunately Doctor Sorensen has a HRSA grant which is going on now which you heard about referenced. But other than that, I mean Medicaid is one of the options to be paid, and that's the same way dentists are. But right now there's only eight hygienists, six in Omaha, who even have a permit and Vivianne, Ms. Chaumont, didn't think that that much money was even being billed at that time. [LB330]

SENATOR CAMPBELL: Not enough people. Any other questions? Thank you, Mr. O'Doherty. [LB330]

DAVID O'DOHERTY: Thank you. [LB330]

SENATOR CAMPBELL: Good afternoon. [LB330]

SCOTT MORRISON: (Exhibit 20) Good afternoon, Senator Campbell. Good afternoon, Senators, and thank you for allowing me this opportunity to testify regarding LB330. My name is Scott Morrison, S-c-o-t-t M-o-r-r-i-s-o-n. I'm a practicing periodontist in Omaha, Nebraska. I'm a past president of the Nebraska Dental Association and I'm currently the legislative chairman of the Nebraska Dental Association. I represent the legislative interests of 80 percent of the dentists practicing in our state. I'm here today in a neutral capacity regarding LB330. Over the past year the NDA initiated and engaged in, under the direction of our current president, a task force that includes representatives from the Nebraska Dental Hygiene Association, Nebraska Dental Assistants Association, and the Nebraska Dental Association. The purpose of this task force is to develop a comprehensive approach to improving the delivery of oral healthcare to all Nebraskans across the continuum of care as a dental team. It was a disappointment when LB330 was introduced by the Nebraska Dental Hygiene Association because a comprehensive dental task force was unaware of the bill or its introduction. It is the NDA's hope to continue the task force and to work towards consensus on the issues of surrounding access to care. That having been said, I would like to point out several things regarding LB330. I think all of you have the map in front of you. The first of those things relates to the removal of the 3,000 hours of clinical experience for a hygienist to practice in an unsupervised setting. The map, as you can see, summarizes how the rest of the country views unsupervised hygiene practice in clinical experience. The red states are those without unsupervised hygiene, and as you can see, there are only 14 states that allow hygienists to practice unsupervised in any setting. Nine of those 14 require a level of clinical experience to practice unsupervised. The second issue is the change of treating children only and allowing the treatment of all patients. The numbers are similar here to that of clinical experience. Only 11 states allow hygienists to practice unsupervised on adults in any setting; and 7 of those 11 require a level of clinical experience. That's not necessarily designated on the map. I believe the Board of Dentistry and the Board of Health have expressed similar concerns in regards to eliminating clinical experience. And the expansion of the hygienist scope of practice to include all patients when hygienists are allowed to practice unsupervised. The NDA is in a neutral position on LB330. It takes no position on whether a change in training is appropriate in a large part due to the fact that little or no data has been compiled to indicate whether 3,000 hours is an appropriate level of training or whether it is an impediment to the delivery of services. In conclusion, if the goal of the bill is to expand access to care, it is important to look at whether there are currently impediments to that access and to discuss how this bill removes those impediments. Without data that gives us that information, it is difficult to support or oppose LB330. I thank you for your time, your service and I'd be happy to entertain any questions that you have. [LB330]

SENATOR CAMPBELL: Questions from any of the senators? Thank you for bringing the information forward. [LB330]

SCOTT MORRISON: Thank you. [LB330]

SENATOR CAMPBELL: Anyone else who wishes to testify? Okay. Senator Cook, would you like to close on LB330? [LB330]

SENATOR COOK: Thank you, Madam Chair. Thank you, fellow members, and I appreciate the questions. Those are all things that we want to find answers for between now and when we discuss it in Executive Committee. I just want to conclude by asking you to consider it in the context of access to dental services for a diverse range of populations, whether that's racial ethnic diversity or people who use Medicaid or the elderly within a nursing home setting. So thank you very much for your consideration. [LB330]

SENATOR CAMPBELL: (See Exhibit 21) Thank you, Senator Cook. For all of our guests we will close the hearing on LB330 and ask that if you are not staying that you just exit very quietly because we're going to go right on to the next bill. And we'll give them just a minute, everybody to gather their papers, including us. Okay, we're going to open the hearing this afternoon on LB406 which is Senator Cook's bill to provide for reentry licenses under the Medicine and Surgery Practice Act. Good afternoon again. [LB330]

SENATOR COOK: Good afternoon again. Chairwoman Campbell, fellow members of the Health and Human Services Committee, I am Tanya Cook, T-a-n-y-a C-o-o-k. I appear before you as the senator representing Legislative District 13 and the introducer of LB406. LB406 would amend Nebraska's physician licensing law to allow the Department of Health and Human Services to issue a reentry license to physicians who have not been actively practicing for two years or more. The bill was prepared by the Nebraska Medical Association at the request of the Nebraska Board of Medicine and Surgery and is modeled on a law passed by Colorado in 2010. Nebraska is currently facing a shortage of healthcare providers across the state. Not only are these healthcare work force shortages occurring now, but the shortfall is expected to grow in the future. LB406 offers a partial solution to the shortage of practicing physicians by allowing reentry licenses to physicians who desire to reenter their critical mission of healing. There are many reasons that a physician might take a voluntary leave of absence from clinical practice ranging from family leave, such as maternity or paternity leave or child rearing, personal health reasons or alternative careers, such as military service, administration or humanitarian leave. Physicians wishing to return to practice after a period of clinical inactivity may experience difficulties in returning due to their failure to maintain their skill and knowledge base. In Nebraska, the Board of Medical Examiners has been faced with the issue of physician competency to reenter medical

practice. It has received applications from physicians who have been away from medical practice for extended periods of time. While the state benefits from having additional physicians, the board must be able to assure that these returning physicians are competent to return to practice before issuing a medical license. LB406 would give DHHS and the Board of Medical Examiners a way to manage and supervise the return of physicians to full-time medical practice. The bill would allow the department, on the advice of the board, to issue a reentry license to a physician who has not actively practiced for two years or has not otherwise maintained competency and it would impose conditions on the returning physician. The bill allows the board to require returning physicians to submit to evaluations and assessments and complete an educational program if necessary. Physicians who are issued reentry licenses would be required to practice under supervision as specified by the board. If the returning physician meets the requirements imposed by the board and demonstrates that he or she is competent to practice without supervision, the department would then issue a regular, unrestricted medical license for the physician. Under LB406, a reentry license would be valid for one year and could be renewed for up to two additional years. In summary, LB406 would allow the state to assure that physicians who are reentering practice have the skills and education to practice competently. I appreciate the committee's consideration and advancement of LB406. Thank you. [LB406]

SENATOR CAMPBELL: Questions? Senator Wallman. [LB406]

SENATOR WALLMAN: Thank you, Chairman. Thank you for testifying. Is this going to affect a lot of doctors you think or do you have any idea? [LB406]

SENATOR COOK: There will be a testifier behind me, from the Nebraska Medical Association, that would have maybe a clearer idea of the numbers of physicians that it would impact. But I think in our environment, with people serving in the military and people reentering the work force, whether it's for an economic reason or family reason, it would be useful for us to have this. [LB406]

SENATOR WALLMAN: Okay, thanks. [LB406]

SENATOR CAMPBELL: Any other questions? Seeing none, thank you, Senator Cook. [LB406]

SENATOR COOK: Thank you. [LB406]

SENATOR CAMPBELL: Opening for the proponents. How many people, other than Mr. Buntain, want to testify on this bill? No other testifiers? Mr. Buntain, proceed. (Laugh) [LB406]

DAVID BUNTAIN: So how much time do I have? (Laughter) [LB406]

SENATOR CAMPBELL: You don't get extra. [LB406]

DAVID BUNTAIN: We had eight people lined up but I told them to go home. (Laugh) No. I'm David Buntain, B-u-n-t-a-i-n. I am an attorney and the registered lobbyist for the Nebraska Medical Association. And we want to thank Senator Cook for introducing this bill. As she explained in her opening, we were asked by the board of examiners in medicine and surgery, I guess we don't call them the board of examiners anymore, the Board of Medicine and Surgery to be of assistance in getting this legislation drafted and introduced. And it is based on a similar law that was enacted in Colorado last year. There has been discussion between the Medical Association and the board of examiners in recent years concerning the phenomenon of physicians who have left the work force and are wanting to return. I think the most typical example would be women who have left to raise children and have made a decision that they don't want to practice medicine, and then they reach a point where they want to come back and the issue is, what do we do to assure that the returning physicians are competent? And I would say that the board of examiners has been managing this issue on a case-by-case basis. And they viewed the Colorado law, as reflected in LB406, as providing a mechanism that would allow them to supervise the reentry so that it's not a question of, are you fully licensed or you don't have a license? But it's really a transitional license to allow for supervision and also for requirements if necessary. I will mention to you that when we first were asked to do this, I did circulate an e-mail to representatives of the other professions to see if this is an issue with other professions. And we were advised that it was not. And I can't explain why that would be. But clearly, it is something that other professions could do as well, if there is a need to do it. So I think Senator Cook's explanation is excellent. I'd be happy to respond to any questions. [LB406]

SENATOR CAMPBELL: Questions that you might want to put forward? I don't have any questions, Mr. Buntain. Oh, I'm sorry. Senator Howard. [LB406]

SENATOR HOWARD: Well, it's just an observation. Thank you, Madam Chairperson. Dr. Schaefer is in support of this? [LB406]

DAVID BUNTAIN: Correct. I believe so. We understood the department would be submitting a letter. But I'm not... [LB406]

SENATOR CAMPBELL: (Exhibit 22) Yes, we do. [LB406]

SENATOR HOWARD: Yes, she did submit a letter and she's in support, which I always appreciate. [LB406]

DAVID BUNTAIN: So do we. [LB406]

SENATOR HOWARD: (Laugh) I'm sure. Sure. [LB406]

SENATOR CAMPBELL: It seems to be a pretty straightforward bill. And certainly, Dr. Schaefer's letter is always welcome. So thank you, Mr. Buntain. [LB406]

DAVID BUNTAIN: Thank you. [LB406]

SENATOR CAMPBELL: Senator Cook, would you like to close on your bill? She waives closing. Smart woman. We will now proceed to the last bill of the day. Senator Krist has for us LB481, to provide exemption from medical radiography licensure for auxiliary personnel and cardiovascular technologists. [LB406]

SENATOR KRIST: (Exhibit 23) Thank you. Good afternoon, Chairperson Campbell and fellow members of the Health and Human Services Committee. For the record, my name is Bob Krist, K-r-i-s-t. I represent the 10th Legislative District in northwest Omaha. I appear before you today--introduction and support of LB481, a bill I introduced on behalf of the Nebraska Hospital Association. And I have to tell you, this is the longest introduction I have had this year. LB481 in its original form amends the Medical Radiography Practice Act to allow different types of personnel within a healthcare facility to assist a licensed practitioner who specializes in cardiology or interventional cardiology in performing cardiac catheterization and cardiac electrophysiology procedures. Since the bill's introduction, however, several parties have come forward with concerns regarding that type of personnel should be able to qualify to assist a practitioner with these procedures and what duties exactly those workers should be able to perform. I had a meeting in my office with the Nebraska Hospital Association and Department of Health and Human Services, including Dr. Schaefer, and I'm happy to report that by communicating this way we have an amendment that you have in front of you today. This amendment simply removes all language regarding auxiliary personnel from the bill. It was decided that hospitals could effectively function without this language. With the adoption of the amendment, the bill would permit cardiovascular technologists to assist a licensed practitioner who specializes in cardiology or interventional cardiology in the performance of diagnostic and therapeutic procedures performed in cardiac catheterization and cardiac electrophysiology laboratories if the activities are performed under the personal supervision and specific verbal instruction of the licensed practitioner who is personally present in the room. The activities authorized by these changes to the act shall not permit cardiovascular technologists to make independent decisions or determinations when assisting the licensed practitioner in the performance of these procedures. Currently the act and its corresponding regulations define medical radiography as, and I quote, the application of radiation to humans for diagnostic purposes, including but not limited to adjustments or manipulation of the x-ray systems and accessories, including image receptors, positioning of patients, processing of films, and any other action that materially affects the radiation dose to the patients, unquote. The performance of cardiac catheterization and electrophysiology

procedures requires the use of fluoroscopic radiology or interpretive fluoroscopic procedures, which, as defined by regulation, means, and I quote, the use of radiation in continuous mode to provide information, data, and film or hard-copy images for diagnostic review and interpretation by a licensed practitioner as the images are being produced, end quote. Little Friday afternoon humor. The act and its corresponding regulations allows a physician to perform such procedures using fluoroscopic radiography but do not allow assistance from cardiovascular technologists in the activities described as medical radiography. Cardiovascular technologists should be allowed to perform tasks as specific directed by the physician, such as changing the C-arm--and I know you all know the machine, so--changing the C-arm, panning the table, raising or lowering the image intensifier, changing the image magnification, replaying captured images, changing the frame rate of image acquisition, changing the pulse rate of fluoroscopy imaging, and positioning the patient, provided the direction given by the physician are specific and the cardiovascular technologist makes no independent decisions, as if the cardiovascular technologist was an extension of the physician's arms. An example of an allowable activity performed under the personal supervision and specific verbal instruction of a licensed practitioner would be to change a dial on the control panel from X to Y. An example of an unacceptable activity would be if the physician asked the technologist to set the machine for a larger patient, because that would have required an independent decision or determination on the part of the assistant that he-slash-she has not been trained to make. Patient safety is greatly enhanced when trained persons assist the physician in cardiac catheterization and electrophysiology procedures. Cardiac catheterization and electrophysiology procedures should be allowed to be performed by a licensed physician who specializes in cardiology or interventional cardiology with the assistance of cardiovascular technologists. During those procedures, the cardiologist, when actively engaged in another aspect of the procedure, should be allowed to direct cardiovascular techs to adjust the patient or C-arm and other activities that do not require independent decisions or determination on the part of the assistant personnel. The proposed changes to the act do not modify the current statutory or regulatory requirements for administering radiation to the patient. Radiation is delivered only by the cardiologist during all cardiac catheterization and electrophysiology procedures. Given the high unlikelihood of a regulatory change from the Department of Health and Human Services, statutory change appears the only viable option. There are professionals who will testify who can explain the benefit of this legislation. I encourage you to direct any specific questions to those folks behind me, because I am all out of facts. (Laughter) [LB481]

SENATOR CAMPBELL: Questions? Senator Bloomfield. [LB481]

SENATOR BLOOMFIELD: Well, you certainly cleared that up. Thank you. That's no question. [LB481]

SENATOR CAMPBELL: That's it? [LB481]

SENATOR KRIST: Wanted to do that for you, Ollie (phonetic). Yeah. [LB481]

SENATOR CAMPBELL: Senator Gloor, welcome. [LB481]

SENATOR GLOOR: Thank you. Senator Krist, you did do that very well. And I've had to take a few good-natured shots because I introduce such technically complex healthcare bills that nobody can understand them, and they sail right through. And you will find, if you can get it out of committee, that's very true; nobody will challenge you in General File, so... [LB481]

SENATOR KRIST: I believe I've done all the due diligence and research I need to. I had the, as Dr. Schaefer said, all the rock stars in my office telling me and coaching me, so... [LB481]

SENATOR GLOOR: I do have a question... [LB481]

SENATOR KRIST: Yes, sir. [LB481]

SENATOR GLOOR: ...out of all that. And that is, so based upon all the folks you've had in your office and the work that's gone into this amendment, to the extent that you know, is there going to be anybody here that raises any significant objections to this? Okay. [LB481]

SENATOR KRIST: Oh. [LB481]

SENATOR GLOOR: This...not everybody is happy. [LB481]

SENATOR KRIST: No doubt. [LB481]

SENATOR GLOOR: Yeah. [LB481]

SENATOR KRIST: Yeah. [LB481]

SENATOR GLOOR: Not everybody is (inaudible). [LB481]

SENATOR CAMPBELL: You have a number of hands behind you. [LB481]

SENATOR GLOOR: Okay. Thank you. [LB481]

SENATOR CAMPBELL: Any other questions for Senator Krist--other than sending him to medical school? (Laughter) Okay. What we're going to do, and I know you've all been

waiting so patiently, but we're going to take a five-minute break to allow the staff... [LB481]

BREAK

SENATOR KRIST: Can I have 30 seconds to review where I was? [LB481]

SENATOR COOK: Oh, please. [LB481]

SENATOR KRIST: I'm kidding. (Laughter) [LB481]

SENATOR CAMPBELL: Don't...you're still...are you kidding? I was just going to look at the clerk just to make sure she still had you on the tape. [LB481]

SENATOR KRIST: Can I sit in my chair while we're doing this? [LB481]

SENATOR CAMPBELL: Of course. [LB481]

SENATOR KRIST: Thank you. [LB481]

SENATOR CAMPBELL: You may. I think that's one of the things that...oh. [LB481]

_____: There's four of us. [LB481]

SENATOR CAMPBELL: Okay. [LB481]

_____: Yeah. [LB481]

SENATOR CAMPBELL: We are ready to go. We will take the first proponent. How many people...did I ask? How many people wish to testify in favor of the bill? One, two, three, four--one, two, three, four. Okay. How many people wish to testify in opposition? One, two, three, four, five. Okay. And the neutral position? All right. Thank you for your patience. I think we're all going to concentrate a little better here. (Laughter) Go right ahead, sir. [LB481]

JEFF CARSTENS: (Exhibit 24) Okay. Madam Chair, members of the committee, my name is Jeff Carstens, J-e-f-f C-a-r-s-t-e-n-s, and I come before you today to support LB481 and would like to thank Senator Krist for introducing this bill. Patient safety is a primary focus of care both at Alegent Health, where I am the medical director of cardiology, and at all the hospitals in Nebraska. Exposure to ionizing radiation is one of the things that occur in a hospital setting as part of a patient's care that can put a patient at risk. It is my opinion and that of all the cardiologists that I have spoken to that this bill will allow us to provide the best care to our patients and will not increase the risk to

those patients. Briefly, what goes on in a cardiac catheterization laboratory: The patient is brought into the laboratory and placed on a table in a standard fashion--head goes in one direction, legs go the other direction--same every time; after that, we begin taking x-ray pictures. All of--everything that proceeds at that point is under the direct supervision and command of the physician. The position of the table, the position of the camera and the C-arm, the way the patient is moved is all under the direct supervision and direction of the physician. Delivery of radiation during the procedure is directly under the control of the physician. There's a pedal on the ground; you step on the pedal to deliver radiation. The person that steps on the pedal is the physician in every case. We have multiple safeguards in place in the catheterization laboratory to decrease exposure to radiation. That includes use of various things, like pulse fluoroscopy and digital imaging and a number of other things that are probably more technical than you really care to know about. There are also alarms that go off at regular intervals as the radiation is delivered to the patients. Everybody can hear those alarms, and they're aware of what they mean. During the case there are several different people that work in the catheterization laboratory: there are radiation technologists; there are cardiovascular technologists; and there are registered nurses. Radiation technologists have very specific training about use of radiation and radiation safety. Cardiovascular technologists also have training about the use of radiation and radiation safety. But in addition to that they have training about patient care, cardiac procedures, cardiac anatomy and physiology, pharmacology, and emergency procedures. RNs are the most patient-centered and have care around the care of patients and delivery of medications. Ultimately, everything, again, is under the control of the cardiologist. And in many hospitals across the state, including Alegent Health, the cardiologist has to be specifically credentialed in the use of radiation and take a test every two years to demonstrate that knowledge. LB481 allows us to continue to provide a high standard of care to our patients. It recognizes the training and certification of the cardiovascular technicians, many of whom were trained in our state. It meets the tenet of favoring the least-restrictive level of regulation consistent with the protection of public health and welfare without unnecessarily limiting access to care--and recognizing that it's the physician, who has training in radiation safety, has ultimate control. I've heard some mention that this should go through the 407 process. I was unaware of the 407 process prior to this, but I've heard about it in just about all the testimony that's occurred today. We do not feel that this is a 407 issue, in that this is not a scope of practice issue. The physician is the medical radiographer; the physician is directly responsible for the delivery of radiation to the patient and patient safety during these procedures. I'd be happy to take any questions. [LB481]

SENATOR CAMPBELL: Any questions from the senators? Thank you very much, Dr. Carstens, for... [LB481]

JEFF CARSTENS: Thank you. [LB481]

SENATOR CAMPBELL: ...your testimony today. The next proponent. Good afternoon. [LB481]

TIM NELSON: (Exhibit 25) Madam Chair, committee members, my name is Tim Nelson, T-i-m N-e-l-s-o-n, and I'm here to speak on behalf of Alegent Health in support of LB481. Thank you for allowing me to testify. And I'd also like to thank Senator Krist for introducing this bill for us. You have my statement in front of you, so I'm not going to reread that, but I would like to bring up a few points to sort of support what I've written and submitted. LB481 is intended to clarify the qualifications of the people that are assisting the cardiologist. As Dr. Carstens stated, he, or the cardiologist present in all of these procedures, is the only person to release ionizing rays; he is the only person to step on the fluoro pedal or to expose the patient to radiation. No other person in the procedure does that; no other person has the authority to do that, because it just doesn't make sense. The physician has to see the image, therefore he generates the image in the x-ray. It's for that reason that we consider the physician to be the medical radiographer in this case and the primary person responsible for radiation safety and for directing and manipulating the x-ray systems that expose the patient to radiation, that generate the images that the cardiologist uses to treat and diagnose those patients. That's our main point. LB481 is not intended to exclude any profession in the cardiac cath lab. In fact, it's meant to include other professions that participate in the cath lab. I've been in and around cath labs for about 30 years now, starting in 1979. And in my experience in working in cath labs and electrophysiology labs, there are a lot of different types of health professionals that work there. Registered nurses would probably be the largest group of professionals; but also cardiovascular technologists, radiologic technologists, paramedics, paramedic specialists, even respiratory therapists participate in cardiac cath lab procedures and are trained specifically for practice in cath labs. Once again, the physician being the primary leader of that whole team, but other people from a lot of different allied health professions cross-train to provide care in the cath lab. From the standpoint of including other professions in the cath lab, this makes it a whole lot easier to staff for those emergency-type procedures. Cath lab staffs are always on call, 24/7, to provide emergency care for heart attacks and other emergency types of procedures that come in. And in order to do that, you have to have at least three people on call every single night. If you were to follow one interpretation of the current regulations that states or that kind of goes by the guidelines that the person assisting the physician has to be a medical radiographer also, this really limits the staffing profiles that you're allowed to put down for staffing those on-call teams and even for day-to-day operations, because there just aren't enough of those people around, and it reduces the flexibility. By including other professions in that particular role assisting the physician--who, again, we're identifying as the primary medical radiographer--you greatly expand the flexibility of staffing and you greatly expand the ability to provide those services in some of the smaller communities throughout Nebraska. Point number three is patient safety. Patient safety is extremely important in any clinical setting. In the cath lab, radiation safety is really just one aspect of patient safety. And I don't want to

minimize that, but the other aspects are directly related to the patient's reaction to the different catheter manipulations, the different drugs that go on, the different techniques involved in opening up coronary arteries, etcetera, etcetera. There is a lot to consider, as far as patient safety goes, in the cath lab. In my 30 years working around cath labs, I can tell you that the equipment and techniques have improved dramatically, to the point where in the last ten years the equipment has been simplified to the point that it provides a lot of safety measures that are built into the equipment, that won't let you exceed certain parameters. Regardless of that, I've never seen, in 30 years, I've never seen a cardiologist stop a procedure because he was concerned about radiation exposure to the patient. The risk is--in relation to the many other risks involved in the procedures, the treatments, and the diagnoses, the risk of radiation exposure is one of the--is minimal, compared to the other risks that that patient goes through. And I don't want to minimize radiation exposure, but relatively speaking, it is less of a risk than some of the other things that are going on in the cath lab. And for that reason the cardiologist in his or her judgment has to weigh that risk of radiation exposure to the risk of the other things that are going on, in order to complete his treatment of coronary artery disease or the other things that go on in electrophysiology labs. It's one consideration. It's not the only consideration; it's just one consideration. [LB481]

SENATOR CAMPBELL: So we probably need to go to questions. [LB481]

TIM NELSON: Okay. [LB481]

SENATOR CAMPBELL: I should have gone through the light system, because all of you are probably new. You have five minutes. And it's green for four and then yellow for one, and then it's going to go to red. And we try to...you'll look up, and you might see me doing that. We try to let people finish, but I wasn't quite sure where you were. So I'm going to stop right there and see what questions...Senator Wallman, I thought you had a question. [LB481]

SENATOR WALLMAN: No. No. [LB481]

SENATOR CAMPBELL: Okay. Senator Gloor. [LB481]

SENATOR GLOOR: Thank you, Senator Campbell. Dr. Nelson... [LB481]

TIM NELSON: I'm not a doctor. [LB481]

SENATOR GLOOR: Okay. [LB481]

TIM NELSON: Thank you. (Laughter) [LB481]

SENATOR GLOOR: You made a comment--I'm not sure what it's based upon; is it

because you're a tech that serves in a cath lab? [LB481]

TIM NELSON: I'm a--my title is operations leader; I am in charge of the cath labs at Alegent Health. [LB481]

SENATOR GLOOR: Okay. Well, the...and I'm going to have to paraphrase it, because I wasn't able to write it all down--but in your 30 years you had never seen a case where a cardiologist stopped a case because of concern about radiation exposure. [LB481]

TIM NELSON: Yes. [LB481]

SENATOR GLOOR: And so my story to you would be, in my 30 years as a hospital administrator, I had staff come to me concerned because cardiologists weren't easing up when they were doing fluoro on a procedure. And so therein lies my problem with this, and that is, my experience is cardiologists, God bless them, are so focused on the cardiac procedure that their primary focus isn't the dosage. A radiologist, on the other hand, is trained in the issues around the dosage. And I would get grief from radiologists on occasion of the need to upgrade equipment so that they could image with even lower doses. There's my predicament with what's being talked about here, is I do trust the radiologist to have as a primary focus. Not sure about the cardiologist--not that they don't have an interest, but it's not their primary focus. Can you help me get over the hump on that concern? [LB481]

TIM NELSON: Yes, I can. First of all, the huge majority of cases that are done in cardiac and EP labs fall well within the guidelines of fluoro time limits, which are 30 minutes or 120 minutes, depending upon facility or even states. But the ones that exceed those, what are considered kind of standard time limits, are ones that are really difficult cases. So for instance, a cardiologist is putting in a biventricular ICD, a pacemaker that delivers a shock to shock patients out of a lethal rhythm. He's in the middle of the procedure; he's trying to place the CS lead, which is a lead that goes into a coronary sinus vein that's a really, really difficult vein to access. Well, he's already got the patient's pocket open to--an incision made; he's already got a couple of other catheters in place; he just needs to get that last lead in place. It takes forever. And I've seen it--I've seen the fluoro time go up to, you know, 100 minutes, 120 minutes. But the cardiologist still persists, because it's so important to get that device in the patient that for him to abandon the patient because of a potential radiation burn...and I personally have never seen a radiation burn, but a potential radiation burn far outweighs the risk of that radiation exposure. So that's why they persist. Then, you know, Dr. Carstens is an interventional cardiologist. If he's in the middle of treating a patient who's come in with an occluded coronary artery, in the middle of a heart attack, he's not going to give up because the fluoro timer keeps going off and off and off. He's going to keep persisting until he can get that artery open. [LB481]

SENATOR GLOOR: But we're going to let him supervise this technician who's doing this procedure... [LB481]

TIM NELSON: Well, he--actually, Dr. Carstens is not...the technician is not doing the procedure either. The technician is helping him pass catheters, move the patient underneath or over the x-ray tube, position the patient appropriately so Dr. Carstens can look at the images that he's requesting of the technician. [LB481]

SENATOR GLOOR: From a technology standpoint, to what extent do we think, across the state, that there are imaging labs, cath labs, interventional labs that have equipment that can minimize the degree of risk? I mean, I recognize the fact that we've come a long way with--and I don't even remember all the terminology anymore--pulse beams and other things that can reduce and make it much safer regardless who's operating that. But is that true only in institutions like Alegent? Or is it pretty commonplace that that equipment has gone in, in most labs across the state? [LB481]

TIM NELSON: It's very commonplace. Pulse fluoroscopy has been around since about 1989. And most cath labs are ten years old or newer. [LB481]

SENATOR GLOOR: Okay. Thank you. [LB481]

SENATOR CAMPBELL: Other questions? [LB481]

SENATOR COOK: I have one question. [LB481]

SENATOR CAMPBELL: Senator Cook. [LB481]

SENATOR COOK: Thank you, Madam Chair. Mr. Nelson, can you tell me the salary and rate of pay? Is there a market difference between those of radiologic techs or other medical radiographers versus the other trained professionals such as the cardiovascular technologist? Are the latter cheaper? [LB481]

TIM NELSON: The...in our organization, cardiovascular technologists and the rad techs are at the same pay scale. [LB481]

SENATOR COOK: Okay. [LB481]

TIM NELSON: Now, there...I'm...in the cath lab they are in the same pay scale. I believe rad techs have different pay scales depending upon their qualifications and which specialty they work in. But I can't speak for other organizations--just ours. [LB481]

SENATOR COOK: All right. Thank you. [LB481]

TIM NELSON: And RNs are at a higher pay scale. [LB481]

SENATOR CAMPBELL: Do you have a follow-up, Senator Cook? [LB481]

SENATOR COOK: No. [LB481]

SENATOR CAMPBELL: Okay. Mr. Nelson, my question: Alegent has certainly a number of hospitals in its system. Does it have rural satellites that it serves? [LB481]

TIM NELSON: No rural cath labs. [LB481]

SENATOR CAMPBELL: No rurals. Okay. [LB481]

TIM NELSON: Yeah. [LB481]

SENATOR CAMPBELL: Because I--if I was listening very carefully to your testimony, you talked about that sometimes in a rural situation it's hard if you need more people to bring in and you don't have all that staff. And I was just trying to figure out--if you had that, I was going to ask you some more questions. But there may be somebody who's coming up who can help with the rural question portion. [LB481]

TIM NELSON: I may be able to speak on that. [LB481]

SENATOR CAMPBELL: Okay. [LB481]

TIM NELSON: As we were preparing for this, we did a survey of the 20 to 22 cath lab departments across the state. And you can imagine they range in size from one cath lab to systems that have up to six. So in talking with the managers or leads or supervisors in those cath labs, really there were only two that we could identify that actually could provide the complete staffing pattern as required by the current regulations--the one interpretation of the current regulations. So most people were using people that were interested in working in the cath lab, more specifically RNs. There were some that were RNs only and maybe one rad tech, which means that that rad tech might have to be on call every single night, if they were to, you know, abide by that particular staffing pattern. So those are the types of situations you run into. [LB481]

SENATOR CAMPBELL: And just on a personal note, Mr. Nelson, a number of years ago I was privileged to follow along with a cardiac surgeon on a follow-along program. I got to sit in a cath lab. And I, I mean, I will just never ever forget that experience. I was just overwhelmed by all the equipment and all that was going on and how far we've come in helping people save lives. It was amazing. [LB481]

TIM NELSON: It's pretty awesome. [LB481]

SENATOR CAMPBELL: It is. Thank you very much for your testimony today. [LB481]

TIM NELSON: Thank you. [LB481]

SENATOR CAMPBELL: Okay, the next proponent. [LB481]

JOSEPH ADAMS: Good afternoon. [LB481]

SENATOR CAMPBELL: Good afternoon. [LB481]

JOSEPH ADAMS: My name is Joseph Adams, J-o-s-e-p-h A-d-a-m-s. I'm a registered cardio-invasive specialist, a certified electrophysiology specialist. I work here in Lincoln. I've been at this since 1972, so I've seen the whole gamut of--from going from the old x-ray machines that had the cradle and a fixed-image plane to what we now have as C-arms, L-arms that are less crude than what we had before. The radiation has been decreased by I'd say over 40 percent to 50 percent of what we used to give people. As a cath lab manager and tech and working in EP, where we do the longest procedures of any of them...and the question came up: Have you ever seen anybody stop a procedure? Yes, we have. And that's my job. When the physician gets there and says, we need to do it more. No, you can't go anymore; we've already reached the limit; we can bring them back. For ablations: if you're going after a bypass track, something that is interrupting your heart rate or making you go fast--bring them back the next day, complete the procedure. But give some rest to that period; bring them back a week later and finish the procedure. When we talked about bi-V ICDs earlier: our norm for a bi-V ICD is only about 45 to an hour nowadays. When we first started putting them in, it could be five hours for somebody to get in and see us. But as the equipment changed, the techniques change; it's become easier and faster. I do hire rad techs, RTs, CVs, and nurses. That is what we're made of. That's kind of our mix, because everybody brings a little bit different to the table. But I went to school to be an RCIS, or at that time a registered cardiopulmonary technologist. We talk about education about fluoro safety of patients: I had that. That's what we're trained to do. And that's what we're looking at now. When I train somebody in my lab, we not only train them about patient care procedures but radiology, the aspects of it, the safety of it, patient safety, your own safety--because you're doing it every day; the patient is only there once or twice. That's what you have to look out for is yourself and your people that are around you, all the time. Imaging machines nowadays--they're digital. They have, basically, large patient, small patient, and baby. You push a button: it sets your technique up for you. There's no longer dialing up kVs or dialing down kVs; they don't even put them on the machine--you can't do it. You can change your fluoro from large to small or a baby. So they're all preset from the factory. When you come in and set up a machine, you tell them exactly what you want, what kind of patients you're doing; and they preset them up. We have a physiologist that come in and check our machines all the time. The

states come in and checks our machine to make sure we're doing everything right and that we're not exceeding the limits that we've put on our machines. I am in support of the bill. I would also support licensing, because I think that's the next step. And right now in Congress there is a imaging bill that all our governing bodies have agreed to support. That means the radiology; CCI, from the cardiology side--everybody is supporting that bill. We're trying to get it through Congress. And it addresses what we're talking about right now, about who can do imaging in specific instances. Any questions? [LB481]

SENATOR CAMPBELL: Questions? Senator Bloomfield. [LB481]

SENATOR BLOOMFIELD: Thank you, Madam Chair. The machines you talk about that you work with--what are the odds of our smaller outstate hospitals having that same technology, or are they going to be using something a little older? [LB481]

JOSEPH ADAMS: Let's say Grand Island--they are getting the newest and greatest machines. You...the basis...I work at a hospital system, so we have three hospitals in Nebraska, and that's one of the things that you do. Probably the place that has the oldest equipment here right now is the Heart Institute. Most of us have digital imaging, flat-plate panels. [LB481]

SENATOR BLOOMFIELD: Okay. So someplace like Scottsbluff or Wayne... [LB481]

JOSEPH ADAMS: Scottsbluff doesn't have a... [LB481]

SENATOR BLOOMFIELD: Scottsbluff doesn't have anyplace... [LB481]

JOSEPH ADAMS: North Platte has a brand-new lab. [LB481]

SENATOR BLOOMFIELD: Okay. What about Wayne? [LB481]

JOSEPH ADAMS: Wayne doesn't have one as I know of. [LB481]

SENATOR BLOOMFIELD: Okay. [LB481]

JOSEPH ADAMS: Norfolk got a brand-new lab. [LB481]

SENATOR BLOOMFIELD: Okay. [LB481]

JOSEPH ADAMS: Any other questions? [LB481]

SENATOR BLOOMFIELD: No. [LB481]

SENATOR CAMPBELL: Mr. Adams, you just said who you worked for, and I missed it. [LB481]

JOSEPH ADAMS: I did not say who I worked for. (Laugh) [LB481]

SENATOR CAMPBELL: Oh, I'm sorry. And you don't have to. [LB481]

JOSEPH ADAMS: No. [LB481]

SENATOR CAMPBELL: You don't have to. [LB481]

JOSEPH ADAMS: Because I'm not representing my facility. [LB481]

SENATOR CAMPBELL: I understand. [LB481]

JOSEPH ADAMS: I'm representing myself. [LB481]

SENATOR CAMPBELL: You're representing yourself. [LB481]

JOSEPH ADAMS: Yeah. [LB481]

SENATOR CAMPBELL: Absolutely. Any other questions from the senators? Thank you, Mr. Adams. [LB481]

JOSEPH ADAMS: Um-hum. [LB481]

SENATOR CAMPBELL: Next proponent for the bill. Good afternoon. [LB481]

BRUCE RIEKER: (Exhibit 26) Good afternoon. [LB481]

SENATOR CAMPBELL: Mr. Rieker. [LB481]

BRUCE RIEKER: My name is Bruce Rieker, B-r-u-c-e R-i-e-k-e-r, vice president of advocacy for the Nebraska Hospital Association. And I wasn't intending to testify, but I wanted to add just a little bit to the scope of the agreement to what we have put together between the original legislation and the amendment that Senator Krist offered today. But before I go into that, one, I learned something as a lobbyist today--that there are no time limits on the senators. And he did such a good job of reading everything that I wrote (laugh) for the introduction. [LB481]

SENATOR CAMPBELL: There's no more time for you, sir, I'm sorry. [LB481]

BRUCE RIEKER: Yeah. Yeah. My time is gone now, huh? Second, on a personal note,

I have been in a cath lab. And I was one of the patients where they actually stopped the procedure, backed up, and restarted it. So I have been in one where the cardiologist said: This isn't working, and so let's back away and start again. I cannot tell you who all were medical radiographers and technicians and cardiovascular techs; so I can't tell you the scope of the people in the room. But I do know the cardiologist called it off, and three hours later we tried it again, and it worked that time--so personal experience. The only thing I want to add to this is that appreciate the testimony that has been given so far; it's been excellent. Other facilities that have been part of this process, that have signed off, that have agreed to what we've put together are BryanLGH, Methodist Hospital, Good Sam out in Kearney, and the Nebraska Med Center. So all of those facilities have been part of the discussion about where we've gotten to as of today and want to make sure that you know that there are other facilities involved who agree with what we're doing. [LB481]

SENATOR CAMPBELL: Questions for Mr. Rieker? Thank you very much. Next proponent. Seeing none, we'll go to the opponents for the bill. First testifier. [LB481]

ALLEN DVORAK: (Exhibit 27) Good afternoon. Senator Campbell, I hope this doesn't--what's counting on my time already. You're running it green. I want to compliment you for having everybody stand up and take a break; I was afraid you were all going to get blood clots (laughter) and that I was going to have to do some deep venous Doppler ultrasound on each of you. [LB481]

SENATOR CAMPBELL: I'll give you some latitude at the end. [LB481]

ALLEN DVORAK: So give me a little extra time, please. [LB481]

SENATOR CAMPBELL: You bet. [LB481]

ALLEN DVORAK: My name is Dr. Allen Dvorak, A-l-l-e-n D-v-o-r-a-k. I'm here as a citizen of the state of Nebraska. I am also here representing the Nebraska Radiological Society. And if someone could pass these out, I would appreciate it. By the way, I'm not going to refer to what is in the two-page statement; I know you're all capable of reading that. What I'm going to talk about, Senator Gloor...I think I probably am the oldest person testifying. I was keeping track; and, Mr. Adams, you're close, but I think I win. I've been in radiology since 1970. And what I'm going to talk about--Senator Gloor, you'll understand this, because you and I are both of the same vintage; but you're younger, of course, than I am. But I'm going to talk about three things which all of you on the Health Committee understand. And those things are safety...or, pardon me, let me--it's quality. Quality. And I'll equate it to safety; one of the other testifiers will talk about that. Access, which I will talk about. And I'm also going to talk about the third leg on the stool that we always talked about: the cost. Because I think those are vital issues to this. And I think this is a very important topic that we are dealing with. As a physician practicing in the

state of Nebraska for over 40 years, I am an advocate for each one of you, for myself, and for the people that we take care of. And that means I want quality healthcare for each one of you and everyone in our state. My life has been devoted to that, and I assure you that that's why I'm here. By the way, I'm a pinch hitter, Senator Campbell. I just--I wasn't supposed to be here, by the way. But one of the colleagues who was going to testify--he had to work. I'm kind of semiretired, so they called me; so that's why I'm here. So you're not getting--I'm not a rock star, I'll tell you; I'm a good utility infielder, though. And I'm here to talk about quality. And I think quality...somebody mentioned a bus earlier today, I think it was one of the other testimony people: having the right people on the right bus doing the right thing--a book was written about that, I think. What I say is, for quality we need to have the right procedure being done for the right indication by the right, appropriately trained physician--cardiologist who's had interventional cardiology training. They need equipment, Senator Gloor, that the administrators and the board can afford. But the personnel that are helping must be appropriately trained; they must be credentialed; and they must have licensure. I agree with the third speaker, Mr. Adams. These people should be licensed. And I think--be happy to address that if any of you have questions. Attitude--I always put down attitude, because I think it's all about attitude. I'm going to invoke some legends here, so get ready. Bob Devaney. And who followed him? Tom Osborne and Bo Pelini. We're not the rock stars; we're the people that are doing the blocking and tackling. The radiologic technologists are those people. We need a quarterback, and the cardiologist clearly is the quarterback; there is no question about that. I was disappointed to hear the second person testifying saying he had never seen a procedure stopped in 30 years. Wow. I'm glad to hear others have stopped procedures, because there are reasons to stop procedures, aside from radiation safety. I'm not going to talk a great deal about radiation safety. One of the following people will talk about it, so we're not going to repeat the same things. I can't believe I'm almost done. Let me tell you about access. There is no problem with access. We have a work force that can handle any problem throughout the state. We have an oversupply of certain areas. And let me talk about cost. When I look at cost, I talk about teamwork. I think--I agree completely with Mr. Adams. It is a teamwork game that we're in. I know we need a rock star; I know we need a quarterback. But I'll tell you, if you don't have the people blocking and tackling, he's going to be sacked every time. And I was very pleased to hear Mr. Adams talk about that's why you have a trained, licensed person in the room. When the cardiologist is so intent on getting into an orifice of a vessel, he or she cannot be thinking about taking their foot off the pedal. It's interesting that none of these people have ever seen a radiation burn; it only takes about 20 to 30 minutes of fluoroscopy to result in erythema on the skin. One of the people following will show you some other things. The reason we don't know about the side effects: people aren't looking for them. There is an institution in Omaha that when they hit the 30-minute number, they make sure that they bring that patient back. You'll hear from another speaker about all effects of radiation aren't immediate; you know, we're not going to glow in the dark. There are mid- to late and latent things. You'll hear more about that, so I'm not going to talk about...I want to

close in thanking each one of you for your patience. I applaud you for listening to this, and I applaud you for your carefully considering this. We need to have, above all, quality healthcare in the state of Nebraska, done by the right people, appropriately trained, appropriately licensed. The statute on the book is very clear right now. I don't know if there are institutions that are out of compliance. You and I are not the people that check those things. But I think it is important, Senator Gloor, as you pointed out, that these pieces of equipment be periodically examined and looked at on a regular basis; that's not part of this legislation. Thank you for listening to me. You can tell I'm not passionate about caring for patients in Nebraska. I'd be happy to answer any questions. And I'd like to follow up on a couple of the comments that were made; I have another point of view on some of those. [LB481]

SENATOR CAMPBELL: Questions? Senator Bloomfield. [LB481]

SENATOR BLOOMFIELD: I'd like to hear that follow-up. [LB481]

ALLEN DVORAK: Well, I'm glad... [LB481]

SENATOR BLOOMFIELD: As long as it doesn't go too long. [LB481]

ALLEN DVORAK: No, it won't. It's...you know, you live up in northeast Nebraska... [LB481]

SENATOR BLOOMFIELD: Yes. [LB481]

ALLEN DVORAK: ...you mentioned. You don't have a problem there, you know. Every one of you...and I looked to see where you're all from. We got three Omaha people, a Lincoln person, Cortland. Every one of you are within, I don't know, 30 or 40 minutes of a cath lab. If you're in Omaha, you're within 5 minutes of a cath lab. They're all over the place. So access is not an issue. Manpower is not an issue in this state. I would like to ask Mr. Adams, and I know that's--I can't ask questions; you can. But are there any active training programs going on in the state for cardiovascular technologists? There are six in our state training radiologic technologists; the output is about 80 per year. There is no work force issue. Did that answer your question? Senator Cook, I think you had--did you ask a question? [LB481]

SENATOR COOK: No, sir, I did not. (Laughter) [LB481]

ALLEN DVORAK: Senator Gloor, I want to come back to... [LB481]

SENATOR CAMPBELL: I know we're going to keep this really short here. [LB481]

ALLEN DVORAK: Yeah. But I want to--I just want to, if I could, this issue about

equipment...I've been...and, oh...I didn't...two...yeah. There are two myths. That what you can't see, feel, hear, taste, or smell can't hurt--that is a myth. The fact is, what you can't see can hurt you. If people are standing there with their foot on the pedal...and I don't want the cardiologist to be thinking about his foot on the pedal. And the second myth is that everything is automatic. Things break down. You need a human; you don't need Watson, a computer, there to tell you that something is broken down. We need trained...there's nothing better than the human to modify all this. And I applaud what the proponent Mr. Adams said. He's right on. That gentleman has his, pardon me, stuff together. [LB481]

SENATOR CAMPBELL: Mr. Dvorak, you can always follow up with us in a letter on any... [LB481]

ALLEN DVORAK: And I would want you to feel free to contact... [LB481]

SENATOR CAMPBELL: ...on any comments that you'd like to make that we didn't cover today. [LB481]

ALLEN DVORAK: Yeah. [LB481]

SENATOR CAMPBELL: But I really am going to move on... [LB481]

ALLEN DVORAK: Oh, and I... [LB481]

SENATOR CAMPBELL: ...because of the time. [LB481]

ALLEN DVORAK: ...again, I appreciate your taking the time to listen. [LB481]

SENATOR CAMPBELL: Right. I'm watching very nervous testifiers out there who want to get up in that chair. [LB481]

ALLEN DVORAK: Thank you all for staying this late on a Friday. [LB481]

SENATOR CAMPBELL: Thank you. Next testifier. Good afternoon. [LB481]

DAN GILBERT: (Exhibits 28, 29) Good afternoon. My name is Dan Gilbert. I am the--that's G-i-l-b-e-r-t. I'm the program director at Regional West Medical Center School of Radiologic Technology in Scottsbluff. And there is a cath lab there. I am appearing today before you in opposition to LB481. I think that one of the major issues that we have with this bill is the disrespect that appears for the risks of radiation. Cardiac catheterization is the one area of radiology that presents the highest level of radiation to individuals. I gave you all a copy of some images that I pulled off of the Internet--showing you different examples of what happens with excessive radiation. And

you can see the first example there is a hair loss. The second one is erythema that has also caused some major burning of the skin. And then the succeeding ones are, actually, situations where the damage has been so severe that the skin is actually necrosed and will not regrow; and it actually took a skin graft from a different part of the body to fill in that spot because of the significance of burning that happened from that. Now, this doesn't happen in every cardiac case, and in the majority of the time it doesn't happen. In fact, one reference that I had--it was said 1 in 10,000 walk away with a burn. The point is, is that we are increasing the complexity of the exams that we're doing. The simple cases of simply putting in a stent and then walking away is not what's happening these days. It's becoming more and more complex. The amount of time that's spent actually doing the procedure, with the foot on the switch, is increasing. And as we increase the number of exposures, then we increase the risk of these types of events happening. Nobody wants that to happen, and we're all in agreement there. The issue at hand is--is making sure that the people who are in the cardiac cath lab are recognizing the risks of the radiation and there's somebody in there who has been adequately educated to say: You need to take your foot off the switch; we need to change the position of the tube; we need to reset the technique; this technique is not working for this patient; does everybody in the room have lead on? If there is not somebody in there taking care of both the patient and the people in the room, in terms of thinking about radiation protection, then we increase the risk of harm to those people in the room. And it's not just the patient who gets harmed. The other issues that occur from excessive radiation can be sterility, can be a depression of blood cells. Long-range damage includes increased risks of cancers, increased risk of cataracts, possibility of genetic damage that will be carried on to future generations because of excessive radiation. So it's not an issue of who should be doing this; it's--what the issue is, is who is adequately educated to do this? Who can take that step and say, we need to think about reevaluating what we're doing here? We...it's hard to--for all of us to think about the units of radiation. So what I tried to do in the handout I gave you is to equate a regular diagnostic cath lab to about 300 chest x-rays. But when you get up to some of the treatments, you're talking about 1,500 chest x-rays or more. And it's the dose--cumulative dose over a period of a person's lifetime that increases the risks of cancers, increases the risk of cataract formation. Oftentimes a burn doesn't show up for three or four weeks after the cardiac event. And then nobody's thinking about this came from a radiation exposure--it's an insect bite; it's a chemical burn; it's a drug reaction. So we just need to be really careful about using radiation, you know, the way we do things. It's not something to take lightly. And, thankfully, we don't have a whole lot of experiences like the pictures I showed you. But we need to prevent those from increasing. I'll be glad to answer any questions anybody has. [LB481]

SENATOR CAMPBELL: Any questions for Mr. Gilbert? Senator Gloor. [LB481]

SENATOR GLOOR: Thank you, Senator Campbell. Mr. Gilbert, thank you for a long trip to make testimony. One of the predicaments that this committee seems to have when

people talk about--and I'll use this term in a very general way--expanding the scope of what individuals can do is, technology has changed, and the technology as a result of that change allows us to look at people's ability to handle something that perhaps they couldn't handle before. And it comes up all the time. My question would be, as relates to the whole area of imaging...and Dr. Dvorak will get a chuckle out of this, but when I first started in healthcare many years ago, radiation therapy consisted of a lead box with a radium source inside. And you lifted the lid and exposed it, and then your step-down was you closed the lid a little bit and a little bit more. And, you know, that wasn't real sophisticated technology, and you for sure wanted somebody who knew what they were doing that could figure things out in terms of the dosage when you were doing that. Now we don't do anything like...I mean, it's humorous when we think about it; that was considered state of the art. Now we have people who get involved in linear accelerators and whatnot, highly trained folks. We put fail-safe after fail-safe after fail-safe, because we know not only could they have burns, we could kill them. To what extent does technology, maybe, have stepped up to the point now where all the things that we're really concerned about--in fact, they're on a fail-safe, so that maybe people who are less trained are in a position to take direction from another professional to do these things? It's a question poorly formed... [LB481]

DAN GILBERT: Yeah. [LB481]

SENATOR GLOOR: ...but... [LB481]

DAN GILBERT: I think that one of the major things that we need to think about is a minimum level of education in terms of radiation protection. And regardless of what kind of equipment we have, there's always that possibility of failure. And, hopefully, a person who has had adequate education is going to be able to pick that up. We don't--we cannot just simply say, you push this button to get the big patient and this push the middle-size patient and this button to push the small patient, because that's too general. And we need not to think about it from that standpoint. We need to think about what is going to work best in every situation. One of the things that has happened recently in radiology is we've gone to digital radiography. And so everybody says: Well, this is the solution to everything; all you have to do is just push this button and the machine comes up, and if the technique is not right you just adjust it a little bit and the problem is solved. The problem is not solved, because now what can happen is, is that somebody can go in there and push the button and it'd be wrong, they adjust it and we've overirradiated the patient. And because the person who is running the machine doesn't know that or doesn't--didn't have the education, they spend their entire career overirradiating somebody. And nobody ever corrects them for it, because the equipment, that fail-safe, makes sure that you end up with an adequate image, but it doesn't necessarily protect the patient. [LB481]

SENATOR GLOOR: Okay. Thank you. [LB481]

DAN GILBERT: Sure. [LB481]

SENATOR CAMPBELL: Any other questions? Thank you very much, sir. [LB481]

DAN GILBERT: Thank you. [LB481]

SENATOR CAMPBELL: Next testifier. [LB481]

BRANDON HOLT: (Exhibit 30) Good afternoon. [LB481]

SENATOR CAMPBELL: Good afternoon to you. [LB481]

BRANDON HOLT: I would like to take this opportunity to thank you all for letting me address you today. My name is Brandon Holt, B-r-a-n-d-o-n H-o-l-t. I'm a medical radiographer and currently serve as the board chairman for the Nebraska Society of Radiologic Technologists and also serve as a board member for the Department of Health and Human Services medical radiography licensing board. I'm also a faculty member in the radiography program at Southeast Community College here in Lincoln. The testimony I will be delivering today reflects my opinions as an educator and a radiographer but does not necessarily represent the position of Southeast Community College. It is my opinion that, if passed, LB481 will cause harm to the public seeking medical care. Providing an exemption from Medical Radiography Practice Act under any circumstances is something that should be approached cautiously. Medical radiation is ionizing, meaning that it has the ability to cause biological changes in the structures with which it interacts. The entire premise of medical radiography is based on the ability of the human body to absorb a specific amount of radiation to allow for the formation of an image. Having a keen understanding of how to properly select technical factors has an impactful bearing on how the image will be created, the quality of the image created, as well as how much radiation dose is delivered to the patient. The practice of delivering radiation is much more complex than simply pressing a button. It is important for those delivering ionizing radiation to have an understanding of how the radiant energy is created, how it will interact with the body, and its physiological effects on the anatomy being irradiated. I respectfully ask that the Health and Human Services Committee carefully consider the long-term effects that this exemption will fabricate and vote against this measure for the good of the public. The progression of fluoroscopy over the years has warranted the need for an increase in education of older and newer styles of fluoroscopy. Changes in fluoroscopic technology are occurring, and there is a need for individuals to be up to date on the best safety practices for fluoroscopy uses and dose. Radiography programs spend a tremendous amount of time providing students with the educational information needed regarding image-intensified fluoroscopy, charge-coupled devices, and flat-panel image receptor fluoroscopy, or what we know now as digital fluoroscopy. Digital fluoroscopy has not completely been proven to

decrease the patient dose in any applications. Trends do show that dose reduction is possible under the proper operating conditions--for example, pulse-progressive fluoroscopy mode. There is still a need for technologists to understand interrogation time, extinction time, and duty cycle when operating the fluoroscopic equipment. Radiography programs ensure that the curriculum is comprised of the most up-to-date fluoroscopy practices for current and future students. Licensed medical radiographers are required to obtain continuing education, which allows them to be informed of newly emerging techniques and procedures. The mandated curriculum, as identified by the American Society of Radiologic Technologists and tested by the American Registry of Radiologic Technologists, has identified the need for students to be knowledgeable in the following components as they relate to medical imaging and fluoroscopy. I'll let you guys kind of read through those yourself, in the interest of time. However, those above stated outlines a few of the concepts that are required to be included in the radiography curriculum. Students and radiographers must have and maintain a comprehensive understanding of patient dose, patient protection practices, radiobiology, pathophysiology, anatomy, physiology, physics, pharmacology, chemistry--the list goes on and on. Students and radiographers must also have skills in troubleshooting fluoroscopic equipment. There isn't a one-size approach to this; we have to be able to troubleshoot the equipment as problems arise. This is important in limiting patient and occupational dose. A few of the items radiographers and students must recognize include--and again that's listed there before you. And lastly, an understanding of patient and occupational radiation dose is extremely important when considering the effects of fluoroscopy. Medical radiographers are educated in all aspects of patient and occupational dose, especially safe administration of ionizing radiation and radiation protection techniques. Radiography programs spend a great deal of time teaching students about relative biological effectiveness and linear energy transfer, two key components that are needed when considering radiation dose. In closing...and then I also list some of the other important things: ALARA; time, distance, shielding; and the understanding of stochastic and deterministic radiation effects. In closing, it is my intent to voice what is best for the patient not the hospital's bottom line. Radiography students and radiographers have a wealth of knowledge in sciences, but they are also patient advocates and will continue to demonstrate the safest radiation practices for the public. Radiation is not a one-size-fits-all approach, even in spite of the equipment design. Whew. [LB481]

SENATOR CAMPBELL: Questions? [LB481]

BRANDON HOLT: Yes. [LB481]

SENATOR CAMPBELL: Any questions? [LB481]

BRANDON HOLT: Sorry, it's a first time for me. (Laughter) [LB481]

SENATOR CAMPBELL: You did fine. You were going pretty fast there. [LB481]

BRANDON HOLT: Did I talk fast? Oh, one thing I did: on the back I did just include some statistical information for you guys to review, if you want, regarding the effects of radiation. As kind of has been touched on up to now, the effects aren't immediately recognized. There is a latency period on some of these things. And some of those latency periods are one, two, and three decades before we even find out the effects of it in patients. So what's happening now may not be seen until 30 years down the road, so... [LB481]

SENATOR CAMPBELL: Okay. Thank you very much for your testimony today. [LB481]

BRANDON HOLT: All right, thank you very much. [LB481]

SENATOR CAMPBELL: Next testifier. How many other testifiers do we have? Okay. I did count right, then. Good afternoon. [LB481]

DENISE LOGAN: (Exhibit 31) Hi. My name is Denise Logan, D-e-n-i-s-e L-o-g-a-n. I am a registered radiologic technologist, multiple modalities, and medical radiographer. I'm currently working as a manager in radiology and radiation oncology and physics and formerly a health physicist for the state of Nebraska. I'm here today to represent the Nebraska Board of Medical Radiography, and I will just read the letter that we came up with as a board regarding LB481. Exemption from licensure for ancillary personnel and cardiovascular technologists. This was written prior to... [LB481]

SENATOR CAMPBELL: The amendment. [LB481]

DENISE LOGAN: ...the amendment. The Board of Medical Radiography is opposed to LB481, which creates an exemption from licensure in the Medical Radiography Practice Act for ancillary personnel and cardiovascular technologists. The board is opposed to this legislation as written because ancillary personnel and cardiovascular technologists are not credentialed professions, and they have no authorized scope of practice to hold them accountable for their actions. The board believes that the cardiovascular technologists should pursue a credentialing review--process 407--to seek credentialing of the profession, so that disciplinary action could be taken against the state-issued credential of cardiovascular technologists who violate the law. We understand that there may be an amendment to LB481 that will require a cardiovascular technologist to be a registered cardiovascular invasive specialist by Cardiovascular Credentialing International in order to assist a licensed practitioner in performing cardiac catheterization. However, the board does not believe that the radiation safety training required by the RCIS credential is adequate to protect public health and safety. Patients and healthcare professionals are exposed to very high doses of radiation in cardiac catheterization labs, and it is absolutely essential for persons who are assisting in

fluoroscopy procedures to have adequate training in radiation safety. In the interest of the public health and safety, the board strongly encourages the Health and Human Services Committee of the Legislature to indefinitely postpone LB481. The position as stated in this letter represents the position of the Board of Medical Radiography and does not necessarily represent the position of the Department of Health and Human Services or the Division of Public Health. And then signed by the board members. [LB481]

SENATOR CAMPBELL: Okay. Any questions for Ms. Logan? Senator Bloomfield. [LB481]

SENATOR BLOOMFIELD: Thank you. You haven't had a chance, I assume, to see the amendment? [LB481]

DENISE LOGAN: I just heard the amendment this morning. [LB481]

SENATOR BLOOMFIELD: Okay. [LB481]

DENISE LOGAN: We met on Tuesday, I believe it was. [LB481]

BRANDON HOLT: Wednesday. [LB481]

DENISE LOGAN: Wednesday, March 2. Thank you, Brandon. And we had heard that there was going to be an amendment, and so we wrote the letter as written... [LB481]

SENATOR BLOOMFIELD: Okay, my question is, does the amendment--since you have seen it--take care of most of your issues or not? [LB481]

DENISE LOGAN: It takes care of none of our issues. [LB481]

SENATOR BLOOMFIELD: None of your issues. [LB481]

DENISE LOGAN: The amendment still does not...what they're still asking for is an exemption. The board would recommend that they go through the 407 process to become licensed. In the state of Nebraska, if you're doing something inappropriate as, for example, as a medical radiographer, then the state can take away your license and sanctions, etcetera, against the individual. If you're simply exempt, there is nothing to keep the public safe. There's no disciplinary action. [LB481]

SENATOR BLOOMFIELD: Okay. Thank you. [LB481]

SENATOR CAMPBELL: Any other questions? Thank you, Ms. Logan. [LB481]

DENISE LOGAN: Thanks. [LB481]

SENATOR CAMPBELL: Last testifier. [LB481]

LINDA BLACK: (Exhibit 32) Good afternoon. My name is Linda Black, L-i-n-d-a B-l-a-c-k, and I am the legislative chairperson for the Nebraska Society of Radiologic Technologists. In my research to testify today, I did a lot of looking at the kinds of things that are going on nationally. And there's a lot of studies out there on radiation and radiation protection and a lot of press and a lot of information out there on the amounts of radiation that patients are receiving in procedures medically. They all basically reach the same conclusions. And that is that there needs to be initial and ongoing education across the board for those people who are doing fluoroscopy, there needs to be more consistent radiation dose monitoring and control, and that there needs to be increased public awareness of medical radiation dose. There's broad agreement that steps need to be taken to reduce necessary exposure, and we do not believe that this bill would take care of that. Now, you've seen and heard a lot of different things today about how people can be overexposed to radiation. Now more than ever, with all of the enhanced awareness to excessive radiation exposure, we feel that this bill does not adequately protect what needs to be done with the patients in Nebraska. There's no prior assessment for the need for this exemption. You've heard from other testifiers that there's not a shortage of medical radiographers. Within the medical radiographer curriculum, there is also things included in that curriculum that talk about interventional procedures; we are taught how to assist physicians and do some of those kinds of things. It doesn't appear that the cost factor would be an issue, because the medical radiographers can assist physicians just as anyone else in the cardiac cath lab, because they have the background to do so. We don't...we think that this would be a very huge disservice to the public, to allow just a straight exemption. After listening to some of the testimony, I think it's very, very important that the group or whomever is interested in doing this...and a lot of our testimonies were written before we saw the amendment--we just saw that yesterday--and it does not address all of our concerns; we don't believe that--just removing the auxiliary personnel does not address our concerns. But we also appreciate the fact that the cardiovascular technologists are a part of the professional team in the cardiac cath lab. But part of being a professional, in a lot of the arenas out there, is accountability. And if you want to be considered a professional and should be considered a professional, there ought to be a level of accountability that goes along with that. And previous proponents were talking about how the--how their--professionals they are; there's no disagreement with that. But along with that, I think it's very important that they do go through the process, become licensed, and be able to really acquire that professional status that they deserve, to be quite frank. A couple of testifiers have mentioned the care bill; that is a national credentialing bill that has been--we've been trying to pass over the last 12 years on the federal level. The--it does address the cardiac cath lab techs; it does provide minimum standards for them. They are in rule--the recommended or the suggested rules; they're

not in the statute. And we all know how that can change. So my hope would be that the committee would request or would direct, if you will, them to go through the 407 process, allow us to get them to the point where they need to be a recognized professional within the state of Nebraska and continue to protect the public and make sure that the education and the testing and all of the things are there that we need in order to make sure that the radiation doses that we're giving not only the patients but ourselves are as low as we can. And with that, I will take any questions. [LB481]

SENATOR CAMPBELL: Are there any questions for Ms. Black? Thank you very much. Is there anyone else who wishes to testify in opposition? And in neutral position? With that, we will close the hearing to LB481. Senator Krist has waived closing, because he had to return to Omaha. Thank you. (See Exhibit 33) [LB481]