[LB1032 LB1103 LB1142]

The Committee on Health and Human Services met at 1:30 p.m. on Thursday, February 16, 2012, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB1032, LB1103, and LB1142. Senators present: Kathy Campbell, Chairperson; Mike Gloor, Vice Chairperson; Dave Bloomfield; Tanya Cook; Gwen Howard; Bob Krist; and R. Paul Lambert. Senators absent: None.

SENATOR LAMBERT: Yo.

SENATOR CAMPBELL: Thank you, Senator Lambert, who also serves as our sergeant at arms. (Laughter) I'd like to welcome you to the public hearings for the Health and Human Services Committee. I'm Kathy Campbell, and I serve the 25th Legislative District in east Lincoln and northern Lancaster County. And as is our practice, we do self introductions, so I'll start with the senator to my far right, sergeant at arms.

SENATOR LAMBERT: Thank you. Good afternoon, I'm Senator Paul Lambert from District 2. I serve a portion of Otoe County, a portion of Sarpy County and all of Cass County.

SENATOR COOK: I'm Tanya Cook. I represent Legislative District 13, that is in northeast Omaha and Douglas County.

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

MICHELLE CHAFFEE: I'm Michelle Chaffee, I serve as the committee counsel.

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

DIANE JOHNSON: I'm Diane Johnson, committee clerk.

SENATOR CAMPBELL: And we have Phoebe and Michael who are our pages this afternoon. And I do want to warn all of you that we really do have the real sergeant at arms, Lois is in the back and she is pretty tough.

SENATOR LAMBERT: She is a lot tougher than I am, yeah.

SENATOR CAMPBELL: I think so, I think so.

SENATOR LAMBERT: I'll guarantee to that.

SENATOR CAMPBELL: We'll take care of some of the housekeeping first. Most of you have been here before, but we'll run through them real quickly. Please turn off your cell

phones or put it on silent so we don't disturb the testifiers. If you will be testifying this afternoon, we need you to complete one of the bright orange sheets. And if you just want to let us know of your presence and that you support or oppose a bill, you can write your name on the white sign-in sheets and put a note there. As you come forward to testify, please hand the orange sheet and any handouts that you might have to the clerk. We don't require handouts in this committee, but if you have them we'd like 12. And if you need help, the pages can help you with that. We do use the light system in the committee, and we will go with four minutes today so that you have a little extra time. When you get...you have green until you get to one-minute warning and that will be yellow and when it's red, you'll look up and see me kind of going time, try to finish. We do ask that as you come forward you state your name and spell it and that is for the transcriber. I know the orange sheet is for the clerk to make sure she types...she has your name correctly. I think that is all of the reminders of the day, and so we will start with our first hearing, LB1032. Senator Wightman is here. And LB1032 is to change the advertisement and display of credential provisions under the Uniform Credentialing Act. Welcome, Senator Wightman. This might be our first time to have you this year if I'm right.

SENATOR WIGHTMAN: Thank you, Senator Campbell.

SENATOR CAMPBELL: Good.

SENATOR WIGHTMAN: Members of the committee, my name is John Wightman spelled W-i-g-h-t-m-a-n. I represent District 36. LB1032 was introduced at the request of the Nebraska Medical Association to begin the discussion of the public policy of the state of Nebraska to assure that patients have accurate information about the training and education of healthcare providers who are providing medical care to them. The bill amends the current section of the Uniform Credentialing Act, Nebraska Revised Statute 38-105, governing identification of credential holders as it applies to those healthcare providers who have direct patient care interaction. The bill would require these providers to clearly identify themselves in three areas. First LB1032 requires the healthcare providers to identify the type of healthcare credential they hold in all advertising and refrain from including in such advertising any deceptive or misleading information or information which misstates or falsely describes or falsely represents a provider's skills, training, expertise, education, board certification, or credential. The general prohibition on deceptive advertising in current law is strengthened to provide clear statutory authority for disciplinary action that applies to all professions if that profession is not adopted for regulations on deceptive advertising and provides clear statutory authority for professional boards that have issued additional regulations on deceptive advertising such as the marriage and family counselor profession. Second, LB1032 requires healthcare providers who have patient care interaction to wear name tags which clearly identify the type of credential held by that provider. The requirement to wear a name tag would not apply if it is precluded by applicable sterilization or isolation protocol. Third,

LB1032 requires healthcare providers to display a statement of the credential which the provider holds in each office in which the provider has patient care interactions. LB1032 further requires students or residents in medical treatment to identify themselves as a student or resident as authorized by their respective practice acts. It does not change the applicability of Section 38-105 to health professions which do not provide direct patient care interactions and makes violations of Section 38-105, as amended, unprofessional conduct under the Uniform Credentialing Act. As with other legislation, the problems or devil with any legislative bill are in the details. I understand that providers have many questions about this bill. The requirement that providers wear name tags and the requirement to post their credentials in offices are not as simple as they may first appear and the issue must be addressed. The proponents understand that this is just the start of the discussion and are willing to work with affected providers to assure that the transparency requirements are workable. After my recent experience, patients need accurate information about the training and education of healthcare providers who are providing medical care to them. I believe that the basic concept is good public policy. And, of course, I have had a lot of experience with them in the last year or two, so. Thank you. [LB1032]

SENATOR CAMPBELL: Thank you, Senator Wightman. Are there questions? Senator Gloor. [LB1032]

SENATOR GLOOR: Thank you, Chairperson Campbell. And I was just going to say, become, unfortunately, an expert in this, Senator Wightman. But there are letters of doctors of veterinary medicine in here and I guess that is a question I have, is the intent here...I mean we are going to assume the patients of vets aren't the ones that we would wear name tags for. I'm guessing that we're wearing name tags for the people who called. But would it be your intent that we would also require vets to wear name tags when they were carrying out their profession? [LB1032]

SENATOR WIGHTMAN: I guess I can't really answer that for sure. I think we're talking about, probably, human healthcare providers at this time. Could, obviously, be broadened to do that; but then I know there are a lot of people that work for veterinarians that are aides and assist them in that regard. I guess it could be or not be, whatever the committee...as I say, this probably is going to end up being more a study in exactly what credentialing we should provide for. [LB1032]

SENATOR GLOOR: Okay. Thank you. [LB1032]

SENATOR CAMPBELL: Other questions? Senator Howard. [LB1032]

SENATOR HOWARD: Thank you, Senator Campbell. And similarly, this is a concern from my group then, social workers regarding whether it was your intent to include mental health practitioners; and I would broaden that to social workers under

this....under your bill. [LB1032]

SENATOR WIGHTMAN: Um-hum. That, I think social workers could be included in it depending on what language you come out with. And I think that's part of the idea is to open it up for study maybe. And some of the other speakers will...proponents will address that issue, probably. [LB1032]

SENATOR HOWARD: You realize that would include case managers with the Department of Health and Human Services. I mean it would be pretty broad reaching. [LB1032]

SENATOR WIGHTMAN: And I realize that. And how broad reaching it should be is something I think that is probably going to require more work than just passing this out. [LB1032]

SENATOR HOWARD: So you're kind of leaving that open for the special... [LB1032]

SENATOR WIGHTMAN: We're leaving that open. [LB1032]

SENATOR HOWARD: That's good. Thank you. [LB1032]

SENATOR CAMPBELL: Any other questions? Senator Wightman, will you be staying to close today? [LB1032]

SENATOR WIGHTMAN: Well, I have the next bill so I'll wait. I may waive at that time. [LB1032]

SENATOR CAMPBELL: Okay. That's fine. Thank you very much for your opening today. [LB1032]

SENATOR WIGHTMAN: Thank you. [LB1032]

SENATOR CAMPBELL: Our first proponent. Good afternoon. [LB1032]

DAVID BUNTAIN: Good afternoon, Senator Campbell, members of the committee. My name is David Buntain, B-u-n-t-a-i-n. I'm the attorney and registered lobbyist for the Nebraska Medical Association, and I'm here testifying in support of LB1032. LB1032 is the result of discussions which have gone on for several years within the medical association as various problems have been brought to our attention where we become aware of incidents where patients are being treated by people where it's not clear what the credential is of the person who is delivering the treatment. And we have several physicians here who will testify about some specific examples. This bill is similar to bills that have been passed in several other states and are being considered by other states.

It's not an issue that is unique to Nebraska. And we recognize that it's a very broad bill the way it is written. I would say, Senator Howard, it would include mental health practitioners as you've said. And I think that our goal in introducing this bill was to get the discussion started. I think I can speak fairly authoritatively to your question, Senator Gloor. This talks about wearing a name tag if you're rendering patient care, and I think under our statutes we...patients are humans, not animals, so I don't think the intent would be to have veterinarians covered by this. But, clearly, there's...medical care, healthcare services are rendered in a variety of settings under a variety of conditions. And as far as the name tag issues concern, we need to work through those issues. And I know some of those have been identified in letters that you've received and other contacts that you've had. We do have concerns about professionals displaying their credentials so that persons who are coming in to be treated see what those credentials are. And then also there...you'll...I think there is some information about deceptive advertising that is going on where we think, really, this is a matter of patient safety and patient care that you, as a consumer of patient care, all of us as consumers of patient care, have a right to know what the training is of the person who is rendering that care. And I would be the first to tell you that some of these issues are within the medical profession, and there would be some physician practices that this would be addressed to. It's not just nonphysicians that we're talking about. And so we're ready to work with Senator Wightman, work with the committee, work with the proponents. We don't expect this bill to advance this year. We think that the public policy is a sound public policy, and we think we can work through so that it is a practical bill and it accomplishes what the goals are. [LB1032]

SENATOR CAMPBELL: Questions? Senator Bloomfield. [LB1032]

SENATOR BLOOMFIELD: Thank you, Senator Campbell. I met with some very nice folks outside the glass to discuss this a little bit this morning; and there were a couple of issues that came to my mind, and one of them is standardization. You know, is everything going to be on a tag that you pin on? Is it going to be sewn into a shirt you're wearing; or what are you going to do there? And the second question that came to my mind as I looked further at it, given the society we function in now, are these going to have to be in several different languages? You know, government regulations require that voter ballots be put out in two or three different languages. If this becomes a government requirement, are we going to be looking at that issue? [LB1032]

DAVID BUNTAIN: Well, I hadn't thought of the second issue, and that is an interesting issue. On the first issue, the goal of the legislation is identification. And we think that it can...we should not prescribe a standard state-issued name tag for everybody or like a driver license, or something like that; but I think we can require that each healthcare provider who is providing patient care to you have a name tag that says who they are and on that says clearly whether they're a medical doctor or a registered nurse or...and that is what the goal is. It could be embroidered in the lab coat. It could be on a tag. I

think those kinds of details could be worked out. It would be enforced through the examining boards for the different professions. The key is that communication of the identification of who the person is. As far as multiple languages, that wouldn't be embraced by this bill. I could see it...it could be a concern some day. [LB1032]

SENATOR BLOOMFIELD: It occurs to me that every time government reaches out to do something, we leave unintended consequences; and I'd like to avoid that if we could with this. [LB1032]

DAVID BUNTAIN: Well, I think that's...we all would. [LB1032]

SENATOR BLOOMFIELD: Okay, thank you. [LB1032]

SENATOR CAMPBELL: Senator Cook. [LB1032]

SENATOR COOK: Thank you, Madam Chair, and thank you. I had a question, kind of the other side of that, really, to cultural competency, which I think you've kind of said you hadn't contemplated; but also, can you tell me a little bit about the training for a medical practitioner for a human being. As I'm recalling, and maybe I've been very fortunate, she or he walks in and says, hello, my name is blank; or they bring someone else in, hello, this is, you know, Suzie Q, she is a student at the medical center. Can she come into the room? Is that part...isn't that part of the training or the protocol or the etiquette of providing service? [LB1032]

DAVID BUNTAIN: I think it is...I would consider that good practice. And it would make sense...I mean...that they do that. I don't know that there is any requirement of it. [LB1032]

SENATOR COOK: Okay. [LB1032]

SENATOR CAMPBELL: Further questions? Senator Gloor. [LB1032]

SENATOR GLOOR: Thank you, Senator Campbell. And, Mr. Buntain, these aren't necessarily questions directed at you; but more for the record and more as a head ups for people who may follow you, who might want to use it as an opportunity to try and address some of this. As you know, I'm...in my past experience, I still carry the scars of trying to get people to wear name tags...(laughter) [LB1032]

SENATOR COOK: Pin holes. [LB1032]

SENATOR GLOOR: And, yeah, pin holes and lapels, I've heard it all, and, you know, making special purchases of magnetic name tags so that it wouldn't put holes in people's uniforms so that we didn't have that excuse to deal with; because it is

important that people know who is taking care of them. And we went so far as to have each department have different colored uniforms so that if a nurse took care of you...nurse, somebody who is in nursing service, they wore a certain colored uniform, people from lab pathology wore a certain colored uniform, so the people knew this is somebody who is drawing my blood. This is somebody who is a nurse. This is somebody who is from radiology. They each wore different colored uniforms. But the problem, as in most things, the devil was in the details because what we put on the name badge was always subject to, not just discussion, but dispute and controversy. No last names, we're not putting our last names on there, or if we're forced to, we'll put little stickers over them; and I don't just want to be an RN, I want to be an advanced practiced pediatric RN. And I think therein is where some of the challenges, as we continue to talk about this, are going to be; because everybody would like to differentiate themselves a little bit more from somebody who may, in fact, have almost exactly the same credentials; but maybe not quite as much study. And abbreviations usually don't work because a RD means a registered dietician, I think; but I'm not sure that a lot of people or patients know that a RD is a...they may think, well, a RD must be like a registered nurse with a "d" rather than an "n." [LB1032]

DAVID BUNTAIN: Right. [LB1032]

SENATOR GLOOR: I mean these all sound like silly things, but therein is the challenge, I think, on how we would make this a reality that would accomplish the goal of people knowing who is taking care of them. [LB1032]

DAVID BUNTAIN: I think you make a good point that we do have an alphabet soup of initials, credentials. Someone who had sent me some questions about this said, can I call myself four different sets of letters. I have to confess, I didn't know what they meant. But I mean, if I don't know them, having been doing this as long as I have, I can assure you that the patients that that person is treating doesn't know. So, I mean, our preference would be that you write out the name of what it is, what your credential is. The name issue has come up a lot. People are concerned for security reasons, personal security reasons. The bill doesn't say full name; it says a name tag. And I know a lot of facilities that use name tags use first names and the credentials. Some use the first initial and the last name and the credential. And you're right. There are a lot of those kinds of things that we would just need to work out. But the complexity of it shouldn't deter us from doing it if it's in the patient's interest. [LB1032]

SENATOR GLOOR: Yeah. [LB1032]

SENATOR CAMPBELL: Any other questions? You know, Mr. Buntain, I don't know if you were here the other day when we were talking about Senator Howard's, I think it was Senator Howard's bill with regard to injections. [LB1032]

DAVID BUNTAIN: I was sitting in this chair when you talked about it. (Laughter) [LB1032]

SENATOR CAMPBELL: Oh, okay. That's how foggy my memory is today. And I alluded to the fact that I had gotten a flu shot at a pharmacy, and we were talking about who is giving the shots here. Can anyone give a shot? Is this the clerk? And as you recall, I specifically asked the person if they were the pharmacist. I think it's important because sometimes people don't wear name tags, and you don't know and after spending...I don't have as much experience as Senator Wightman; but having spent much of the month of November with my husband in and out of the hospital, I can tell you how critical it was for us to know who is walking in his room and what are they doing to him. And they were all well trained. They introduced themselves. They all had a name tag. They did a very good job. But as a family member, I wanted to know who was walking in there. And that's why I cosigned on this bill because I think this conversation does need to take place. [LB1032]

DAVID BUNTAIN: Your example of the pharmacies and giving vaccinations occurred to me as I was getting ready for today because I think that's an excellent example of people receiving...I mean it's routine healthcare, but it is healthcare...and not knowing whether that person has a credential and what that credential is. [LB1032]

SENATOR CAMPBELL: Any other questions? Thank you, Mr. Buntain. [LB1032]

DAVID BUNTAIN: Thank you. [LB1032]

SENATOR CAMPBELL: Our next proponent. Good afternoon. [LB1032]

MARY FINNEGAN: Good afternoon. [LB1032]

SENATOR CAMPBELL: And your name? [LB1032]

MARY FINNEGAN: Good afternoon, Madam Chair and distinguished members of the Health and Human Services Committee. My name is Dr. Mary Finnegan, F-i-n-n-e-g-a-n, and I'm a board certified dermatologist practicing in Omaha, Nebraska. And I also serve as president of the Nebraska Dermatology Society. I'm here today to share our support for LB1032 regarding disclosure of healthcare providers' credentials. Enacting this important piece of legislation will provide Nebraskans with increased transparency regarding the qualifications of the healthcare professionals delivering their care. Gone are the days when only physicians wore white coats or scrubs. Gone are the days when we walked to your neighborhood doctor's office and the doctor was the receptionist, medical assistant, nurse, and physician. Today there is a wide array of individuals on the front lines of outpatient care. This creates a great deal of confusion for patients. Our citizens have the right to know the credentials and the level of training

of the healthcare provider making their important diagnosis, pushing medications into their intravenous line, holding a scalpel, or pointing a laser at their face. Patients have the right to know the credentials of the person to whom they entrust their lives each and every day. I'll give you an example of a situation about two weeks ago where I brought my two-year-old son into a pediatrics express facility after hours believing, as a physician, that he was, potentially, suffering from an ear infection. I called to make the appointment and was scheduled, was checked in at the front desk, brought back to the exam room, vitals were taken by the nurse, and my son was seen by a physician...by an individual who introduced themselves as doctor so-and-so. They made the diagnosis and then they'd ask that I follow up with our physician in approximately one week. And because she had seen my son, I felt, maybe, she could see him in a week since she had just examined his ears and I said, now where is your practice and can you tell me your name again? And it turned out that she was a medicine pediatrics resident who had not completed her residency training. Even as a physician I had called and made the appointment and was not even on the radar to ask if the person who was seeing my son was a board certified pediatrician. I'll give you another example of the gym that my family belongs to, to go exercising that's located in west Omaha. There is a beauty salon located on the first floor of the gym, and I walked in and noticed that they are advertising services for injecting Botox and fillers into the face, providing chemical peels, medical grade chemical peels. And as a dermatologist, I was curious as to who was performing these services. And no where on brochures, on the display advertising the services, when I inquired in terms of making an appointment they never informed me who would be providing those services. I had to actually ask who would be providing the services, and I was told it would be a nurse practitioner. My last example is as a physician practicing the field of...or the specialty of dermatology, I have patients who have gone to a pharmacy chain in Omaha for Botox injections. And they felt that they had been seen by a dermatologist when, in fact, they had been seen by a nurse practitioner. As you know, there's a wide spectrum of treating and expertise among caregivers. In spite of the fact that some wear name badges, in a clinical setting it is often impossible for patients to know whether the person providing their care is a physician, nurse, physician assistant, pharmacist, dentist, dental hygienist, or medical assistant. I'll admit physicians have contributed to patient confusion when we set up our offices and have all providers wear the same scrubs or white lab coats. In my office, I provide...I employ two physician assistants, we all wear white lab coats but they're embroidered with our credentials so patients have visible representation of who is a physician and who is a physician assistant. [LB1032]

SENATOR CAMPBELL: Dr. Finnegan, are we pretty close? [LB1032]

MARY FINNEGAN: Just about there. [LB1032]

SENATOR CAMPBELL: Because we may have questions. [LB1032]

MARY FINNEGAN: Okay. Those are the main points. [LB1032]

SENATOR CAMPBELL: Main points you want to cover. Questions? Yes, Senator Gloor. [LB1032]

SENATOR GLOOR: Thank you, Senator Campbell. Thank you, Dr. Finnegan. [LB1032]

MARY FINNEGAN: Thank you. [LB1032]

SENATOR GLOOR: Given your attention to detail, I'll bet you're a great doctor. (Laughter) [LB1032]

MARY FINNEGAN: Thank you. [LB1032]

SENATOR GLOOR: Would you suggest...I think you answered this, but I want to make sure I understand. If you were being...if a dermatologist was providing care, would their name badge then say Dr. Jane Doe, MD, Board Certified Dermatologist? Is that...versus somebody who might say Dr. Jane Doe, MD, non-board certified dermatologist? I'm trying to get back to, and this is where this gets to be a challenge, what a name badge would look like that is an identifier that doesn't become too busy or accomplishes what we're looking for. Are we going to say board certified and that's enough, or do we have to also have people say non-board certified if they're non-board certified? [LB1032]

MARY FINNEGAN: I know that that is a very fine point because there are some groups that may...a person may not be board certified, but be still practicing within their trained scope. [LB1032]

SENATOR GLOOR: Probably not many, but... [LB1032]

MARY FINNEGAN: Correct. Personally, I would like to see it say board certified dermatologist... [LB1032]

SENATOR GLOOR: Okay. [LB1032]

MARY FINNEGAN: ...or mention the specialty because there are other specialities advertising dermatology services that are trained in residency programs. For instance, we're trained for four years to become experts in the field of skin disease management that are not trained in the field at all that...so, I hope that answers your question. [LB1032]

SENATOR GLOOR: Yeah, yeah it does, thank you. [LB1032]

SENATOR CAMPBELL: Senator Bloomfield. [LB1032]

SENATOR BLOOMFIELD: Thank you, again, Senator Campbell. With all the degrees and letters in the alphabet soup we deal with, are we going to get to the point where we're carrying a one foot square sign around on somebody's chest? [LB1032]

MARY FINNEGAN: I think it's a good start because there are so many people that don't wear any sign at all. I think it's a good difference to have a sign versus nothing at all. [LB1032]

SENATOR BLOOMFIELD: We don't want a sign like this on somebody's chest. [LB1032]

MARY FINNEGAN: Right. I think a very practical sign that has their credentials on would make a world of difference. And it would give the patient an opportunity to think about who they're seeing. [LB1032]

SENATOR BLOOMFIELD: Thank you. [LB1032]

SENATOR CAMPBELL: Any other questions? Thank you, Dr. Finnegan. [LB1032]

MARY FINNEGAN: Thank you. [LB1032]

SENATOR CAMPBELL: Our next proponent. Welcome. [LB1032]

KATHRYN CHANDRA: (Exhibit 1) Thank you, Madam Chair, and distinguished members of the committee. My name is Kathryn Chandra, that's K-a-t-h-r-y-n, Chandra, C-h-a-n-d-r-a. I'm the assistant director of state policy for the America Academy of Dermatology Association in Washington, D.C. I'm here today in support of LB1032. Research conducted by the American Medical Association indicates patients are often confused about the differences between various types of healthcare providers. We believe patients deserve to have increased clarity and transparency regarding the qualifications and expertise of those providing their care. Confusing and misleading advertisements undermine the reliability of our healthcare system. Unfortunately, only half of patients surveyed believe it's easy to identify who is a licensed medical doctor and who is not by reading what services they offer, their title, and other licensing credentials in advertising and marketing materials. It is the position of the American Academy of Dermatology Association that all providers should be required to identify or disclose their degree or field of study, board certification if applicable, specialty, and licensure to each patient either via a name badge or in writing and in all marketing materials. In order to improve transparency, LB1032 would require that all advertisements for healthcare services identify the type of credential held by the healthcare professional. In addition, all healthcare providers engaged in direct patient encounters must wear a name tag and that clearly identifies the type of credential held.

And finally, LB1032 requires all healthcare providers to post a sign in each of their office locations which clearly identifies the credential held by the provider in writing. Asking medical professionals to display their credentials and capabilities allows patients to make informed choices about their healthcare. It is not an effort to drive patients to physicians for their care as opposed to other providers. LB1032 is also not an effort to pit physicians against nonphysician providers. It is simply about transparency. Eighty-seven percent of patients support legislation to require that healthcare providers display their level of training and legal licensure including full disclosure in all advertising marketing materials. LB1032 simply gives patients what they want. In addition, patients surveyed by the American Medical Association indicated that knowing their healthcare provider's credentials was important to them, especially in the event of a complication or medical emergency. Nebraska is not alone in improving transparency for patients in medical advertisements and requiring healthcare professionals to wear name tags which identify their licensure or credentials. Connecticut, Tennessee, and Utah in 2011; Arizona, California, Illinois, and Oklahoma in 2010; and Pennsylvania in 2009 have all passed legislation with provisions similar to those contained in LB1032. These states and others continue to make improvements to medical advertising laws in the best interests of patients. Currently, similar legislation is pending in nearly a dozen states in this legislative session. On behalf of the American Academy of Dermatology Association, I urge the committee to support the provisions of LB1032 recognizing some specifics may need to be worked out among the various parties involved and ensure that the bill's provision clearly require all healthcare providers to spell out their credentials on name tags and advertisements and post this information in each of their office locations, again, to improve transparency for all Nebraska patients. Thank you again for the opportunity to address you today. [LB1032]

SENATOR CAMPBELL: Thank you for your testimony and giving us some background on other states. Questions? Any questions? Thank you for your testimony. [LB1032]

KATHRYN CHANDRA: Thank you. [LB1032]

SENATOR CAMPBELL: Our next proponent. Good afternoon. [LB1032]

DAVID INGVOLDSTAD: Thank you. Good afternoon, Senator Campbell and members of the committee. My name is David Ingvoldstad spelled I-n-g-v-o-l-d-s-t-a-d. I'm an ophthalmologist and a medical doctor in practice in Omaha, Nebraska. I'm also the president of the Nebraska Academy of Eye Physicians and Surgeons, and I'm speaking also on behalf of that organization. I'm here today to testify in support of LB1032. Now I've heard that LB1032 may face some opposition from healthcare provider groups who feel that wearing an ID badge or posting their credentials may pose some level of burden. While I do understand those concerns, we should remember that this legislation is not about us, the healthcare workers; it is actually about our patients. The goal is simple, to improve patient safety in our state and create a culture of transparency in

healthcare and advertising for medical services. I hope to demonstrate to the committee that our patients want this legislation and our patients need this legislation. Now most of us in this room understand that the term "doctor" has many different meanings. However, many patients do not understand the difference in education and training among the various providers who favor the term "doctor" in a healthcare setting. For example, this includes medical doctors and doctors of osteopathic medicines are MDs and DOs, PhDs, doctors of pharmacy, doctors of nursing, doctors of dental medicine, doctors of dental surgery, chiropractors, pediatrists, optometrists, doctors of homeopathy, doctors of theology, doctors of physical therapy, and so on. In addition, other healthcare workers may look like doctors or nurses or physician assistants in their dress or actions, but may not always clearly display their true credentials for patients to see. This can be quite confusing to any patient, including a patient who is a healthcare provider themselves. Providers at every level play a critical role in the success of the healthcare team. But in Nebraska there is no system in place to ensure that patients understand the differences in these providers. This confusion is fundamentally...undermines the safety and reliability of our healthcare system. Now I say this not just based on personal anecdote or opinion, but on objective data. According to a recent survey conducted by the Global Strategy Group and published by the American Medical Association, patients are confused about their providers. Fifty-one percent of those surveyed stated that it was not easy to identify who was a licensed medical doctor and who was not by reading the services they offer. Sixty-seven percent thought a podiatrist is a medical doctor; 33 percent thought an audiologist is a medical doctor. In contrast, 68 percent were not aware that otolaryngologist is indeed a medical doctor. Ninety-six percent of people replied that they felt all healthcare professionals should be required to clearly state their level of training in advertising and marketing materials. So not only is it plain common sense that we, as a provider, should be required to tell patients who we are; but in fact, patients are strongly in favor of this type of clarity. LB1032 is just the sort of legislation that would help with this. Now the content of this bill is in no way intended, in my opinion, to burden healthcare workers, and I understand that details need to be worked out going forward. This bill is really, though, about transparency for patients, patient education, and patient safety. It is intended to simplify and provide patients with information they need to make an informed decision. This will also protect providers who may make unintended errors of omission in a way that they portray themselves. And yes, it is also intended to protect patients from intentional misleading advertising or portrayals that we sometimes see. I respectfully ask the committee to consider this legislation going forward, and I would like to thank Chairperson Campbell and the committee for allowing me to testify today. Thank you. I'll take any questions. [LB1032]

SENATOR CAMPBELL: Thank you. Are there questions? Senator Gloor. [LB1032]

SENATOR GLOOR: Thank you, Senator Campbell. Thank you, Dr. Ingvoldstad, good to see you again. [LB1032]

DAVID INGVOLDSTAD: Good to see you too. [LB1032]

SENATOR GLOOR: Thanks for taking the time to come down. [LB1032]

DAVID INGVOLDSTAD: Sure. [LB1032]

SENATOR GLOOR: You brought up an otolaryngologist and so my question is, what do we put on a name tag that doesn't confuse a patient. I mean, do we put doctor MD, doctor MD otolaryngologist, I... [LB1032]

DAVID INGVOLDSTAD: Sure. [LB1032]

SENATOR GLOOR: Again, the devil is in the details. And I'm trying to figure out... [LB1032]

DAVID INGVOLDSTAD: It is, and I...you know... [LB1032]

SENATOR GLOOR: ...clearly, I'm supportive of the intent, I'm just trying to figure out how not to confuse people. [LB1032]

DAVID INGVOLDSTAD: When discussions first started taking place about this with the NAMA leadership and some of the people in our leadership and others, I thought, boy, this is a great idea, we should all wear name tags and tell people who we are. And then it's become obvious that there are details that need to be worked out, and I think some of these details are a real challenge. I mean we have otolaryngologist. Do I tell people that I'm a vitreoretinal surgeon board certi...you know, and...no, I think you limit it; and we want to clarify this for patients and make it simple, not make it egregious and as Senator Bloomfield pointed out, have a placard that is this big around your neck. I think that there are different levels...there is a name tag on one hand and then there is advertising on the other hand. And on the advertisements, in my mind, when you flip through the Yellow Pages and you look at some of the ads, there are a lot of errors of omission where it is stated this procedure is a chemical peel, or Botox injection is provided, or a doctor so-and-so or provider so-and-so; but it doesn't necessarily list who is providing the service. To what level you specify, you know, the training...that is really up for debate, and I understand that. [LB1032]

SENATOR GLOOR: Thank you. [LB1032]

DAVID INGVOLDSTAD: But I think that, you know, a general clarification is what the goal, intent, of the bill is. [LB1032]

SENATOR CAMPBELL: Senator Bloomfield. [LB1032]

SENATOR BLOOMFIELD: Thank you, again, Senator Campbell. And Doctor, I'm not opposed to where you're wanting to go with this; but another question comes to mind. Is there anything preventing you from doing this in your own practices now; there's no restrictions to you putting your own name tags on or anything, is there, at this time? [LB1032]

DAVID INGVOLDSTAD: No, that's correct. [LB1032]

SENATOR BLOOMFIELD: Okay. Thank you. [LB1032]

SENATOR CAMPBELL: Any other questions? Thank you for coming, Doctor. [LB1032]

DAVID INGVOLDSTAD: Thank you. [LB1032]

SENATOR CAMPBELL: Our next proponent. Okay. We will take those who are opposed to the bill. [LB1032]

JERRY STILMOCK: Good afternoon, Senators. My name is Jerry Stilmock, J-e-r-r-y, Stilmock, S-t-i-l-m-o-c-k, testifying on behalf of my clients, the Nebraska State Volunteer Firefighters Association and the Nebraska Fire Chiefs Association. Though both of the titles of my clients specifically state firefighters; the two groups also represent, as I represent, EMTs, first responders throughout. So as voiced by Senator Wightman and others to start a dialogue, we just merely wanted to make sure that you all were aware of the fact that EMTs in the field oftentimes they will duplicate themselves. A firefighter will also serve as a emergency medical technician thereby completing two roles with bunker gear, etcetera. We just felt it was important to come forward and let you know that we're attentive to what Senator Wightman is trying to do, certainly cooperating in whatever way that we can. But in the field of what we're...what the volunteers do, it would be an impediment to be able to comply with this bill as written. [LB1032]

SENATOR CAMPBELL: Okay. [LB1032]

JERRY STILMOCK: That's my message. Thank you. [LB1032]

SENATOR CAMPBELL: Are there any questions? Thank you, Mr. Stilmock. [LB1032]

JERRY STILMOCK: Thank you. [LB1032]

SENATOR CAMPBELL: Good afternoon. [LB1032]

JONI COVER: (Exhibit 2) Good afternoon, Senator Campbell. [LB1032]

SENATOR CAMPBELL: I'm going to stop you just a minute, do we need...do you have your orange sheet? [LB1032]

JONI COVER: I do. I was just going to give you this all when I was done. There you go. [LB1032]

SENATOR CAMPBELL: And we may explain that the reason that she wants it at the beginning is so that your name is spelled right as she types. We all know your (inaudible.) [LB1032]

JONI COVER: Good afternoon, my name is Joni Cover, J-o-n-i C-o-v-e-r, and I'm with the Nebraska Pharmacists Association; I'm executive vice president. And we are here, I guess, in kind opposition to LB1032. I don't know if you can have kind opposition, but that's what we're doing. We certainly understand the intent of the bill. And we agree as pharmacists who provide patient care to patients all across the state; it is a good idea to identify yourself. But we think that maybe there are some unintended consequences of the bill, and we've spoken with the Medical Association and have indicated our willingness to continue to work with them and to discuss the issue. I think that this would be difficult to enforce. And it just...I guess I was under the impression that some of the issues that have been brought forward may be addressed by the Uniform Credentialing Act currently, but maybe it doesn't go that far. So again, we're willing to work with the committee and with the Medical Association to address our concerns and offer our opposition. Happy to answer any questions. [LB1032]

SENATOR CAMPBELL: Thank you. Are there any questions? Thanks for coming today. [LB1032]

JONI COVER: Thank you. [LB1032]

SENATOR CAMPBELL: (Exhibits 3-12) Other opposition to the bill LB1032? Those who wish to testify in a neutral position? Okay, for the record I do want it to show that the committee received letters from the National Association of Social Workers, Nebraska Chapter, who were in opposition; the Nebraska Physical Therapy Association who were in opposition; the Nebraska State Athletic Trainers Association, neutral; Nebraska Academy of Physician Assistants, opposed; the Nebraska State Board of Massage Therapy, one massage therapist exempted; the Nebraska Board of Medicine and Surgery, supports; the Nebraska Board of Veterinary Medicine and Surgery, oppose; the Nebraska Board of Pharmacy, neutral; the Nebraska Hospital Association, neutral; and a letter from the Nebraska Nurse Practitioners and Nebraska Nurses Association in a neutral position. Senator Wightman, would you like to close? Senator Wightman closes...waives closing, I should say. And so we will proceed to the next bill...oh, I'm sorry, and we do have a letter from the Nebraska Pharmacists Association. Correct? Okay. I want to make sure. So, Senator Wightman, we'll go ahead and start on the next

one for you. Our next bill this afternoon for hearing is LB1103, also brought by Senator Wightman. The bill would provide access to deceased family members' medical records. Senator Wightman, you can go right ahead whenever you're ready. [LB1032]

SENATOR WIGHTMAN: (Exhibit 13) Thank you, Madam Chairperson and members of the committee. For the record I'm John Wightman, spelled W-i-g-h-t-m-a-n, representing District 36. LB1032 (sic) was introduced at the request of the Nebraska Association of Trial Attorneys to begin a discussion of the public policy of the state of Nebraska concerning access to the medical records of a deceased person. The proponents understand that this is just the start of the discussion and are willing to work with affected providers to assure that the provisions are workable and also provide needed protection to the deceased person's privacy. LB1103 would provide a mechanism for persons to access medical records of deceased family members. The intent is to allow such access without the need for opening an estate and appointment of a personal representative. State law is silent as to who is entitled to request such records in that situation where there is no personal representative appointed. LB1103 is intended to clarify who should or may be able to do so. The federal HIPAA Act does extend a person's privacy rights beyond death, but also explicitly requires providers to release records to authorized individuals. The complications come when a patient dies and no need exists to open a probate estate and a court to appoint a personal representative. Many people use other legal vehicles to avoid probate; and we've talked about those in the last several days, including frequently deeds to property, living trusts, transfer on death, and all sorts of things so that maybe they can avoid all probate or administration of an estate. HIPAA allows the state of Nebraska to adopt the state law to determine who can access the deceased's medical records. My office has been contacted by several healthcare providers that have raised a legitimate concerns that medical record personnel do not have the ability to determine if the person requesting the medical record is authorized under the priority set forth in LB1103 as drafted. The records department is not a court. The provider's staff do not have the information or training to determine if the person requesting the record has the necessary priority. In order to address these concerns, an amendment AM2015 has been or will be circulated and has been developed for discussion that would do the following: the patient can by written agreement and the provider's medical records state that he or she does not want his or her medical records released to anyone or to certain named persons, the patient's right of privacy extends in that situation beyond their death; a person requesting the medical records must present...under the proposed amendment, a certified death certificate for the deceased and submit a statement under oath that verifies the identity and status as a person with priority to have access to the records. If the log that accompanies the deceased's medical records shows that a person has already requested access to the record, but has been sworn as to their identify and status; the record may not be released to the second person requesting the record. At that point it should be left to the courts to decide who should have access to the medical records. What we're trying to do is avoid the necessity of having to go to the court anymore than would be necessary.

LB1103 and this proposed amendment are a starting point. Access to a deceased person's medical record is a growing problem that Nebraska law needs to address. I would like to address one thing in the proposed amendment if you have that in front of you, and it's AM2015, and going down on the first page and then we provide who would be in the list of priorities and the first one would be a personal representative, and I didn't catch this until later, should have, an agent appointed by the deceased patient under a power of attorney for healthcare who is authorized to act for the deceased patient after death probably is not workable because power of attorney ends upon the patient's death. And so as a result, that one probably should be omitted or should be clarified; but that probably is not going to be in the list of priority. I think it can be an agent appointed by the personal representative as opposed to an agent appointed by a power of attorney, but...so with that I would take any questions you may have. There will be other proponents. [LB1103]

SENATOR CAMPBELL: Questions that the senators have of the bill? Seeing no questions, Senator, you're going to waive closing? [LB1103]

SENATOR WIGHTMAN: I'll waive closing. [LB1103]

SENATOR CAMPBELL: Okay, that would be great. We will proceed to the proponents for LB1103. Good afternoon. [LB1103]

GREG COFFEY: Good afternoon, Senator Campbell, members of the committee. My name is Greg Coffey, last name is spelled C-o-f-f-e-y. I'm here on behalf of the Nebraska Association of Trial Attorneys. I'm an attorney with Friedman Law Offices here in Lincoln, Nebraska. And NATA has approached Senator Wightman about presenting this bill for us because this is something that we do see. As a matter of judicial economy, you hope not always to have to go to court to fix things that should be simple. And the way the law reads right now this is something where you would have to go to court. If you have a parent of a minor child that gets killed and there is a life insurance policy that would take care of, for example, burial expenses; but the insurance company, let's say for example, finds some issue that will require medical records to establish or resolve the dispute, the parents are going to be forced to go hire an attorney to open up an estate so that a personal representative can be appointed to obtain the medical records, and that's going to involve significant expense. We get calls in our office from time to time from people who need estates opened, not often for the purpose of just getting medical records; but we do get calls from people that we have to say, I'm sorry, this is not something that is economically practical for us to do for you. And it would be nice if the law was such that people could avoid the step of having to call me to get an estate opened just to get medical records of a deceased family member if the law, as Senator Wightman described, can be changed so that there is a priority of people who can obtain access to those records. I can think of...that example that I gave you, but I'm sure there are dozens of other examples where people might

need to gain access to the medical records of a deceased family member and presently their only solution would be to go open an estate at a cost that could be potentially exorbitant. I mean if you've got to drive a lawyer out to a county several counties away and you've got to find somebody that lives within that county to serve as a personal representative and something like that, it just makes a lot more sense to change the law so that those people can obtain access to their deceased family member's medical records. And I'm willing to accept whatever questions. [LB1103]

SENATOR CAMPBELL: I would assume that there's not a lot of people that know that this is a problem until it faces them. [LB1103]

GREG COFFEY: Oh, absolutely. [LB1103]

SENATOR CAMPBELL: Would you say that that is accurate? [LB1103]

GREG COFFEY: I think that that is absolutely true. I can tell you from my own family's experience, my brother lost his son in an accident in New York. He was a 19-year-old kid traveling by bus to Canada to go sightseeing and suddenly they needed to obtain access to his medical records many states away. This was something that...if they had had to go obtain medical records and hadn't had people in New York who were willing to work with them, it could have been a monumental expense if this was somebody...there was a bus accident out in...near Gibbon not really long ago where there were people from all over the country that were crossing Nebraska and got into a very serious accident. Well, if there had been multiple fatalities in that accident, you would have had people from Illinois or California or wherever that were trying to find lawyers in Nebraska who could help them obtain access to these kinds of records that, you know, they were all taken to the hospital in Kearney. You're talking about a significant expense that could be avoided if the law was modified slightly to allow people to gain access to those records. [LB1103]

SENATOR CAMPBELL: So it's a case where the law prohibits rather than omission. [LB1103]

GREG COFFEY: I think it's just an omission. I think that if you just add deceased family members' records and then provide, as Senator Wightman's bill does, a list of priorities of people who can gain access to those records, it's not...I think it's just an oversight, and this oversight can be corrected by making a couple of minor modifications to the law. [LB1103]

SENATOR CAMPBELL: Thank you for your testimony. Any other comments or questions? Thank you for coming today. [LB1103]

GREG COFFEY: Thank you. [LB1103]

SENATOR CAMPBELL: The next proponent. Anyone else who wants to testify in favor? Those who are opposed to LB1103? Those who would like to testify in a neutral position? [LB1103]

JERRY STILMOCK: Senators, good afternoon. My name is Jerry Stilmock, J-e-r-r-y, Stilmock, S-t-i-l-m-o-c-k, testifying on behalf of the Nebraska State Volunteer Firefighters Association and the Nebraska Fire Chiefs Association in a neutral capacity to LB1103. One of the items that I was concerned about was addressed by Senator Wightman in the proposed amendment in terms of the power of attorney and the law of land power attorney upon the person passing away...the principle passing away once that act happens, the power of attorney is terminated, is extinguished. So I was glad to hear him say that. The second issue is the ability of volunteer ambulance service, volunteer EMT service in a community to recognize, not so much the surviving spouse, in terms of the litany of those that would be entitled to and priority, personal representative and then it moves different relations. The spouse, that's relatively, perhaps, discoverable that the provider of the healthcare services would be able to make that determination; but then as you slide down the list, who is an adult? If I say I'm an adult son, an adult daughter, and perhaps that's what the under-oath item that appears in the amendment that you all have in front of you, maybe that takes care of the issue of how does the provider know by simple declaration here is a letter from Jerry Stilmock that says I'd like the medical records of Omaha Fire in relation to the emergency call made in relation to my father. I'm the son of Frank Stilmock. Probably need something more than that once we slide down the ladder of children, parents, adult brother, sister, those were items that said, well, if somebody submits a letter to the volunteer rescue squad and it includes the letters of personal representative issued by the court, that's readily understandable, we can handle that. The third item is an element of why do we protect people's privacy? Why do we have, even, this proposed legislation in the first place is because we hold dearly the privacy rights of others. What happens if you violate that privacy rights...those privacy rights? You're probably looking at some type of consequences; might be a lawsuit, might be something else. So people in general want to protect those privacy rights, particularly in the medical area. What if a mistake is made in handling...handing...delivering those medical records to somebody that should not have been entitled to them? We, as the provider, we relied on that statement to us that you were entitled to them. We were incorrect. So I think another element goes to if we're going to hand documents over to somebody that's claiming that they're entitled to them, then we, in turn as the providers, we ought to have some type of immunity that protects us in case we give them out to the wrong party justifiably and reasonably relying on those representations that were made to us. So I think as providers, I'd ask the committee to consider whether or not some level of immunity would be recognizable in case we give out those records, though on a justified basis, to somebody that turns out to be, oops, you made a mistake. Those are my comments in relation to Senator Wightman's bill and I'd be happy to try to answer any questions

should there be any. [LB1103]

SENATOR CAMPBELL: Any questions from the senators? Thank you, Mr. Stilmock. [LB1103]

JERRY STILMOCK: Thank you. [LB1103]

SENATOR CAMPBELL: (Exhibit 14 and 15) Anyone else in a neutral position? Okay, we need to note for the record that we received a letter from the Nebraska Health Information Management Association in a neutral position; and the Nebraska Hospital Association in a neutral position. And with that Senator Wightman has waived closing so we will close the public hearing on LB1103 and move to LB1142, Senator Nordquist. Good afternoon. [LB1103]

SENATOR NORDQUIST: (Exhibits 16, 17, and 18) Thank you. Thank you, Madam Chair, members of the committee. For the record I'm Jeremy Nordquist, represent District 7 which covers downtown and south Omaha. I thank you for your attention to this issue. We had a previous hearing on it this summer, LR197, which examined issues related to the implementation of an all-payer claims database in Nebraska. Quite frankly, I'm very committed to the concept of a healthcare database that allows employers, individual consumers in the state to evaluate how and why and where our healthcare dollars are being spent. Has been the primary criticism of healthcare reform wherever it's been enacted that improving access without addressing costs will bankrupt our state or country. And I would argue we cannot do anything about addressing the costs if we don't know and we don't have the data to tell us where and how our healthcare dollars are being spent. I see this bill as a necessary compliment to the establishment to a health insurance exchange in our state, and I see it as a critical component to analyzing the cost effectiveness of our healthcare system. The potential of a healthcare database which collects data on healthcare services, costs, and quality is tremendous. The challenge is getting from that concept to the realization. In states like Massachusetts, Maine and New Hampshire, patients use data from these systems to compare prices for health services. Soon state officials plan to offer quality ratings, cross-referenced with the cost data, to help patients make the most informed decision possible. In New Hampshire public health researchers are tracking frequency and location of disease; incidents by tracking claims data; and with one of these systems, we can...it is potential to test...we could test new payment methods and see how the reimbursements compare to those with each other and with Medicare and Medicaid. Providers can track how their quality of care stacks up to their peers and track the efficiency of medical home pilot projects. Employers could evaluate commercial insurers' reimbursement data to compare, contrast, and analyze what they get for their premium dollars as compared to the value of other insurers that are offering. I know this concept, certainly, maybe, seems threatening to some who benefit from the lack of information that we currently have; but I firmly believe that we need to make real

advancements and reduce some costs and the only way to get there is to ultimately know what those costs are and where they're coming from. As you remember from our interim study in early December, Denise Love from the National Association of Health Data Organizations presented before this committee, as well as Deb Bass from NeHI and Kevin Conway from the Hospital Association; and they all presented a little different perspective on why a system like this would be important to our state. But they all did agree on that the investment is an important long-term investment to make. In Denise Love's testimony she stated that the payoff can be significant down the road, but it's not an easy thing to build. And that's why I brought this bill today to establish an advisory committee to make recommendations on what a system like this would look like. Like any given tool, we need to have the form of it to follow the function of it that we want in it. It is my intent that the advisory committee would be comprised of the major stakeholders in our healthcare system and would determine what kind of function we would want this database to provide our state. Based upon those functions, we could determine what the database then would look like. In her testimony, Denise said that you really need to be strategic about how you go about something like this. And that's, ultimately, what the intent of this bill is to get the people around the table and to come up with a kind of strategic plan that we need. There's the many states that have moved forward with this, so the wheel has already been invented and we certainly don't need to go about reinventing that; but we can look to that as models. There is certainly models out there for privacy protection of the data and I, like I said, believe in this concept deeply. I was reading through the interim study transcript, and Senator Krist had some good questions at the interim study about how does this interact with the electronic medical records and claims data that hospitals already have available. And I think the key here is that that's perfect for the individual patient or the individual practitioner; but on the global level, policymakers, the really...you have NeHI which pulls the information for the specific provider to see, you know, where is this patient being treated, what's their comprehensive medical history look like. But you don't have anything on utilization and healthcare cost kind of on a global picture. And that's what we would be trying to build towards here. The fiscal note shows $6,000 for the cost of the meetings. I certainly introduced another bill, and I didn't put in this one, that you could remove per diems and make it solely voluntary which is an option to eliminate the fiscal note. And certainly with technology today, there's no reason that people have to travel far to have the kind of meetings that would be required for this. So the bill lays out specific acts for the advisory committee to come back to us and that would be...we would want a system to provide information to consumers and purchasers of healthcare to determine the capacity and distribution of healthcare resources; to identify the need and inform health policy; evaluate the effectiveness of intervention programs; review costs among various treatment settings, providers, and approaches; and ultimately to improve the quality and affordability of healthcare. So that would be the goal we would ask the committee to look towards building a system that would get to those. I did hand out, actually, from today in the Washington Post research that was done on...it was American autoworkers they looked at specifically, Chrysler, Ford and General Motors and the cost variation

between those individuals. And on the second page you'll see a graph which shows what kind...what makes up the cost variation for those patients, for those workers, I should say. And 33 percent was specifically to variation in price by what...not attributed to their health status; so, basically, we're comparing procedure to procedure, and out of this population a third of the variation was specifically the difference in price. So almost equal to the difference in the health status of the workers which was 37 percent. So, variation in price among providers has a tremendous impact on our system. And I think shining a light on that and having sunshine on that would help us bring down costs in the entire system and make our system more efficient. So, thank you. [LB1142]

SENATOR CAMPBELL: Senator Krist. [LB1142]

SENATOR KRIST: Just briefly, the Director of Insurance which, essentially, resides in the executive branch, is going to appoint the members. Are we going to go through the normal confirmation process in your mind? I don't see that in writing. [LB1142]

SENATOR NORDQUIST: We didn't put that in, but I think for the reason we wanted to...we kind of have it on a shorter time frame. But if this is something we wanted to do over a couple of years and wait until next session to make the confirmations, that could be as well. I think the idea to not have the appointment, just to have him put together an advisory committee with the members that are listed was more to move the process along and only have like...I think we asked him to come back by December with some thoughts. So it would be a six-month project or something. [LB1142]

SENATOR KRIST: Would you be amenable to say that this is an E clause action, we want to get it up and running and that the next appointment would go through the normal confirmation process. [LB1142]

SENATOR NORDQUIST: Yeah, we could do that, absolutely, yeah. [LB1142]

SENATOR KRIST: Okay, and the other things is, is this term to be a one-year position, a two-year position, three-year position? [LB1142]

SENATOR NORDQUIST: Well, I don't know that we...and I, actually, don't think we put a end date. And I think, really, we were looking initially at just getting it...a plan and recommendations for getting it off the ground. So really the work is six months; but if we want something more ongoing to continue to make tweaks on it, we can do that. But I think we're thinking more of just get these stakeholders together for six months, come back to us with what they think would work, and that would probably be the end of it. [LB1142]

SENATOR KRIST: Okay. Thank you. [LB1142]

SENATOR NORDQUIST: Yep. [LB1142]

SENATOR CAMPBELL: Other questions? Senator Nordquist, did you...this is just a procedural question, did you provide the letter from Dr. Smith? [LB1142]

SENATOR NORDQUIST: Yeah, I'm sorry, I meant to mention that, and that's supposed to be in the neutral capacity. [LB1142]

SENATOR CAMPBELL: Okay. [LB1142]

SENATOR NORDQUIST: I believe, so, just...they asked me to submit that, so. Yeah, sorry about that. [LB1142]

SENATOR CAMPBELL: That's quite all right. I just wanted to make sure I had it correct. Any questions? Okay. Will you be staying, Senator? [LB1142]

SENATOR NORDQUIST: Thank you. Yep, I sure will. [LB1142]

SENATOR CAMPBELL: All right, the first proponent. Good afternoon. [LB1142]

KEVIN CONWAY: (Exhibit 19) Thank you, Madam Chair. Good afternoon to you and good afternoon to committee members. My name is Kevin Conway, K-e-v-i-n C-o-n-w-a-y. I'm the vice president of health information for the Nebraska Hospital Association. I'm here today on behalf of our member hospitals in support of LB1142. It is my understanding the intent of LB1142 establishes a healthcare database. It also establishes the healthcare database advisory committee. The advisory committee, in my understanding, would guide the development of the healthcare database. The NHA understands the valued information that can be collected from healthcare data. Since mid-'90s, we've maintained a healthcare database that consists of hospital inpatient and outpatient activity used for a variety of services and information. We really understand the complexities of how to gather this data, how to maintain the technology to shepherd the data, and the dissemination of the data through information processes. It is used for a variety of services. The member hospitals find value in the reports we provide them. We have partnerships in both public health and research endeavors. I think two good examples of public health partnerships are...one is the Nebraska Department of Health and Human Services, there's an injury prevention program we routinely provide information for their use. We also run another program called the CODES Out...it's CODES which stands for Crash Outcomes Data Evaluation System. Again, that's worked with the Nebraska Department of Roads in preventing and eliminating automobile accidents and severity of automobile accidents. Really, at this point, I have two recommendations on LB1142. One is the makeup of the advisory committee. I would recommend that the provider is actually multiple providers representative; one from each, what I call, sector of the provider community. The type of data that hospitals,

physicians, dentists, pharmacists, optometrists use is different, and so the collection of that data would have different nuances. So I recommend that representatives of each one of those sectors be involved in the committee. I also recommend that there is a representative from a local health department. The local health departments use this data in a slightly different fashion than the State Department of Health and Human Services for public health purposes. So I recommend that there's also a local health department that is active in data use and data dissemination to their endeavors. I would also recommend that there is a participant from an existing data aggregated organization. So, they may have history in how to use this data, the best processes, the best way to shepherd the data. The second recommendation is the governance of the committee. At this point the advisory committee would be underneath the Department of Insurance. I think there are plenty of examples where if it's actually a public/private partnership, it tends to work better. There are some data organizations in other states that operate that way. In Nebraska we have two good examples. One is the Nebraska Telehealth Network, and NeHI. Those are both organizations that are, basically, private organizations with a public partnership. At this point I recommend that the committee move this to General File, LB1142, with the recommendation changes that we have made...recommended. [LB1142]

SENATOR CAMPBELL: Are there any questions? Thank you for your testimony. [LB1142]

KEVIN CONWAY: Thank you. [LB1142]

SENATOR CAMPBELL: Other proponents. [LB1142]

MARK INTERMILL: (Exhibit 20) Good afternoon, Senator Campbell, and members of the committee, my name is Mark Intermill, M-a-r-k I-n-t-e-r-m-i-l-l, and I'm here today to support LB1142. Many of the reasons why we support this bill have already been stated by previous testifiers. I would say that healthcare reform, if it is to be successful, whatever form it takes, will depend on its ability to control costs and provide quality outcomes for patients. And what we're talking about here with...developing information is essential to being able to evaluate that and also being able to provide information to consumers. I agree with Mr. Conway that I would like to see an expansion of the group, of the members of the group. I think additional providers would be useful. I also think having an additional consumer would be helpful as well. I've attached to the testimony, to my statement, just a piece of information that AARP has produced related to prescription drug utilization. This is the type of information, I think, we could produce from this committee that would provide consumers with information about the prescription drugs or other forms of treatment that they are able to utilize, and to best utilize, and also the cost of those treatments and those prescription drugs. This would empower consumers to be able to better utilize, or more efficiently utilize, the healthcare services that they need. So, for those reasons we do support LB1142 and we would

encourage the committee to advance it to General File. [LB1142]

SENATOR CAMPBELL: Are there any questions for Mr. Intermill? Thank you very much. [LB1142]

MARK INTERMILL: Thank you. [LB1142]

SENATOR CAMPBELL: The next proponent. Anyone else wish to speak in favor of LB1142? Anyone in opposition to LB1142? Any in a neutral position? Good afternoon. [LB1142]

JAN McKENZIE: (Exhibit 21) Senator Campbell, members of the Health and Human Services Committee, it is my great pleasure to be here today. It's the first time I've been in your committee this session. For the record my name is Jan McKenzie spelled J-a-n M-c-K-e-n-z-i-e. I'm executive director and registered lobbyist for the Nebraska Insurance Federation. We're here today in a neutral capacity on LB1142 as one of those stakeholders that I believe Senator Nordquist mentioned in desiring to have involved in the recommendations and the study process. I would like to leave for the committee...I'm sorry, I only made one copy because I took it off the Iowa Health and Human Services Web site and it's in blue, a lot of it, so it does not reproduce very well. But it is their analysis and study that they just have submitted relative to this issue in Iowa, and I think it outlines and identifies some of the key components and issues and challenges and recommendations that I thought you might find helpful in your decision-making process in discussing the bill. [LB1142]

SENATOR CAMPBELL: Are there any questions? Thank you very much for bringing the study, we'll take a look at it. [LB1142]

JAN McKENZIE: Thank you. [LB1142]

SENATOR CAMPBELL: Anyone else in a neutral position? Okay, we need for the record, to know that we received a letter from Dr. Smith who is the president of the UNMC Physicians; but he is sending the letter, I think, on his personal behalf in a neutral position. And then a letter of support from the Nebraska Nurses Association. So, Senator Nordquist, you would like to close? [LB1142]

SENATOR NORDQUIST: Just wanted to say that I'm certainly willing to work with the committee on the makeup of the board and recommendations for that, and also if we can bring the costs down to make it no General Fund impact, I think that would be important. I think the analogy was made by Denise at the interim study from her organization that our healthcare system is like the top of the line Bentley: we've spent all the money we can, but we really don't have a dashboard in the thing. We don't have a gas gauge or a speedometer to see where to do any kind of analysis on our systems.

So I think it's important that we start to move down that road to set up a system like that. [LB1142]

SENATOR CAMPBELL: Okay. [LB1142]

SENATOR NORDQUIST: Thank you. [LB1142]

SENATOR CAMPBELL: Any further questions that you would like to ask? Thank you, Senator Nordquist. [LB1142]

SENATOR NORDQUIST: Thank you. [LB1142]

SENATOR CAMPBELL: And with that we will close the public hearings and we will take just a quick break for the committee and come back for an Exec Session. [LB1142]