[LB705 LB732 LB916]

The Committee on Health and Human Services met at 1:30 p.m. on Friday, January 31, 2014, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB705, LB732, and LB916. Senators present: Kathy Campbell, Chairperson; Bob Krist, Vice Chairperson; Sue Crawford; Mike Gloor; Sara Howard; and Dan Watermeier. Senators absent: Tanya Cook.

SENATOR CAMPBELL: Good afternoon and welcome to the hearings of the Health and Human Services Committee. I'm Kathy Campbell representing District 25 and I serve as the Chair for the Health and Human Services Committee. We'd like to welcome you to the hearings and very much appreciate your taking time out of your day to share your thoughts with the committee. I'm going to go through some of the housekeeping hints and tips that you're going to need to know this afternoon as we proceed. If you have a cell phone and even if you have a tablet of some sort, would you make sure that it is on silent or it's turned off. Tablets make noise and we've finally figured out that that has been a distracting point. Handouts are not required in the committee if you're going to testify. If you choose to have handouts, we would like 15 copies. And the pages who are sitting to my far left will be glad to help you with those. If you are testifying today, please complete one of the bright orange sheets on either side of the hearing room and print as legibly as you can. When you come forward, you can give them to Brennen who is the committee clerk and he will make sure that any handouts you have the pages will distribute them. When you come forward and sit down to testify, we do have a light system in the Health Committee. We have five minutes and it'll be green when you start and it'll seem like it's green for a very long time. And it'll go to amber-yellow and that means you have one minute left. And when it goes to red, you're going to look up and you're going to see me trying to get your attention. Because what we try to do here is be very fair to the first testifier that comes for the day to the last testifier. And as you sit down, we ask that you identify yourself by name and spell your name. The transcribers who listen to what Brennen puts together need to hear you spell your name to make sure their records are correct. And with that, it is our custom in the Health Committee to do self...indentify who we all are up here. So we'll start on my far right.

SENATOR WATERMEIER: Dan Watermeier, Syracuse, District 1.

SENATOR HOWARD: I'm Senator Sara Howard. I represent District 9 in midtown Omaha.

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

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

SENATOR CRAWFORD: Sue Crawford, District 45, eastern Sarpy County, Bellevue,

and Offutt.

BRENNEN MILLER: Brennen Miller, committee clerk.

SENATOR CAMPBELL: And our pages today, Emily and Stuart are both at the University of Nebraska-Lincoln. And Stuart is studying English and is from Lincoln, and Emily is studying political science--firsthand view here (laughter)--and her hometown is Sioux Falls, South Dakota. Stuart and Emily have just been terrific in helping people with what they might need, so don't hesitate to ask them for help. Senator Cook is out of town at a meeting today and Senator Krist will be joining us. I think he is opening on another bill. So we will start with our first hearing today, LB732, Senator Kolowski's bill to change asset limitation for certain programs for public assistance. Senator, I think this is your first time with us this year. [LB732]

SENATOR KOLOWSKI: Yes it is. [LB732]

SENATOR CAMPBELL: But you've been here before and we're glad to have you back. [LB732]

SENATOR KOLOWSKI: (Exhibit 1) Thank you so much. Good afternoon, Chairwoman Campbell and members of the Health and Human Services Committee. My name is Rick Kolowski, R-i-c-k K-o-l-o-w-s-k-i, and I represent District 31. Over the interim, my office, the Retirement Committee, and a number of experts worked on LR213, a study to examine college savings in Nebraska and ways that we can increase participation in our state's 529 plans and to go a step further and look at financial literacy in this state. The premise was that if kids save for college no matter how small the amount might be, then they are more likely to go to college. And the earlier they start to save, the earlier they get on track to go to college. We held an interim hearing where experts in the field painted a detailed picture of college savings and financial literacy in Nebraska and the United States. We heard from State Treasurer Don Stenberg, Voices for Children, First National Bank who manages our 529 plans, college students, and university professors. They highlighted the barriers that are keeping our families from saving and some solutions to those barriers. From this interim study, we compiled a committee report which I have given to you and want to thank Kate Allen, legal counsel for the Retirement Committee, for her work in pulling this together. I want to take a moment to turn your attention to the tabbed page in the report and to thank the Department of Revenue for compiling this information. We asked the Department of Revenue to compile information on the demographics of people in this state who are using 529 plans by looking at their 529 fillings in their personal income tax returns. As you can see from this information, Nebraska families with an adjusted gross income below $50,000 will make up nearly half of the state's population, account for only 6.8 percent of those who made 529 filings in 2011. Meanwhile, Nebraskans reporting an income of over $100,000 will make up less than 18 percent of the population, constitute nearly 45 percent of all 529 plan

participants. This underscores the important work we need to do to make sure that college savings is an accessible option for all families, especially our lowest income families who need to start saving early to be able to afford college. LB732 is one way we can make college savings more accessible...a more accessible option for our lowest income families. LB732 removes 529 savings plans, student scholarships, and work study income from asset limit tests for the certain public programs--the Supplemental Nutrition Assistance Program, the Aid to Dependent Children, and the childcare subsidy program. This would help low-income families from having to choose between long-term and immediate well-being when considering college savings. If you would please turn to page 2 of LB732, I will walk you through the main points of this bill. In this bill, we are addressing the medical assistance program, the Supplemental Nutrition Assistance Program, SNAP, and Aid to Dependent Children, and the childcare subsidy program. (1) this year under the Affordable Care Act, college savings and educational income have already been excluded from asset limits for the medical assistance program. So this bill will not be changing anything regarding this program. (2) for the Aid to Dependent Children program, this legislation would exclude college savings from their asset limits and would clarify the exclusion of educational income since currently they exclude student financial assistance without defining what that is in their regs. (3) asset limits for college savings are already excluded for the Supplemental Nutrition Assistance Program. SNAP currently excludes all financial assistance given to students in the form of grants, loans, and scholarships and does not exclude assistantships, fellowships, and stipends. This bill would broaden the exclusions for SNAP to include all educational income. (4) for the childcare subsidy program, this bill would exclude college savings and educational income as both are not currently excluded for this program. This is just one immediate step we can take to help Nebraska's youth and their families. I look forward to working with you in the future to taking bigger steps to help support college saving and financial literacy in Nebraska. Thank you again for gathering today for what I foresee to be a very informative hearing. I'm anxious to get to our testifiers, so I'll ask you to hold questions for my conclusion if you would. Thank you. [LB732]

SENATOR CAMPBELL: All right. We shall do that. [LB732]

SENATOR KOLOWSKI: Thank you, ma'am. [LB732]

SENATOR CAMPBELL: And so we'll expect that you'll be here to close. [LB732]

SENATOR KOLOWSKI: Yes, I will. [LB732]

SENATOR CAMPBELL: That's great. We will take our first proponent for LB732, who favor the bill. [LB732]

AUBREY MANCUSO: (Exhibit 2) Good afternoon. Thank you, Senator Campbell, members of the committee. My name is Aubrey Mancuso, A-u-b-r-e-y M-a-n-c-u-s-o,

and I'm here on behalf of Voices for Children in Nebraska. We're here in support of LB732 today because we think it's an important first step in ensuring that lower-income families can save for college. Nationally, there's been a growing recognition of the importance of addressing the issue of accessibility to higher education, and attached to my testimony you'll find a copy of an issue brief we produced last year that highlights some of the research in this area that I'll share with you briefly today. A couple of factors have led to a growing problem of access and affordability in higher education. One is that the cost of higher education is increasing at a rate much faster than family incomes. The average tuition and fees at a public four-year institution in Nebraska increased by 16 percent over the last five years. At the same...over the same time period, nonadjusted medium income increased by only 2.2 percent. State budgets have also remained tight, limiting public funding for higher education. Over that same five-year period, per student state spending on higher education decreased by 17 percent. And this creates an essential challenge on two fronts. One is that our economy needs educated workers. Some current projections estimate that by 2020, 71 percent of all jobs in Nebraska will require higher education, and at current rates of attainment only 47 percent of the population would have some form of higher education by that time. There's also been a growing challenge of young people burdened by student debt. Approximately 63 percent of Nebraska students graduate with debt and that average debt burden is over $24,000. We think that creates a challenge not only for the individual consumer but for the larger economy. Debt can really hinder the purchasing power of young workers and also their ability to invest in assets that lead to longer term security, like purchasing a home. So states and cities have really started to take a leadership role in addressing the issues of access and ability in higher education. And much of the research and promising practice in this area has been around the issue of educational savings. The data that Senator Kolowski provided really highlighted the fact that our current educational incentive which is in the form of a tax deduction really isn't reaching the families who most need assistance in paying for higher education. And research has shown that not only does a savings account provide a resource to pay for some of the cost, but it also found that it impacts the individual aspirations. One study that's often cited found that students enrolled in an educational savings plan were six times more likely to attend college than peers who were not enrolled who had similar circumstances. So a couple of examples that I'll just highlight quickly of things that are going on around the country. And one is the Kansas Investments Developing Scholars program, and this actually provides matching deposits of up to $600 per child per year for households below 200 percent of the federal poverty level who are saving in 529 plans. Another example comes from the state of Nevada where they're actually seeding a $50 college savings account for every child entering public kindergarten, and they've committed to doing that for at least the next three years. These are just a couple of examples, but I think that LB732 provides a first step in laying that groundwork for ensuring that we're not creating additional barriers for lower-income families who are trying to improve their situation. Thank you, and I'm happy to take any questions. [LB732]

SENATOR CAMPBELL: Any questions, Senators? Aubrey, I just have one. [LB732]

AUBREY MANCUSO: Sure. [LB732]

SENATOR CAMPBELL: And I know you have two programs here. Are other states doing what this bill would do in terms of, you know, not counting that income? [LB732]

AUBREY MANCUSO: Yes. And I think it's...I have more data on this but it's a little bit complicated. Some states do it where they specifically exclude 529 programs and some states take another approach which is similar to what's in Senator Crawford's LB430 where they just exclude assets up to a certain level across the board. But several of their states, especially in SNAP program, which our SNAP program already does exclude it and to various other degrees in the other programs. Actually in childcare, we're one of only two states that has any sort of asset limit. And the other state is Rhode Island and they're talking about getting rid of theirs, so. [LB732]

SENATOR CAMPBELL: Right. Any other follow-up questions? Thank you for your testimony. [LB732]

AUBREY MANCUSO: All right. Thank you. [LB732]

SENATOR CAMPBELL: I didn't miss a question over there, did I? Aubrey was looking over there. Good afternoon. [LB732]

TIP O'NEILL: (Exhibit 3) Good afternoon, Senator Campbell, members of the Health and Human Services Committee. I'm Tip O'Neill, that's O-'-N-e-i-l-l. I am the president of the Association of Independent Colleges and Universities of Nebraska. It's always a pleasure to appear here before the Health and Human Services Committee. I don't get here that often. I'm mostly stuck in Education. (Laughter) [LB732]

SENATOR CAMPBELL: We're a friendly group. [LB732]

TIP O'NEILL: Okay. A lot friendlier (laughter). But I want to say it's kind of opportune that I am here because our sector does educate a lot of health professionals in this state. In fact, we award more than half of the baccalaureate and above degrees in the health sciences, in the independent sector here in Nebraska. And so we support LB732. You know, people don't necessarily think of our sector as, you know, the private colleges as one that enrolls a lot of poor students and minority students but, in fact, the independent colleges and universities have the highest percentage of minority students of an sector in the state, including community colleges. Michelle probably knows that from personal experience as a former colleague of mine in higher education, former dean of students at Concordia. But we have a lot of minority students in our sector and

we know of the unmet financial need of students in this state and the great sacrifice that families have to make to enroll students in colleges and universities, both public and private nonprofit colleges and universities in this state. And so we think that bills like Senator Kolowski's here that remove barriers from students so that they can attend colleges with as few financial barriers as possible are good policies for the state. We hope you and the other committee members will support this bill. I'd be happy to answer any questions. [LB732]

SENATOR CAMPBELL: Questions? Mr. O'Neill, I have a question. We obviously are seeing some students who do not qualify for a Pell Grant but still would not have the income level to afford that, because Pell Grants would cover a number of students or it's not enough. [LB732]

TIP O'NEILL: Well, the maximum Pell Grant for the 2013-14 award year is $5,645. But, again, that's the maximum level. [LB732]

SENATOR CAMPBELL: Oh, okay. [LB732]

TIP O'NEILL: So it varies by family income, so. And, again, it depends on the tuition price of the institution, it depends on whether the student is a dependent student or an independent student. You know, so there are a lot of factors that factor into what the cost is for the student and depending a particular institution. [LB732]

SENATOR CAMPBELL: I recently retired from a children's foundation and I had donors who were willing to help with tuition and so forth and really paid attention to the students who at some point their parent didn't fill out the Pell Grant, didn't turn the paper, didn't whatever, and really they qualified. But unfortunately because of that paperwork the student really needed financial aid... [LB732]

TIP O'NEILL: Right. [LB732]

SENATOR CAMPBELL: ...quite a bit of it. [LB732]

TIP O'NEILL: And that's why we need to publicize the availability of services like EducationQuest provides here in Lincoln and Omaha and Kearney. They do a great job for people who need help in filling out FAFSA and those financial aid forms, and they do it for free. And, you know, every state tournament and stuff like that, they advertise a lot and yet there are people who don't seem to get that word. [LB732]

SENATOR CAMPBELL: Any questions or comments from the other senators? Thank you, Mr. O'Neill. Always good to see you. [LB732]

TIP O'NEILL: Appreciate it. Thank you. [LB732]

SENATOR CAMPBELL: And the Education really is pretty friendly too. (Laughter) [LB732]

TIP O'NEILL: I was just joking. [LB732]

SENATOR CAMPBELL: I wanted to say that because Senator Kolowski is here (laughter) and he's on the Education Committee and... [LB732]

TIP O'NEILL: I knew that. [LB732]

SENATOR CAMPBELL: Our next proponent. Anyone else who wishes to speak in favor of LB732? Okay. Anyone in the hearing room who wishes to testify in opposition to the bill? Okay. Testimony in a neutral position? Seeing none, Senator, we're to you. [LB732]

SENATOR KOLOWSKI: Senator Campbell, members of the committee, thank you very much for the time today to hear this bill, and I want to thank all of those who testified today that we have a great opportunity to make a difference in the lives of many students and many families by moving this forward, and I hope you'll give that your consideration, and I know you will. I would like to end with a couple of just quick snippets of some comments. I did contact Dr. Ken Bird, you know, I had worked with him with this program. And I just wanted to mention as he was the...he's the ex-superintendent of the Westside schools and also is the director of the Avenue Scholars program in Omaha dealing with high potential but low-achieving and very poor students throughout the metro area. And he's very much in favor of this direction as well as they work with both Metro Community College and UNO with the students that they work with in the high schools going on to their next level. And he gave this his full support. My next two comments are really something that's spread 50 years apart and I do want to share it with you from a personal aspect. I think it's important. In my college days back in ancient history, we had...we were chasing Sputnik with the Russians launching, and in 1962 when I graduated from high school and went to college, we had the opportunities of applying for something called NDEA loans, National Defense Education Act loans. And I owe the federal government a great deal because that helped get me through the school that I attended and it had a great impact on my life because every year...as a teacher, every year I taught we had certain forgiveness in that. So as I moved on through my life and my teaching experiences, I had my master's from UNO, my Ph.D. from UNL, and I had both of those done, shingles on the wall and paid for before I even finished my NDEA loans because of the forgiveness over a number of years which was tremendous advantage and experience to go through from a financial side and a very positive payback I hope to our society in that way. Fifty years hence at the current time learning about these programs and what 529s could do from this perspective, and my wife, a former educator as well, we have taken our first 529 out for our oldest grandchild who is now a kindergartner in school. And when the other three

follow entering kindergarten, we're going to start a 529 for each of them. So we'll have a 13-year collection time K through 12 as they move onto college and a little something to remember grandma and grandpa by we hope. So I think they have many functions and I think they're great...it's a great tool to help families out and most of the money seems to be sitting in grandparents hands today compared to a struggling family's compared to a different situations that we might have all grown up with. So I share those with you only as a point of interest and I hope you'll...and I know you'll give this full consideration. I thank you for your time today. [LB732]

SENATOR CAMPBELL: (See also Exhibit 4) Thank you, Senator. Always good to have you with us. And with that, we will close the hearing on LB732. [LB732]

SENATOR KOLOWSKI: Thank you. [LB732]

SENATOR CAMPBELL: Thank you very much. Our next hearing is LB705. Senator Coash has a bill to change personal needs allowance under Medicaid. And Senator Coash is a regular here (laughter) and we... [LB705]

SENATOR COASH: It's my second home. [LB705]

SENATOR CAMPBELL: ...and we appreciate your partnership on a lot of bills. So welcome, Senator Coash. [LB705]

SENATOR COASH: Thank you. Well, good afternoon, Chairwoman Campbell. Good afternoon, members of the HHS Committee. I am Colby Coash, C-o-a-s-h. I represent the 27th District right here in Lincoln, here to introduce LB705. It's a very simple bill. It changes the personal needs allowance under Medicaid. If enacted, the Department of Health and Human Services shall include in the standard of need for the eligible aged, blind, and disabled persons $75 per month for a personal allowance if such persons reside in an alternative living arrangement that includes a boarding home, a certified adult family home, a licensed assisted living facility, a licensed residential child caring agency as defined in the statute, or a licensed center for the developmentally disabled and a long-term care facility. My interest in this issue came from a good old fashioned handwritten letter that I got from a constituent who lives in Lancaster Manor right here in Lincoln. The resident told me that she receives $50 a month allowance, but $25 of that $50 is automatically deposited into her cemetery plot fund. This leaves her with only $25 a month to purchase all of her toiletries, clothing, and other personal items. After some research, I learned that Medicaid personal allowance funds has not increased since 1999, 15 years ago, when it increased from $40 to $50. The funding for LB705 would come from General and federal matching funds and not from reimbursements to providers. This bill can have a significant impact on people in need. And with that, I would ask for your support. Thank you. [LB705]

SENATOR CAMPBELL: Questions for Senator Coash? I don't see any questions. Senator, will you be staying to close? [LB705]

SENATOR COASH: I think so. [LB705]

SENATOR CAMPBELL: Okay. [LB705]

SENATOR COASH: Thank you. [LB705]

SENATOR CAMPBELL: Terrific. Thank you. Our first proponent for LB705. [LB705]

KEITH FICKENSCHER: (Exhibit 5) Senator Campbell, members of the committee, I'm Keith Fickenscher, K-e-i-t-h F-i-c-k-e-n-s-c-h-e-r. As Senator Coash said, the Medicaid personal needs allowance has remained in effect at $50 since 1999. I thought it was earlier than that as a matter of fact. It must have been something less than $50 when I was administrator of the Grand Island Veterans Home in '96 because I remember in some of the foxhole chats I had with residents then they were complaining that it was too low and they couldn't buy anything. But the point is that it's obvious to those of us who live on the outside of the nursing home door that we have failed to acknowledge how 30 years of inflation has affected those who live on the other side of the nursing home door. And the opportunities for them to spend money on things to improve their quality of life have expanded tremendously over the course of three decades, things like over-the-counter pain relievers that they have relied on for years but which Medicaid nor Medicare will pay for or haircuts and perms. In our salon at Lancaster Manor, salons are...excuse me, haircuts are now $12 and perms are $16. So if a lady got one a week, in four weeks she would have used up her entire allotment of the personal needs allowance. But then they have things like opportunities now to buy snacks like popcorn, ice cream, or sandwiches. If they want a personal phone in their room, that can run up to $40 a month. Or as Senator said, many residents spend $20 to $25 a month to prepay their funeral expenses so their kids won't be burdened. Or if they want to go to a favorite restaurant or go shopping at some store, they have public transportation they have to pay for. Add all that up and you'll find the $50 comes up short, leaving nothing for jewelry, clothing, or subscriptions. So, yes, this increase of $25 is needed, it is warranted, and it is long overdue. Thank you. Any questions? [LB705]

SENATOR CAMPBELL: Thank you, Mr. Fickenscher. [LB705]

KEITH FICKENSCHER: Thank you, Chairwoman. [LB705]

SENATOR CAMPBELL: Are there any questions from...Senator Gloor. [LB705]

SENATOR GLOOR: Thank you, Senator Campbell. Keith, it's good to see you. [LB705]

KEITH FICKENSCHER: Thank you, Senator. [LB705]

SENATOR GLOOR: You're as sharp as a tack as ever. [LB705]

KEITH FICKENSCHER: Well, thank you. That's not what my wife says, but go ahead. [LB705]

SENATOR GLOOR: (Laughter) why do you think it took so long for this to be brought forward? Like you said, you can trace this back a ways because of your work. [LB705]

KEITH FICKENSCHER: You know, as a matter of fact I was embarrassed by the fact that it took so long when a resident of our facility wrote that letter. I thought about all the time I've known this and that I didn't do anything about it and that I brought it up at the Health Care Association Board meeting and everybody said, oh, wow, I just never thought of it. And so I'm embarrassed by that. And as somebody who's supposed to be an advocate for all the residents of the building, the fact that I didn't think of it and bring this up is an embarrassment. But I'm much more in tune with those things now. So I don't know. It's really strange that we didn't think of it. [LB705]

SENATOR GLOOR: Do you know, is the association supportive of this? Are they... [LB705]

KEITH FICKENSCHER: Totally. [LB705]

SENATOR GLOOR: Okay. Have they issued a letter or perhaps that's a question for Senator Coash. [LB705]

KEITH FICKENSCHER: They'll be here, the association. [LB705]

SENATOR GLOOR: Good, good. Thank you. [LB705]

KEITH FICKENSCHER: Thank you. [LB705]

SENATOR CAMPBELL: Any other questions of the senators? Thank you very much. [LB705]

KEITH FICKENSCHER: Thank you. [LB705]

SENATOR CAMPBELL: (Exhibits 41 and 42) We'll note for the record so that Senator Coash knows we have a letter of support from the ARC of Nebraska and from the Nebraska Association of Area Agencies on Aging. And I'm sure there are other letters and we'll read them into the record as we get them. Our next proponent for the bill. Right on cue. Good afternoon. [LB705]

NICK FAUSTMAN: (Exhibit 6) Good afternoon. I'm Nick Faustman, N-i-c-k F-a-u-s-t-m-a-n. I'm with the Nebraska Health Care Association, which is the parent association to the family of entities including the state's largest association for nursing facilities, that's the Nebraska Nursing Facilities Association otherwise known as NNFA, and the state's only association dedicated specifically to assisted living facilities, the Nebraska Assisted Living Association which I'll refer to as NALA. Both NNFA and NALA represent nonproprietary, proprietary, and governmentally run long-term care facilities, and NNFA and NALA both support LB705. LB705 raises the personal needs allowance for Medicaid residents in nursing homes and assisted living facilities to $75 per month. Administrators from member facilities report that the current levels of $50 in nursing facilities and $64 in assisted living facilities have not been adjusted for many years. I thought it was actually longer than the 15 years as well, but as Senator Coash reports, at least 15 years. And as caregivers, we are sympathetic to the needs of these individuals and, sadly, the current levels of the personal needs allowance is quite prohibitive. For example, some women living in nursing homes cannot afford things like having their hair done more than once or twice in a month and then have any resources left over for basic things, such as clothing, phones, stationary, stamps, snacks, or even their favorite magazine. This modest increase to a resident's allowance would make a world of difference to so many. Thank you for considering this important proposal. We urge the committee to advance the bill to General File. [LB705]

SENATOR CAMPBELL: Are there questions for Mr. Faustman? Senator Gloor. [LB705]

SENATOR GLOOR: Thank you, Senator Campbell. Nick, is there any way that this would be seen to be self-serving for the industry? I mean, I can't imagine that those dollars would be paid out to the nursing facilities in any way, shape, or form. [LB705]

NICK FAUSTMAN: No, and I don't think so. I think that was maybe the association...one of the association's concerns at first, but given the history that, you know, with inflation and cost of living increases, it's, you know...our members witness this firsthand in several individuals within the facility simple don't have the resources. [LB705]

SENATOR GLOOR: Sure. [LB705]

NICK FAUSTMAN: And I think it's just overlooked unfortunately as Mr. Fickenscher had said. [LB705]

SENATOR GLOOR: Well, and as an example, at least to my knowledge getting your hair cut or styled usually you pay who does that directly. There's just a place within the home where that can be accomplished. Is that usually the... [LB705]

NICK FAUSTMAN: In many cases, that is the case. [LB705]

SENATOR GLOOR: Yeah. Well, I assumed as much but thought it was probably worth getting on the record in case it comes up during discussion or debate. So thank you. [LB705]

NICK FAUSTMAN: I appreciate that. [LB705]

SENATOR CAMPBELL: Any other comments? Mr. Faustman, and I should have made this comment earlier. But when I served on the Lancaster County Board, we had responsibility for Lancaster Manor, and there were times, and I'm sure you would see this all across the state, in which if a resident really needed something, some of the staff members would have to step forward and try, you know, buy that small thing or help them buy. I remember once it was a birthday present for their grandchild. And you just begin to wonder, you know, why didn't we not think of this earlier, so. I'm sure the staffs all across the state have helped residents. [LB705]

NICK FAUSTMAN: Um-hum. Absolutely. [LB705]

SENATOR CAMPBELL: Thank you very much for coming today and your testimony. [LB705]

NICK FAUSTMAN: Thank you very much. I appreciate it. [LB705]

SENATOR CAMPBELL: Our next proponent. Good afternoon. [LB705]

KENT ROGERT: Good afternoon, Chairman Campbell, members of the committee. My name is Kent Rogert, R-o-g-e-r-t, and I'm here today representing Leading Age Nebraska, which is an association of nonprofit nursing homes. And I won't go into any further detail of why we support it because it's been previously said, but we do of course support it. Senator Gloor, I guess to answer a couple of your questions maybe additionally, I think self-serving actually could be the other way around. We would ask, you know, that there's a fiscal note here and we'd ask that the note get funded in an order not to take away from what the nursing homes get as...or assisted livings as their provider rates. [LB705]

SENATOR KRIST: Thank you, Senator Rogert. [LB705]

KENT ROGERT: Um-hum. [LB705]

SENATOR CAMPBELL: Any other questions? Thank you, Senator. Always good to see you. [LB705]

KENT ROGERT: Thank you. You too. [LB705]

SENATOR CAMPBELL: Our next proponent. [LB705]

BRAD MEURRENS: (Exhibit 7) Good afternoon, Senator Campbell, members of the committee. For the record, my name is Brad Meurrens, B-r-a-d M-e-u-r-r-e-n-s, and I am the public policy specialist with Disability Rights Nebraska, the designated protection and advocacy organization for persons with disabilities in Nebraska. I'm here today in support of LB705. Disability Rights Nebraska fully supports the increase in the personal needs allowance for persons living in these alternative living arrangements under Medicaid. It is often difficult for persons in these alternative living arrangements to acquire the personal necessities with the meager $50 that current statute allows them to have. Given the length of time that has elapsed without any corresponding increase in this personal needs allowance, we believe that this committee shouldn't even...or that the proposed increase is long overdue. That's a given. Additionally, we would respectfully suggest that this committee not be afraid to increase the allowance to, say, something around $95, given the long time frame that has elapsed when it hasn't been increased, and acknowledging that the purchasing power of $75 now in the year 2014 may be kind of limited for purchasing the needs of individuals who are living in these arrangements. And we would urge the committee to advance this bill out of committee. [LB705]

SENATOR CAMPBELL: Any questions or comments? Anyone? Thank you for coming. [LB705]

BRAD MEURRENS: You're welcome. [LB705]

SENATOR CAMPBELL: Our next proponent. Seeing no one, testifiers in the room who would like to oppose LB705. Testimony in a neutral position. Senator Coash, we're back to you. [LB705]

SENATOR COASH: Thank you, Senator Campbell. Maybe this will make consent calendar. (Laughter) No, I appreciate the testimony, appreciate Keith coming from Lancaster Manor. That's a very special place in my district in our community and I've spent some time there talking with the residents. And what I found there at one point over the holidays you might find a tree in Lancaster Manor where visitors can pick an ornament and on that ornament will have a resident's name and then something that they want that they can't afford. And you don't find things written on those ornaments that are very lavish. You find things like lotion and Tylenol and a haircut gift certificate to the salon. So those are the kinds of things that I think are...we may take for granted. I was happy to get that letter from my constituent and happy to bring this to the committee's attention. Thank you very much. [LB705]

SENATOR CAMPBELL: Thank you, Senator Coash. We'll do Senator Howard and then

Senator Krist. [LB705]

SENATOR HOWARD: Thank you, Senator Campbell, and thank you, Senator Coash, for bringing this bill to us. How much do other states allow for standard of need? [LB705]

SENATOR COASH: You know, I don't know, but I'm going to find out because I think that would be a...it would be a good thing for the committee and for me to know where we stack up. [LB705]

SENATOR HOWARD: And then just out of curiosity, I was trying to figure it out in the fiscal note which was why I was sort of hunting around, do you know, this is run through the Medicaid program, is this based on our current FMAP? Is there an increased FMAP based on the population that we're working with? [LB705]

SENATOR COASH: I don't know. [LB705]

SENATOR HOWARD: If you don't...I mean, I can try to find it out as well. [LB705]

SENATOR COASH: We'll get that answered for you. [LB705]

SENATOR HOWARD: That would be wonderful. Thank you. [LB705]

SENATOR CAMPBELL: Senator Krist. [LB705]

SENATOR KRIST: Well, you stole my FMAP question. (Laughter) My only other question is have you considered somehow putting a trigger on this so that it...we rise to a certain level in that cost of living increase or whatever? [LB705]

SENATOR COASH: I did. I did consider that. And from time to time in other committees we hear about triggers like that, and a lot of times the argument is that binds a future Legislature which is something we try not to do. If we try to say you have to make it a point decision time...point in time decision, and if we said it would bump up into a future Legislature's purview, that might be problematic which is I assume why it hasn't been done like that in the past. But I'm certainly open to that if it can be done within the rules. [LB705]

SENATOR KRIST: Well, I guess my suggestion would be that we probably should check with CMS about how that could be done or if it is done and fix it at one time. But that would be, again, the CMS question, so. Thanks for bringing the bill. [LB705]

SENATOR COASH: Yeah, we...thank you. [LB705]

SENATOR CAMPBELL: I just want to follow up on Senator Krist's question because I think it's a really good one. I think if we checked with Liz Hruska or Sandy, they could tell us whether there are triggers in the Medicaid program somewhere or other programs. And I'd probably get a quicker answer than trying to call CMS, but (laughter). [LB705]

SENATOR COASH: We'll talk to Liz. [LB705]

SENATOR CAMPBELL: I think it's a worthy question. Thank you, Senator Krist. [LB705]

SENATOR COASH: I think so too. And I'll follow up on that. [LB705]

SENATOR CAMPBELL: Okay. Any other comments? Thank you very much. [LB705]

SENATOR COASH: Thank you. [LB705]

SENATOR CAMPBELL: All right. If you are leaving, we ask that you leave quietly and take all conversations out into the corridor. [LB705]

SENATOR KRIST: I'm guessing this one is not going to go that fast. [LB916]

SENATOR CAMPBELL: Think so? Wise man that you are. [LB916]

SENATOR KRIST: Yeah. [LB916]

SENATOR CAMPBELL: We will proceed to open the public hearing on LB916, Senator Crawford's bill to eliminate integrated practice agreements and change provisions regarding nurse practitioners. Good afternoon. [LB916]

SENATOR CRAWFORD: (Exhibit 8) Good afternoon. Good afternoon, Chairwoman Campbell and fellow members of the Health and Human Services Committee. My name is Sue Crawford, C-r-a-w-f-o-r-d; and I represent the 45th Legislative District and Bellevue, Offutt, and eastern Sarpy County. Today I am presenting to the committee LB916, which is a bill to remove the integrated practice agreement for nurse practitioners in Nebraska. I'd first like to thank those on the committee who have signed on to LB916 as cosponsors, including Chairwoman Campbell and Vice Chair Krist as well as others on the committee, and others on the committee who have voiced their support for this legislation. As we begin the discussion, I want to call your attention to the question at hand in LB916, which is whether to strike language pertaining the integrated practice agreement from the Nurse Practitioner Practice Act for the state of Nebraska. As I was preparing to discuss this bill, I took time to read over the entire Nurse Practitioner Practice Act. I'd like to call your attention to a part of that act that is, in your green copy, on page 3, line 5. That section of the act reads, "A nurse practitioner

shall function by establishing collaborative, consultative, and referral networks as appropriate with other health care professionals. Patients who require care beyond the scope of practice of a nurse practitioner shall be referred to an appropriate health care provider." Notice that LB916 does not strike this language. It does not strike the requirement that nurse practitioners work collaboratively with other providers. All of the nurses and nurse practitioners that I know speak passionately about the importance of working with other providers. This requirement for nurse practitioners to collaborate, consult, and to refer patients remains in our statute. We have integration of healthcare and the requirement for collaboration, consultation, and referral in our statute here. An integrated practice agreement signed by a physician is not needed for integrated and collaborative care in Nebraska or for requiring or encouraging nurse practitioners to work collaboratively. Throughout my time learning about this issue, I have been working with a dedicated group of nurse practitioners and others who believe strongly in the collaborative relationships most nurse practitioners have with physicians and other providers. Nurse practitioners across the state enjoy strong professional bonds with physicians through working for the best interests of patients, teaching our future health professionals, and consultation and referral. I do not have to convince any of you that our healthcare delivery and finance system has changed radically over the course of the last few years and that business as usual is no longer an accepted way of providing care. We know that as Nebraska lawmakers look to the future, that our state faces existing shortages in primary care and mental health practitioners but also great new opportunities for innovation in telemedicine, population health, and collaboration. Whether it is through interim study groups like LR22 that this committee assists in leading, work by nurses as a profession to consider changes in their education standards, or other bills or studies that we introduce as individuals, there are many issues for us to consider to strengthen our healthcare system and encourage innovation. However, again I want to emphasize the question at hand in LB916. It is the question of whether to strike the requirement for an integrated practice agreement for nurse practitioners. This is a change that was supported by the Technical Review Committee and the Board of Health. Even Dr. Acierno acknowledges in his report that, quote, what is apparent is that both nurse practitioners and physicians believe that the practice agreement has not worked out as intended. I want to reiterate to those who may suggest that this issue needs further study, that this provider group has already completed a yearlong credentialing review. These reviews are extremely comprehensive and require multiple public hearings. I have been told that the nurse practitioners are very pleased that they underwent this rigorous process, and were actually the first provider group to complete their review under these new requirements. As you would see if you took time to read through the pages and pages of this study, you will see that this study cites many other studies of over decades of research that has been done on allowing nurse practitioners to have full practice authority. Let me just share a few items from some of those studies and testimonies from that report. There has been no increase in malpractice complaints or action taken against licensure by state boards of nursing in those 16 states with experience with full practice authority for

nurse practitioners. A 2008 Government Accountability Office report notes that the number of primary care physicians grew by 1 percent annually while the number of nurse practitioners grew 9 percent annually during the same ten-year window. Seventy percent of new psychiatric/mental health nurse practitioner graduates in our state, who we desperately need here in Nebraska, seek employment in other states, citing fewer practice restrictions in those other states. I asked the page to pass around a blank copy of the integrated practice agreement that is listed on the department's Web site for each of you to see. You may be surprised to learn that some nurse practitioners pay upwards of $25,000 per year for this document. I find it hard to imagine that this signed document that is housed in Lincoln advances healthcare in Nebraska. However, we do know that it clearly stands in the way of recruiting and retaining the health work force we need and stands in the way of allowing our trained nurse practitioners to practice throughout the state, including in rural areas, where health shortages are most severe. One of the other arguments you may hear is that nurse practitioners have less training than physicians and so it would be dangerous for them to practice in primary care without an IPA. Doctors may argue that a nurse practitioner would miss a diagnosis that a doctor would catch. It is true that nurse practitioners and doctors have different training. It is not just different in hours, it is different in approach. I assert the same argument could be made in reverse, that there are diagnoses that a physician might miss, with their medical model perspective, that a nurse practitioner, with their attention to lifestyle and collaboration with other providers might catch. Moreover, let me remind you that the existing IPA does not provide or require any check, any second check, on all nurse practitioner diagnoses. All health professions are working hard to improve diagnostics. Removing the IPA from statute, the question before us today with LB916, does not remove any existing second check on diagnostics. It does allow a more patients in our state to have access to diagnostics more quickly. Before I conclude, to allow you to hear from those who have come to testify for LB916, let me reiterate that LB916 does not remove the obligation from nurses to collaborate, consult, and refer with a network of other professionals. In my time on this committee, I have seen that we are clearly moving into the direction of integrated and patient-centered care. Despite the word "integrated" in its name, the IPA is not integrated care. I, along with others on this committee, am working hard on other initiatives in this state to strengthen patient-centered medical homes and other team-based care models. My commitment to LB916 is consistent with these efforts to create more opportunities for patient-centered care in our state and more flexibility for effective collaboration between our providers. Today you'll be hearing testimony from a number of individuals across the state regarding the barriers to care that the integrated practice agreement presents for our nurse practitioners. You will learn more about the issues surrounding the safety and wellness provisions that all nurse practitioners must adhere to; their education, training, licensure, and board certification requirements; the efforts to recruit and retain nurse practitioners to practice in underserved areas; as well as the personal experiences of practice owners providing care to many of our neediest citizens. I would welcome any questions that you might have, but you might prefer to hear everyone else first and have

me answer questions at the end, because many people after me may be able to answer your questions better. [LB916]

SENATOR CAMPBELL: Senator Gloor. [LB916]

SENATOR GLOOR: Thank you, Senator Campbell. Thank you, Senator Crawford. You threw out a statistic that I'd like you to repeat because I didn't quite catch it. And it had to do with the integrated practice agreements in 16 states where it... [LB916]

SENATOR CRAWFORD: Yes. Um-hum, um-hum. [LB916]

SENATOR GLOOR: ...currently exists... [LB916]

SENATOR CRAWFORD: Yes. [LB916]

SENATOR GLOOR: ...or where they don't exist. [LB916]

SENATOR CRAWFORD: So it...there has been no increase in malpractice complaints or action taken against licensure by the state boards of nursing in those 16 states with experience with full practice authority for nurse practitioners. And that comes from a nurse practitioner 2012 liability update... [LB916]

SENATOR GLOOR: Okay. [LB916]

SENATOR CRAWFORD: ...that I can give you the full cite for, if you'd like. [LB916]

SENATOR GLOOR: Thank you. [LB916]

SENATOR CRAWFORD: Thank you. [LB916]

SENATOR CAMPBELL: Other questions? Senator Krist. [LB916]

SENATOR KRIST: On page 4 of the green copy, starting with line 15, I'm assuming that some of these are technical changes to the actual certification and checking the background information and... [LB916]

SENATOR CRAWFORD: Sure. [LB916]

SENATOR KRIST: ...degrees of all. [LB916]

SENATOR CRAWFORD: Right. [LB916]

SENATOR KRIST: Do I understand what's been made here as a change: who

has..."shall provide to the department," which is the Department of Health and Human Services, "(1) evidence of a master's degree or doctorate degree in nursing and completion of an approved nurse practitioner program...evidence of separate coursework in" dah da-dah da-dah, on and on. [LB916]

SENATOR CRAWFORD: Um-hum. [LB916]

SENATOR KRIST: Tell me why we eliminated that and why we would not require a minimum time to be supervised before, because... [LB916]

SENATOR CRAWFORD: Sure. [LB916]

SENATOR KRIST: ...it seems consistent with...that both...and I'll go back to these again later on in asking questions of... [LB916]

SENATOR CRAWFORD: Sure. [LB916]

SENATOR KRIST: ...of both pro and con. But the Technical Review Committee...both Technical Review Committee and the Board of Health recommended that there should be a period of supervision and practice. [LB916]

SENATOR CRAWFORD: Right. I'd be happy to answer that. And again, I think others behind me will answer...will also be happy to answer that question, so I encourage you to ask it to those behind me as well. [LB916]

SENATOR KRIST: As many times as I want to? [LB916]

SENATOR CRAWFORD: Absolutely. Absolutely. (Laugh) Until you're satisfied, Senator Krist, with the answer. Yes. So the key of LB916 is to remove the integrated practice agreement. So at the bottom of that page, the "two thousand hours of practice" language is under an integrated practice agreement. [LB916]

SENATOR KRIST: Okay. [LB916]

SENATOR CRAWFORD: So with the aim of removing the integrated practice agreement, it removes that restriction as well. Now, some people coming behind me will talk about what that means and what those 2,000 hours looked like before. And I think you'll find in their arguments that they are not perhaps...that those hours are not necessarily improving collaboration and training of care for effective health outcomes. So again, that is the idea there, the idea that if there are changes in education, changes in hours, there are other places, other bills, other studies...and right now the nurses are working hard as a profession to go through all of their training and education and make decisions about what is appropriate in their training programs, themselves. And so

those discussions are appropriate in those places. It needs to be struck from the statute language as it's written now, because as it's written now those 2,000 hours were under this integrated practice agreement; and if we're getting rid of the integrated practice agreement, that gets rid of that language as well. [LB916]

SENATOR KRIST: And just a further...and I'm sure, as you say, there will be people behind you, but it seems to me you just enabled the department to set a standard level that's not in the statute, based upon the way I'm reading this. So it's a concern. [LB916]

SENATOR CRAWFORD: Okay. I'd be happy to talk about that. Thank you. [LB916]

SENATOR KRIST: Okay. Thanks. [LB916]

SENATOR CAMPBELL: Any other questions? I would have say, Senator Crawford, my question is the same as Senator Krist's, after reading the 407 report. So I'm glad you have people coming who will address it. [LB916]

SENATOR CRAWFORD: Yes. I knew that would be an issue, so I asked people to give that some thought and be ready to talk about that. Thank you. [LB916]

SENATOR CAMPBELL: Thank you. Seeing no other...and I know you'll be here to close. [LB916]

SENATOR CRAWFORD: I will. [LB916]

SENATOR CAMPBELL: Okay, our first proponent for LB916. [LB916]

SENATOR HOWARD: Yikes. [LB916]

SENATOR KRIST: This looks like Mr. Burns coming to testify. [LB916]

SENATOR HOWARD: A lot of paper. [LB916]

SENATOR KRIST: It's a little too much. [LB916]

SENATOR CAMPBELL: I think he talked to him and got him to do it. [LB916]

SENATOR KRIST: Ooh. [LB916]

SENATOR CAMPBELL: Good afternoon. [LB916]

KATHY HOEBELHEINRICH: (Exhibits 9-17) Good afternoon. Before I start...I'm Kathy Hoebelheinrich, H-o-e-b-e-l-h-e-i-n-r-i-c-h. And I'd like to submit--and those are being

distributed--letters of support from AARP, the Center for Rural Affairs, the American Association of Nurse Practitioners, the National Council of State Boards of Nursing, Dean Juliann Sebastian, Dean Eleanor Howell, and Ruby Houck, nurse practitioner. Good afternoon, Senator Campbell, members of the committee. I'm pleased to have the opportunity to speak to you today. I've been chair of the Credential Review Committee for Nurse Practitioners. While the proposal before you is removal of the IPA... [LB916]

SENATOR CAMPBELL: Can we stop for just a minute? Do you have a question? [LB916]

BRENNEN MILLER: Could you please spell your name for me? [LB916]

KATHY HOEBELHEINRICH: Yes. [LB916]

SENATOR CAMPBELL: She did, but... [LB916]

BRENNEN MILLER: Did you? Could you do it one more time? [LB916]

KATHY HOEBELHEINRICH: Sure. (Laughter) Are you going to give me longer time on the green light for that? [LB916]

BRENNEN MILLER: Yeah. (Laughter) [LB916]

KATHY HOEBELHEINRICH: And you won't be surprised I've been doing this for 30 years. H-o-e... [LB916]

BRENNEN MILLER: Okay. [LB916]

KATHY HOEBELHEINRICH: ..b-e-l-... [LB916]

BRENNEN MILLER: That's all I needed. Thank you. [LB916]

KATHY HOEBELHEINRICH: (Laugh) Thank you. [LB916]

SENATOR CAMPBELL: Okay, go right ahead. [LB916]

KATHY HOEBELHEINRICH: All right. The hearing today is the culmination of a successful credentialing review. And the product of that is right here in the box. And there are a few of us in the room that have read all of it, a lot more in the room that have contributed to that. I do wish to acknowledge the vision and collective efforts of you, Senator Gloor and Campbell. You led the initiative for the statutory revision in 2011 with the credentialing review process. As Senator Crawford has stated, nurse practitioners were the first applicant group to test the revisions, and we accomplished what we

believe lawmakers intended: a thorough and a comprehensive review of the evidence, fair discussion of opposing information in a mediated forum, and, finally, thoughtful inquiry and recommendations on the basis of clearly established criteria. And here are the prevailing issues. There is evidence of the difficulties securing an IPA, and you'll hear more about that later. There's also evidence that public access to care would be improved. Nebraska has an aging rural population with associated relatively high rates of chronic disease and disability. There is an increased need for primary care services for all age groups merely because of the ACA. Work force shortages are exacerbated by an aging physician work force and persistent difficulties attracting and retaining physician providers in rural areas. Work force data demonstrates that nurse practitioners are moving ahead of other providers to fill the gaps for primary care services in the state. It has also been shown that qualified graduates do move to other states with relatively fewer practice restrictions. The removal of practice restrictions in other states has also been shown to increase the number of licensed nurse practitioners in rural areas and improve access to basic health services for Medicare patients. Our credentialing review committee conducted an extensive review of the malpractice literature. And, contrary to what you've been told in recent days, it is well documented that malpractice premium rates for all providers increase in response to what the insurance industry terms as an "analysis of risk exposure." Physicians have long been subject to higher litigation rates, and there is no disagreement that nurse practitioners are trending that way with the progression of regulatory reform and fewer practice restrictions. Conversely, malpractice insurance rates do increase, with the recommended addition of policy riders, for any provider engaging in supervisory relationships with nurse practitioners. The proposal before you does not remove the current statutory requirements that nurse practitioners hold malpractice liability insurance. It also does not change the fact that nurse practitioners are fully licensed autonomous providers practicing under their own scope of practice, meaning that we bear full responsibility and accountability to consumers for the patient-care decisions that we make. Removal of the integrated practice agreement within the practice act will provide us in Nebraska with full practice authority. Full practice authority is that collection of state practice and licensure laws that allows us to evaluate patients; diagnose; order and interpret diagnostic tests; initiate and manage treatments, including the prescription of medications. Nurse practitioners have full practice authority in 18 states including neighboring Iowa, Colorado, and Wyoming. An additional six states including neighboring Minnesota and Kansas have announced pending initiatives this year to expand their practice authority. Full practice authority for advanced practice nurses is neither new or untested in practice, as we've experienced with the certified registered nurse anesthetists. And you'll hear from them later. In conclusion, nurse practitioners have completed a thorough and objective assessment of the evidence to date. We have also openly and fairly responded to the recommendations and concern raised by those groups and individuals charged to do so during the course of our credentialing review. There are processes, practice precedents, and/or evolving consensus standards to assure lawmakers charged with the safety, health, and welfare

of our citizens that unrestrained removal of the practice agreement requirement between nurse practitioners and physicians can improve access to much-needed healthcare services in the state. Senators, on behalf of Nebraska nurse practitioners, I wish to thank you for your interest and support of the proposal before you. I also wish to acknowledge your commitment to the health, safety, and welfare of our citizens. [LB916]

SENATOR CAMPBELL: Thank you for your testimony. Senator Krist. [LB916]

SENATOR KRIST: Kathy, thanks for coming and for your testimony. One of my favorite terms is "scope of practice." [LB916]

KATHY HOEBELHEINRICH: Sure. [LB916]

SENATOR KRIST: And so tell me why this bill is not a change in scope, from your perspective. [LB916]

KATHY HOEBELHEINRICH: Thank you. The terms of the credentialing review...that was a very confusing element. And, actually, the scope...it's more of an issue of verbiage. Or...or this is considered a scope of practice discussion. In reality, there is no change in our scope of practice. Our scope of practice exists separately from the practice agreement. [LB916]

SENATOR KRIST: Okay. Thanks. [LB916]

KATHY HOEBELHEINRICH: Um-hum. [LB916]

SENATOR KRIST: And I agree. I just want... [LB916]

KATHY HOEBELHEINRICH: Okay. [LB916]

SENATOR KRIST: ...for the record, I want to make sure that we... [LB916]

KATHY HOEBELHEINRICH: Okay. [LB916]

SENATOR KRIST: ...we talk about it in the proper terms. And if you're not doing anything then that would have done now, or back then, then... [LB916]

KATHY HOEBELHEINRICH: No. In fact, for the vast majority of us, nothing will change. The practice agreement is largely an issue of access to care where there are not physicians to enter into those agreements. [LB916]

SENATOR KRIST: Thank you. Thank you, Chair. [LB916]

SENATOR CAMPBELL: Senator Howard. [LB916]

SENATOR HOWARD: Can you...thank you for your testimony. [LB916]

KATHY HOEBELHEINRICH: Sure. [LB916]

SENATOR HOWARD: Can you explain to me the impact of the 2,000-hour requirement and why it was removed? [LB916]

KATHY HOEBELHEINRICH: Sure. Yes. And thank you; I appreciate the opportunity to clarify that. I think there may...somewhere along the way there...that 2,000 hours may be represented as perhaps a clinical component or an extension of education, and it is not. In fact, the 2,000 hours...one of the pieces of paper we did hand you is an attestation form stating that as a new graduate I have practice protocols and I'm entering into this 2,000 hours...supervisory period. And so I submit an attestation form saying that I have protocols. And then I...at the end of those 2,000 hours, I submit a statement saying that I've completed 2,000 hours; that's it. That's...there are no outcomes; there's no additional reporting. You could do nothing in that supervisory period. And for myself personally, that was exactly my experience. There was no measurable difference at the hour 1,999 and 2,001 for me. And I would venture to guess that...and, certainly, you know, I've heard from colleagues, where, you know, those protocols did not exist. The protocol language...I also want to clarify, protocols are a badly outdated provision. In my day, I had a manual on my desk; that was my protocols. I may have referred to those for some obscure diagnoses. Now with all the electronics that we have, I could pull up the standards of care on an issue in a meeting that occurred somewhere else yesterday. And then the question becomes, am I accountable to that standard of care that was revised yesterday or a manual on my desk that is badly outdated? And so those protocols, those were truly pencil-and-paper tools at their inception. And they become a liability issue for us. [LB916]

SENATOR CAMPBELL: Okay. Did you want to follow up, Senator Howard? [LB916]

SENATOR HOWARD: I guess when you talk about the 2,000-hour being...you have to attest to it, that there's no sort of... [LB916]

KATHY HOEBELHEINRICH: No accountability. [LB916]

SENATOR HOWARD: ...certification of... [LB916]

KATHY HOEBELHEINRICH: Nothing. [LB916]

SENATOR HOWARD: ...of competence. [LB916]

KATHY HOEBELHEINRICH: Absolutely. [LB916]

SENATOR HOWARD: Would it be better for us to ask you to perform 2,000 hours and then have a...take an exam or something like that? [LB916]

KATHY HOEBELHEINRICH: No. And I say no because in order to be licensed, we've already met educational standards and we're certified. That 2,000 hours...and you'll hear from someone behind me; we have nurse practitioners that cannot even secure an agreement for the initial 2,000 hours. We have individuals waiting to practice and cannot secure an agreement for 2,000 hours that essentially...there's no measurable outcomes attached to that that I'm aware of or that anyone that I'm acquainted with has ever had to produce to say: I've completed these 2,000 hours; here were the objectives of that, and here's what we've accomplished. And certainly in healthcare that's what we're all looking for, where you state ahead of time what is it that you wish to accomplish and how do you measure that. And that does not exist. [LB916]

SENATOR CAMPBELL: Senator Gloor. [LB916]

SENATOR GLOOR: Thank you, Senator Campbell. I want to go back to scope of practice in a real-world sense. I'm going to go back to three previous visits to primary care physicians. [LB916]

KATHY HOEBELHEINRICH: Um-hum. [LB916]

SENATOR GLOOR: The most recent one, which actually has been within a couple of weeks... [LB916]

KATHY HOEBELHEINRICH: Um-hum. [LB916]

SENATOR GLOOR: ...was the removal of a suspicious mole... [LB916]

KATHY HOEBELHEINRICH: Um-hum. [LB916]

SENATOR GLOOR: ...which my primary care physician excised and sent off for pathology. Could a nurse practitioner have done that within the scope of practice, pulled out the scalpel, cut it out? [LB916]

KATHY HOEBELHEINRICH: She could have with...if she had been trained to do so and her setting supported that. Now, let me phrase it this way, there could be...myself, trained as an adult nurse practitioner, I can certainly work in the same setting with a nurse that has been trained to do that, as I have. I do not do that. Yeah. But certainly...certainly she could... [LB916]

SENATOR GLOOR: Okay. [LB916]

KATHY HOEBELHEINRICH: ...if the setting supported that and she had been trained to do so. [LB916]

SENATOR GLOOR: Previous visit was to have a colonoscopy done, and that was done by my primary care practitioner. [LB916]

KATHY HOEBELHEINRICH: Yes. [LB916]

SENATOR GLOOR: Could that have been done by a nurse practitioner? [LB916]

KATHY HOEBELHEINRICH: No. It's not... [LB916]

SENATOR GLOOR: Okay. [LB916]

KATHY HOEBELHEINRICH: ...in our scope of practice. [LB916]

SENATOR GLOOR: Okay. That's kind of some of the drill-down I'm wanting to do. [LB916]

KATHY HOEBELHEINRICH: Okay. Okay. And I can give you another example. My practice area is diabetes. And, certainly, I adjust medications, review blood sugars. If I have a patient walk in with a foot wound, and I've had that happen, I'm qualified to evaluate that foot wound, and then I need to make a decision in terms of, can I manage that, or do I need to refer them to a surgeon. [LB916]

SENATOR GLOOR: How about writing a script for beta blockers? [LB916]

KATHY HOEBELHEINRICH: I...I have the credentials to do that; however, that particular class of medications I probably would not. [LB916]

SENATOR GLOOR: Okay. Thank you. [LB916]

KATHY HOEBELHEINRICH: Yes. [LB916]

SENATOR CAMPBELL: And I may be redundant in my question, to Senator Krist's, but why do you think that the Technical Committee put in the ancillary recommendation? [LB916]

KATHY HOEBELHEINRICH: For the...for the transition to practice requirement? [LB916]

SENATOR CAMPBELL: Yes. [LB916]

KATHY HOEBELHEINRICH: The...again, I'm not sure that--and in hindsight--that we fully articulated those 2,000 hours, what...exactly what that was, or is not, is probably the more accurate way to describe that. [LB916]

SENATOR CAMPBELL: Um-hum. [LB916]

KATHY HOEBELHEINRICH: And transition to practice...you have to remember that nurses aren't the only new graduate healthcare professionals. We all have new graduates, and they're all transitioned to practice without specific statutory clauses. You know, I challenge you to name another healthcare professional anywhere that is not a new graduate and does not have the support they need on an employment situation to transition to practice. And it's not in statutory language. [LB916]

SENATOR CAMPBELL: Okay. Any other questions? Thank you. [LB916]

KATHY HOEBELHEINRICH: Anything else? [LB916]

SENATOR CAMPBELL: Our next testifier. Is all of that material to be given to the clerk, that's left on the table? [LB916]

KATHY HOEBELHEINRICH: No. Oh, sorry. [LB916]

SENATOR CAMPBELL: That's okay. I just didn't know if we were supposed to take it away. Good afternoon. [LB916]

CATHY PHILLIPS: (Exhibits 18-24) Madam Chair, members of the committee, my name is Cathy Phillips, spelled C-a-t-h-y P-h-i-l-l-i-p-s. I am here today representing Nebraska Nurse Practitioners in support of LB916. Thank you for allowing me to testify. I am a psychiatric nurse practitioner in Hastings. I diagnose and treat both acute and chronic mental illness. In 13 years of practice, I have been fortunate to establish myself as a competent provider in a multicounty area through routine and active collaboration and referral with other healthcare professionals. NPs are expert and deliberate collaborators. I precept students and mentor new NPs to develop collaborative networks, something all professionals do. Professionals do not collaborate and refer because it is required in statute, but because it is vital to providing care. Nebraska law mandates that NPs maintain a collaborative agreement with a physician in the same specialty area and in the same geographic location. This integrated practice agreement, or IPA, is a practice barrier for NPs and an access-to-care barrier for Nebraskans. Fortunately, I work in a hospital-owned clinic and my IPA is with a hospital-employed psychiatrist at no cost to me. Others are less fortunate. They or their employers pay from $500 to $2,000 monthly for an IPA for which no service is received. One colleague

works for an urgent care clinic whose owners pay for the IPA with a non-clinic-employed physician. This NP and physician have never met. And another colleague made international calls to her collaborating physician, who is often out of the country. This NP left Nebraska for Alaska, a full practice authority state, and remarked she could practice more easily in remote rural Alaska than in Nebraska. NP practice owners are particularly vulnerable. They pay IPA fees to remain in business. They are at risk when a collaborating physician moves or retires. A waiver option exists but is time-limited, a tenuous way to run a practice, wondering if another IPA can be secured. Protocol prohibits hospital-employed physicians from providing IPAs to non-hospital-employed NPs, due to conflict of interest. There are qualified NPs who want to open or maintain practices and, frequently, they have no collaborating physicians available. I am submitting four letters from rural psychiatric NPs: three are practice owners in Scottsbluff, Kearney, and Geneva who could not be here; one is a new graduate from Wood Lake. Their stories illustrate the IPA barriers pertinent for rural Nebraska and for psychiatric care. There are over 1,000 NPs in Nebraska. Many rural counties rely on them to fill voids in provider shortages. In some counties, NPs may be the only healthcare provider. Decades of research shows that NP clinical outcomes and patient satisfaction measures meet or exceed physician comparators. No evidence supports that requiring an IPA results in higher-quality care. In states with full practice authority, NPs gravitate to rural areas. And as Senator Crawford pointed out, Nebraska lost 70 percent of qualified psychiatric NPs to these states from 1982 to 2008. The Rural Health Research Center encourages full practice authority to address rural provider shortages. The Institute of Medicine and the National Governors report support removing barriers to nursing practice. Eighty-eight Nebraska counties are psychiatric provider shortage areas; 37 have no psychiatric provider. However, mental healthcare issues in no way supersede those of primary care or any other shortage area. Nebraska has 65 primary care shortage counties, and we recognize the interdependence of mental health in primary care. NPs are part of the solution to these shortages. We can and do provide high-quality, cost-effective, and accessible healthcare for Nebraskans if allowed to do so. We ask for your support of LB916 to remove the IPA requirement for Nebraska nurse practitioners. Thank you for your service to our state. I'm happy to answer any questions you might have either about psychiatric care or shortages or otherwise. [LB916]

SENATOR CAMPBELL: Senator Krist. [LB916]

SENATOR KRIST: We've heard over and over again in the time I've been on this committee that there are critical shortages of critical care, and psychiatric care is obviously one of those. Just for my information and consistent with what's already been said, your education included what to get to where you are today? [LB916]

CATHY PHILLIPS: I have a master's degree from Creighton University; I am licensed by the state of Nebraska as an advanced practice registered nurse, nurse practitioner; and

I'm credentialed by the ANCC as a psychiatric-mental health clinical nurse specialist nurse practitioner. [LB916]

SENATOR KRIST: And how long have you been doing it? [LB916]

CATHY PHILLIPS: Thirteen years. [LB916]

SENATOR KRIST: Did you have a problem transitioning to practice? [LB916]

CATHY PHILLIPS: No, I did not. I had a network that was available to me that was developed. As the previous testifier mentioned, all professionals mentor their own. And you set up your networks initially when you're doing your clinical preceptorships, and then networks evolve from there as well with other healthcare professionals. [LB916]

SENATOR KRIST: What's the geographic area that you cover from Hastings? [LB916]

CATHY PHILLIPS: Boy, I...we cover...I provide psychiatric services in a hospital-owned clinic. I cover for...in the absence of psychiatrists on the inpatient unit in the hospital, and I provide services in long-term care and assisted-living facilities as far south as Red Cloud, as far east as York, Fullerton, Central City, Grand Island, Minden, Kenesaw, and the Hastings area as well. [LB916]

SENATOR KRIST: Thank you. Thanks for what you do. [LB916]

SENATOR CAMPBELL: Any other questions? Thank you. [LB916]

CATHY PHILLIPS: Thank you. [LB916]

SENATOR CAMPBELL: Our next testifier. I'm going to take this time to give an announcement, and this is on behalf of the clerk. We would like to remind you to write clearly (laughter) on the orange sheets. [LB916]

BRENNEN MILLER: That wasn't because of whoever that person was; it was (inaudible) (laughter). [LB916]

SENATOR CAMPBELL: I waited to give the announcement because I (inaudible). He actually had sent me the note before we started the hearing, and I neglected to mention it. And to fill out the section on who they represent, on the orange sheet--that's very important--even if it is "Self," so that we know, for the record, who you are representing. And if it is just yourself, that's great. [LB916]

SENATOR KRIST: You're not writing prescriptions, in other words. (Laughter) [LB916]

SENATOR CAMPBELL: Oh, well, I don't think that you all, probably, are any less hard to read when you write it than any other group we have, so we keep reminding people. Thank you very much. And you go right ahead. [LB916]

JAMIE PETERS: (Exhibit 25) Good afternoon, Chairman Campbell and members of the committee. I am Jamie Peters, J-a-m-i-e P-e-t-e-r-s, co-owner of Health at Home, which is a nurse practitioner-owned practice that provides compassionate care to the homebound elderly population. The residents that we serve are unable to leave their homes, due to chronic health conditions. I am pleased to have the opportunity to speak to you in support of the proposal before you to remove the integrated practice agreement requirement for nurse practitioners. I would like to make the following points. The IPA poses a barrier to my practice in an innovative, highly successful model of home healthcare that serves otherwise forgotten elders and their caregivers. Nurse practitioners are uniquely qualified and educated to work in interdisciplinary team models of care like home health services. My effectiveness as a highly qualified, skilled provider in home healthcare--consultation, collaboration, and referral to other healthcare professionals--is not defined by the terms of the IPA agreement. There is no place like home. And house calls by nurse practitioners are an excellent way to assist older adults from falling prey to the revolving-door syndrome of emergency department visits and re-hospitalizations that frequently follow the hospital stay. For most individuals, aging is accompanied by chronic disease and progressive disability. Geography, being part of the sandwich generation with children and older parent tasks, and employment are a few of the challenges encountered when Mom and Dad need help with healthcare and medical appointments. Patient referrals for our services are not physician-driven. Instead, they come from family, nursing staff who have experienced the problems of the multiple medical appointments that take families away from work and result in too many costly and unnecessary referrals for acute care services. Until Health at Home was available, adult children had often elected for an emergency room visit via ambulance for their aged parent rather than spending the hours of sitting at the physician's office waiting for that 15- to 20-minute appointment. Few would argue with the merit or need for this innovative care model. However, the requirement to have an IPA has posed a barrier to my practice with this underserved population. In order to start my practice, I needed a physician to sign the form. Although imitation may not be the sincerest form of flattery, it was distressing to find six months into starting the practice that, without my knowledge, my collaborating physician had initiated the same practice and had become my primary competitor. I had no choice at that time but to stay with him, as my practice would be shut down immediately and those forgotten elderly would no longer be receiving the healthcare if I did not have that IPA. By taking my own house calls 24 hours a day, 7 days a week, my practice has become very successful and provides a service that our present IPA physician simply would be unable to offer. Our practice has reduced hospital readmissions in one of our referring facilities by 82 percent. We require nursing staff to contact the nurse practitioner before sending the client to the ER of the hospital. The nursing model has long emphasized prevention and continuity of care as a

priority, in contrast to the more traditional episodic medical model of care that responds after illness has occurred. In a traditional medical model of care, phone calls to an on-call provider from the family or the nursing staff will almost certainly result in a referral to the ER simply because the provider is less familiar with the patient or the circumstance. Nurse practitioners view patients and families as active participants in their care. Our patients and their families are fully engaged in the care planning. For those individuals facing end-of-life decisions, that means that they can choose not to enter the emergency department or the hospital again. My previous IPA/competing physician is no longer in the house call business. After hours of research, which ultimately was taking me away from my patient care responsibilities, I was able to locate a physician willing to enter a contract. We have a good relationship, but as a new practice owner I do struggle with a financial burden imposed for the mere sake of his signature on a practice agreement. At this time, we meet weekly for the sole purpose of obtaining his signature on prescriptions for durable medical equipment, supplies, to third-party payer requirements. The physician never sees these patients, and his signature is the extent of the involvement in the plan of care and treatment decisions that I make. I am very competent in my knowledge and skills as a home healthcare provider. I am also competent that my practice is an asset to my community, but, most of all, my practice enables my clients to remain in their own homes. My practice is more than a signature on a piece of paper, a prescription pad, or an invoice. [LB916]

SENATOR CAMPBELL: You can go ahead and finish. [LB916]

JAMIE PETERS: All right (laughter). I am pretty much there. I wish to thank you for your interest in the proposal to remove the integrated practice agreement. [LB916]

SENATOR CAMPBELL: Okay. Thank you, Ms. Peters. Questions? Senator Howard. [LB916]

SENATOR HOWARD: So from what you're describing, it sounds like the IPA doesn't impact your patients at all? [LB916]

JAMIE PETERS: It does. In my practice, because I'm in the home setting, it's...when I need to have a certain order or when I need to do something for an individual, often I have to go back to my physician to have things signed. He may need to sign paperwork, and he never knows this patient. It's me that's doing the care; it's me seeing that individual. [LB916]

SENATOR HOWARD: So, then, do you believe that if we got rid of the integrated practice agreement, there would still be a collaborative relationship? [LB916]

JAMIE PETERS: Personally, in my practice, how I do it in my practice, I may be working with an individual that has a physician, that I would collaborate with that physician. It's

not my physician that I have the IPA agreement with that I would collaborate. It would be with the physician that knows this patient. My physician that has the IPA agreement with me doesn't know this patient, does not...is never involved with that care. So I, as a provider, I would collaborate with the individual that I know knows this individual, which would be their physician or a specialty. [LB916]

SENATOR HOWARD: Okay. Thank you. [LB916]

JAMIE PETERS: Um-hum. [LB916]

SENATOR CAMPBELL: Senator Krist and then Senator Gloor. [LB916]

SENATOR KRIST: So I'm a pilot; you've got to put it in simple terms. [LB916]

JAMIE PETERS: Okay. [LB916]

SENATOR KRIST: You are forced to pay a physician for that physician's signature, and that physician never sees the patients that you're dealing with. [LB916]

JAMIE PETERS: Correct. [LB916]

SENATOR KRIST: And when you're dealing with this in the home, you would normally have to have scripts written or have to have something done; those would be another physician. So, in fact, you are collaborating on a daily basis to take care of the patient because you're not capable of doing, maybe, everything that needs to be done. Is that...? [LB916]

JAMIE PETERS: Everyday practice, if I was to write a prescription, yes, I could do that. But if I came to a situation where I believed that this was past something that I was comfortable with... [LB916]

SENATOR KRIST: Okay. [LB916]

JAMIE PETERS: ...it's my responsibility as that provider to know when I need to collaborate. [LB916]

SENATOR KRIST: Okay. [LB916]

JAMIE PETERS: So in that situation, whether I was to utilize my IPA physician that does not know this patient or to utilize the other resources that I have available, often in my practice I choose to use a separate provider, a provider that I feel is in that specialty or a physician that has seen that patient in the past. [LB916]

SENATOR KRIST: Got it. Thank you so much. [LB916]

SENATOR CAMPBELL: Senator Gloor. [LB916]

SENATOR GLOOR: Thank you, Senator Campbell. Thank you, Ms. Peters. Help me differentiate what a change in statute might mean versus what third-party payers would require. In other words, are there still going to be third-party payers--insurance companies, specifically--who might require a physician's signature in order to authorize a DME purchase, as opposed to what the law would allow? [LB916]

JAMIE PETERS: Oh, wow, this is a good topic for me because this very much affects my practice because DME is another whole topic than what we're here today about because the IPA is separate than DME equipment, but they're all interlinked. And so, for example, my practice is very much affected by DME equipment. [LB916]

SENATOR GLOOR: Sure. [LB916]

JAMIE PETERS: I may be able to write an order for many things, but I still have to have my physician's signature that has signed my IPA signed for a toilet riser, a wheel chair, incontinent pads. I mean, it's...there's so many items that have to be signed by my physician. I would say I probably take to the physician that I work with...this might be on the low amount, 300 to 400 forms a week. [LB916]

SENATOR GLOOR: And that's not a requirement of the payor, that's because that's what an IPA requires? [LB916]

JAMIE PETERS: No, that's interlinked to DME equipment. [LB916]

SENATOR GLOOR: I mean, if this went forward, would you still need to get the signature of the attending physician for that particular patient? [LB916]

JAMIE PETERS: I think this is something, probably, I need to visit with our committee to visit about. Yes, I still have to have the DME equipment signed by a physician. [LB916]

SENATOR GLOOR: Okay. [LB916]

JAMIE PETERS: At this point. [LB916]

SENATOR GLOOR: But that...that, I'm guessing, that that's a requirement of the payor and Medicare... [LB916]

JAMIE PETERS: Right. [LB916]

SENATOR GLOOR: ...or whatever the private insurance company is. [LB916]

JAMIE PETERS: Correct. [LB916]

SENATOR GLOOR: It's not something affected by this agreement. If this agreement went away, it would be there, but it would be there because that's the requirement of the payor. [LB916]

JAMIE PETERS: I think that's correct. [LB916]

SENATOR GLOOR: Okay. [LB916]

JAMIE PETERS: And I would like to visit with them a little... [LB916]

SENATOR GLOOR: Okay. There's a lot of nodding heads in the background. (Laughter) [LB916]

JAMIE PETERS: There's a lot...yeah, please help me, yes. I just know that's a big piece of my practice, lots of signatures. [LB916]

SENATOR GLOOR: Okay, thank you. [LB916]

SENATOR CAMPBELL: Senator Krist. [LB916]

SENATOR CAMPBELL: So at the current time, and you're visiting Mrs. Smith, and Mrs. Smith needs something and you have talked to her physician, can that physician sign for the DMEs? [LB916]

JAMIE PETERS: Yes, oh I collaborate with physicians. For example, if I'm seeing...if I have a referral from a home care agency or a physician to go in and see a patient, I would go in there and see them. If I have any questions or concerns, I would always take it back to that physician that's working with that patient and I would say: would you like me to take this to my physician to sign this or are you comfortable signing it? Some...it's...you know, it varies. [LB916]

SENATOR CAMPBELL: So it's mixed terms of whether the physician says, no, I want you to go back or, no, I'll sign it. [LB916]

JAMIE PETERS: In many times...in many cases, the patients that I am caring for, they don't have that physician because they're in their homes. They're homebound so they don't have that option to have that backup. [LB916]

SENATOR CAMPBELL: Okay. Any other questions? Thank you, Ms. Peters. [LB916]

JAMIE PETERS: Thank you. [LB916]

SENATOR CAMPBELL: Our next proponent. Good afternoon. [LB916]

KELLEY HASENAUER: Good afternoon. Are you ready for me? [LB916]

SENATOR CAMPBELL: Sure, go right ahead. [LB916]

KELLEY HASENAUER: (Exhibit 26) All right. My name is Kelley Hasenauer, spelled K-e-l-l-e-y H-a-s-e-n-a-u-e-r. I am a full-time nurse practitioner and business owner in North Platte. I'm licensed in the state of Nebraska and I support removing the integrated practice agreement from the licensure requirements of nurse practitioners in Nebraska. I have been licensed as a nurse practitioner in Nebraska for almost 13 years and I currently own and operate Platte Valley Women's Healthcare, which is a women's primary care clinic in North Platte. During my career as a nurse practitioner, I have been actively involved in mentoring and training graduate and doctoral level nurse practitioner students. I've served as an assistant professor at the University of Nebraska Medical Center in the college of nursing. And I currently train several students each semester in my clinic. In 2011, I was appointed to serve as the APRN representative on the Nebraska State Board of Nursing in which I currently serve, but I must be clear that this is personal testimony and does not necessarily represent the opinion of the board. Through this testimony, I would like to address the IPA on three levels. First, as a highly trained healthcare professional, I would like to describe for you how the IPA has limited my ability to provide healthcare services in Nebraska. As a business owner, I would like to share the struggles I've had with applying for a waiver of the IPA. And finally, as an educator and member of the State Board of Nursing, I would like to address how public safety is ensured with the proposed licensure change. In 2010, my family and I relocated to Lincoln, Nebraska, from North Platte. I've been accepted into a doctorate of nursing program. I had nine years of experience as a primary care nurse practitioner. And it was my intention to volunteer as a provider at Peoples City Mission here in Lincoln while I was in school to finish my doctoral degree. When I notified the State Board of Nursing of my change in employment, you can imagine my frustration when they said I could not offer volunteer services at the homeless shelter because I did not have a current IPA. I had 18,000 hours of primary care experience at that time and was not allowed to volunteer because no physician had signed a form at that time. Now I'm not sure how many of you in this room hold a license, but whatever your profession, I am certain that the ability to hold a license and maintain your practice does not involve a distinctly different profession. All the IPA served to do in this example was to keep a qualified healthcare provider from providing services to a highly underserved profession. In the spring of 2012, after I graduated with my doctoral degree, I returned to North Platte to open Platte Valley Women's Healthcare in partnership with a physician colleague. Our practice was the first professional corporation in Nebraska to be

co-owned by a physician and a nurse practitioner. In our first 18 months of business, we were extremely busy seeing approximately 2,000 women for health and primary care services. In November, my physician colleague announced that he was leaving our practice to become a hospital employee in another community. We have a wonderful working relationship and he is willing to maintain my integrated practice agreement, but should something happen to him tomorrow, should he be in a car accident, should he have a stroke, I would instantly be unable to see the 20 patients on my schedule tomorrow. The only way a nurse practitioner in Nebraska can be licensed without an IPA is by obtaining a waiver from the state board. In his recent report, Dr. Acierno described the waiver as a viable option for nurse practitioners unable to obtain an IPA. So in November, due to the incredible risk that I was taking on as the sole owner of our clinic, I felt it was imperative that I obtain a waiver to ensure that my ability to care for my patients would not be interrupted. My application discussed the practical difficulties of locating another physician to sign an IPA, including the reluctance of other physicians in my community to help a competing business. Interestingly, I was only given a three-month short-term waiver which does not at all meet the needs of my business despite the fact that I have over 13 years of full-time primary care experience. If Dr. Acierno feels that this is a viable option for experienced nurse practitioners to apply for a waiver, I should be the primary candidate for a full-time waiver of the IPA. The National Council of State Boards of Nursing is an organization whose purpose is to assist state boards of nursing in their quest to protect health, safety, and welfare. It works closely with the State Board of Nursing to develop the guidelines for licensure. Utilizing their model, nurse practitioner licensure ensures that graduates are safe to practice in the following ways: First, all nurse practitioners in Nebraska are educated at the master's or doctoral level. They have to graduate from a program that is nationally accredited or they're not allowed to sit for the boards. New graduate nurse practitioners are already experienced healthcare clinicians before they even enter their graduate programs and they must complete rigorous undergraduate and graduate programs with in-depth clinical components. Would you like me to continue? [LB916]

SENATOR CAMPBELL: Let's try...Kelley, let's just try to hit the high points. [LB916]

KELLEY HASENAUER: Absolutely. [LB916]

SENATOR CAMPBELL: Because I think you've got... [LB916]

KELLEY HASENAUER: Yep, yep. [LB916]

SENATOR CAMPBELL: I don't want to shut you off, because I know you have some other points, but if you could kind of get...describe them rather than read them. [LB916]

KELLEY HASENAUER: During the nurse practitioner training, they develop the close, collaborative relationships that are required of them once they're done practicing. And

all nurse practitioners are required to not just be board certified at the beginning of their licensure, but they have to maintain that licensure...that board certification for their entire scope of their licensure which is very distinctly different from both our physician colleagues and physician assistant colleagues. So, in conclusions, nurse practitioners are highly trained. The IPA limits our ability to provide services. As business owners, it puts our businesses and our patients at risk. And finally, I'd like to conclude that as an educator and member of the State Board of Nursing, our current licensure requirements are in the strong standard with national guidelines for nurse practitioners. [LB916]

SENATOR CAMPBELL: Questions? Senator Krist. [LB916]

SENATOR KRIST: Your continuing certification is, obviously, continuing education...? Can you describe briefly... [LB916]

KELLEY HASENAUER: Yes, there are several ways that we can maintain our board certification. We can teach other nurse practitioners, because through teaching you're also learning. And so if you can prove a certain number of hours that you've preceptored nurse practitioners, that will meet part of one. You have to have active practice, meaning you cannot just be a stay-at-home mom and maintain your licensure. You have to be actively practicing to continue your skill set. And you have to maintain a certain number of continuing education hours. [LB916]

SENATOR KRIST: Okay. Thank you. [LB916]

KELLEY HASENAUER: Um-hum. [LB916]

SENATOR CAMPBELL: Other questions? Kelley, I have two questions, and I know that you discussed this once before, not necessarily today, but I think you mentioned that after 2015 nurse practitioners...and tell me how that's linked to the Ph.D. [LB916]

KELLEY HASENAUER: Okay. Nurse practitioner education, like I hope physician education, PA education, physical therapy education, and pharmacy education, we are evolving rapidly. Our knowledge base is growing. And what has been set as a gold standard for accreditation of our schools by 2015 is that all students who enter nurse practitioner programs, as of the year 2015, will be graduating with a doctoral degree. So there will be all nurse practitioners after 2015 will be graduating with doctoral degrees. There will be no more even master's programs. [LB916]

SENATOR CAMPBELL: And the second question is, because I'm sure you're very familiar... [LB916]

KELLEY HASENAUER: Um-hum. [LB916]

SENATOR CAMPBELL: I want to go back to Senator Krist's question initially and why do you think the technical committee and then the Board of Health repeated this ancillary recommendation? [LB916]

KELLEY HASENAUER: Of the 2,000 hours of practice? [LB916]

SENATOR CAMPBELL: Well, it was some form...this is exactly how it reads: there should be some form of supervision or mentorship for new nurse practitioners for the first years of their practice. The time period for such supervision or mentorship practice should be relative to the experience and demonstrated competency of the nurse practitioner in specific areas of practice. And I believe...I believe that both the technical committee and the Board of Health they mirror each other. [LB916]

KELLEY HASENAUER: Um-hum. I... [LB916]

SENATOR CAMPBELL: And I thought you might want to comment on that. [LB916]

KELLEY HASENAUER: I would love to. I would invite you, if you're really interested in that point, to go back and read the Board of Health hearing minutes. We had such an incredible discussion at the Board of Health hearing between myself and some of my physician colleagues. And during that hearing, I think that many of their opinions, as I explained the high standards to which nurse practitioners licensure is held in our state; many of their opinions changed through that hearing. And I think if you read those, you'll see that reflected. It's very clear that nurse practitioner, in the basic licensure of a brand new graduate, that that student has already met a rigorous, accredited education. They're already board certified. They've already had a tremendous amount of clinical experience. And all the data throughout the nation shows that at that point they are ready to practice as a nurse practitioner. [LB916]

SENATOR CAMPBELL: So you think they drew this recommendation... [LB916]

KELLEY HASENAUER: I think that recommendation was prior to that final hearing. And that I think that if some time had been given following that, there would have been some changes. [LB916]

SENATOR CAMPBELL: It's in the report that's come to us that...and I don't know whether my colleagues have all printed it off yet, but we'll double-check that. [LB916]

KELLEY HASENAUER: Yeah. Yeah, I would invite you to. And, you know, there are safeguards in place for new graduates of any profession in healthcare. Whenever you enter a community to practice as a nurse practitioner, or a physician, or a PA, you need to apply for credentialing both with the hospital that you're going to be working with, possibly with the clinic that you're working with, or possibly with insurance carriers. And

all of those pieces have requirements in place for new graduates and newcomers to the community. Not even just new graduates, if I'm a foreign-born physician and I come to a rural hospital to practice, that hospital has methods in place to ensure that I am safe to practice. The State Board of Nursing or the State Board of Medicine isn't the person watching that practitioner. It's the others in the community. Does that make sense? [LB916]

SENATOR CAMPBELL: Sure. Thank you very much. [LB916]

KELLEY HASENAUER: Yes, um-hum. [LB916]

SENATOR CAMPBELL: Any other questions? Thank you for your testimony. [LB916]

KELLEY HASENAUER: Yes, very much. [LB916]

SENATOR CAMPBELL: Our next proponent. Anybody need a break? Okay. Good afternoon. [LB916]

MARLENE DERAS: (Exhibit 27) Good afternoon. I am Marlene Deras, D-e-r-a-s, Administrator of the Health Professions Tracking Service at the University of Nebraska Medical Center, College of Public Health. I was invited to testify on behalf of LB916 which proposes to amend provisions relating to the practice of nurse practitioners. I am speaking for myself in a neutral position. I'm not representing the University of Nebraska. The Health Professions Tracking Services or HPTS has been in operation at UNMC since 1995. Through an extensive survey process involving both healthcare professionals licensed in Nebraska and Nebraska healthcare facilities, HPTS maintains and continually updates a relational database linking the Nebraska healthcare professionals and facilities. The HPTS process maintains information regarding professionals' professional status whether they're full-time, part-time, primary and satellite locations and an estimate of hours spent at each practice location. This detailed information allows for the calculation of the number of professionals practicing, as well as data regarding full-time equivalency beneficial in terms of capacity. HPTS is used by the state of Nebraska for federal and state shortage area designations and the office of rural health migration studies. Following is a summary of available data regarding the nurse practitioner work force in Nebraska. In January, 2013, we published a report through the UNMC Center for Health Policy that described the nurse practitioner work force in Nebraska that focused on primary care during the period 2007 through 2011. Forty-four percent of primary care nurse practitioners practicing in Nebraska practiced in rural areas. There was a steady growth in the number of primary care nurse practitioners practicing in Nebraska representing an increase of 33 percent during that period. Recently I reviewed the HPTS data between the years 2007 and 2013 for all nurse practitioners with a primary practice in Nebraska, regardless of provider speciality. HPTS data indicates the number of nurse practitioners grew to 877 by the

end of 2013, representing a 70 percent net increase. In 2007, the number of nurse practitioners represented 12 percent of healthcare professionals. In 2013, nurse practitioners represented 16 percent. When I say healthcare professionals, that's physicians, nurse practitioners, and PAs. I reviewed data for this time period to determine the degree of attrition for nurse practitioners moving out of state. HPTS either received notification or learned through research that 41 of the 121 practitioners no longer practicing in Nebraska have moved out of the state. Thank you for this opportunity. [LB916]

SENATOR CAMPBELL: Thank you for the data. Questions? Senator Gloor. [LB916]

SENATOR GLOOR: Thank you, Senator Campbell. And thank you for your testimony. And you've got some numbers here that I'd like to track down by way of addressing a concern I have about how we're using our nurse practitioners. You know that 44 percent of nurse practitioners who practice in a rural area, is that a trend that is upwards? Is that a trend that was downwards? Maybe that's in there, and I'm just not following, but... [LB916]

MARLENE DERAS: That was issued in another report to look at how it's trending and I believe it's going upward, but I would need to check and get back to you to confirm that. [LB916]

SENATOR GLOOR: One of the arguments that's made about giving nurse practitioners the ability to practice more independently is it will address our primary care needs. But nurse practitioners have also come to me with concerns. Not that there's anything we can do about it legislatively; not that there's anything that any of us might be able to do about it, but there is such a drive, as we know, towards reimbursement and what we pay for as hospitals, specifically, get winnowed down and what insurers and the government will pay for. And so the focus continues to grow on some of the speciality care, some of the speciality procedures for which reimbursement is still pretty high. And the concern has been that large facilities that have specialty care units are hiring nurse practitioners to be scribes, to follow the specialists around to be able to do the documentation necessary to make sure that reimbursement is maximized. And this isn't...I'm not arguing that this is a bad thing; it is a reality thing that I'm sure that the wages paid to the nurse practitioners are quite enticing. I'm sure that the reimbursement impact for the institutions or the practitioners is significant or this wouldn't happen. But I also have concerns that if we talk about trying to allow nurse practitioners to expand the scope of what they're able to do to address primary care needs that we, inarguably, have that the system and the way the market pushes might gobble up those nurse practitioners into far more lucrative...not just for the practitioners, but for the institutions, far more lucrative employment programs. And a scribe isn't exactly what we are hopeful to see in nurse practitioners if this goes through. [LB916]

MARLENE DERAS: Um-hum. [LB916]

SENATOR GLOOR: There's a lot in there. But it's clearly an issue that I think needs to be put on the table. And so if we can look at trends, if we know that in spite of that we're seeing more nurse practitioners locating to rural areas, I think it helps to dispel that concern. [LB916]

MARLENE DERAS: And I would have to get back to you as far as training. [LB916]

SENATOR GLOOR: It would be helpful for me to see it. [LB916]

MARLENE DERAS: Okay, and your interest is the split between urban and rural specialty and primary care. [LB916]

SENATOR GLOOR: Yeah. If what is happening within the market is that we're taking advanced practice nurses and we're using them to maximize reimbursement. We have an issue that gets back to this whole process of where we can get our primary care practitioners, especially in rural areas? [LB916]

MARLENE DERAS: Okay. And the scribe, I'm not familiar with that, but I believe there will be people following that have knowledge. [LB916]

SENATOR GLOOR: Okay, and thank you. But you've got, obviously, some data at your fingertips that might be able to help erase my concern, hopefully, about what might be happening in the market. Thank you. [LB916]

MARLENE DERAS: Okay. Thank you. [LB916]

SENATOR CAMPBELL: And you can just furnish that to my office and we'll see that it's given to all the members. Okay, any other questions? Thank you for the data and your willingness to get more (laughter). [LB916]

MARLENE DERAS: It's what we do. Thank you. [LB916]

SENATOR CAMPBELL: Okay, thank you. Our next proponent. How many other...more proponents do we have? One, two, is there someone over here? Yep, okay, so we have two people over here, is that right, and one person...three. Okay, thank you. All right. [LB916]

SEAN SCRIBNER: (Exhibit 28) Hi, my name is Sean Scribner, that's S-e-a-n S-c-r-i-b-n-e-r. And I'm here on behalf of the Nebraska Nurse Anesthetists Association. I'm the vice president of the association. I currently work at the VA Hospital in Omaha. I also work in Pender, Nebraska, and Wayne, Nebraska, on a temporary basis to cover

call there. Our organization represents 360 nurse anesthetists. And our members provide anesthesia in 99 percent of the hospitals in Nebraska. Eighty-three of Nebraska's 93 counties are solely serviced by nurse anesthetists. We feel we play a pretty integral role in healthcare delivery in Nebraska. And it was in this very room over two decades ago, our senior colleagues were at a public hearing on the health and human services regarding a bill which would remove the supervision of nurse anesthetists by physician and the independence of nurse anesthetists. And at that hearing we heard testimony very much like what I expect you'll hear today later and that we were told that if legislation were to go through and we were allowed to practice independently, that patient harm and even death would be a certain result, that we might as well get ready and line the streets with coffins. But I'm here to tell you that it has not happened. CRNAs have been practicing independently now since 1992 and none of those dire predictions have come true. What has happened is that Nebraska has become a venue and an attractive place for nurse anesthetists to come and grow their practice, raise their families. And so they've strengthened and improved and extended healthcare in Nebraska. All we have to do is look at the future population projections in our state, the accessibility and affordability of healthcare and we can see the crucial role that Advanced Practice Nurses are going to play in the future, and those include nurse practitioners. None of the members of this committee were serving, obviously, in 1991 or 1992, when our practice was changed, we feel for the better. But the senators involved in that decision at that time, they deserve our consideration today. They considered and they examined controversial healthcare issue and they decided to make a change. It wasn't a change that everyone agreed with or that they thought was in the best interest, but it improved healthcare and it helped Nebraskans, and thus as a result the very quality of life within the state. You guys have been charged today with the very same thing. And the Nebraska Association of Nurse Anesthetists urges this committee to undertake the same course of action. Thank you for the opportunity to be heard. And I'll answer any questions. [LB916]

SENATOR CAMPBELL: Any questions? Thank you for your testimony. Our next proponent. Good afternoon. [LB916]

LINDA L. LAZURE: (Exhibits 29 and 30) Hi. It's good to see friendly faces. Senator Campbell and members of the Health and Human Services Committee, I'm Linda Lazure, L-i-n-d-a L-a-z-u-r-e. I'm former chair of the Nebraska Board of Health and former president of the Nebraska Nurses Association. I was the president back in 1996 when the LB414 was passed; that was 20 years ago. And I must mention, since we're throwing around statistics, that there were less than 100 nurse practitioners when we started that legislation. The NNA and the nurse practitioner group worked with the Nebraska Medical Association and the Nebraska Hospital Association to craft the final version of LB414. Representatives from each of our groups were at the signing. I invited them. Then-Governor Nelson described the bill as one of the most collaborative final products that he had ever seen. Today I'm speaking as a public citizen. You know I'm

on the board of nursing and LR22, but I'm speaking only for myself. I can assure you that the 1996 insertion of the IPA into the LB414, the original statute, was not...was not predicated on evidence-based practice, nor was it a validated factor to assure safe care to Nebraska citizens. The IPA was an expedient political compromise. I did think at the time, however, that the IPA could open the long-closed door to the collaborative practice by providing a mere affidavit, the piece of paper that you saw, that the nurse practitioners could identify at least one physician colleague for "consultation, collaboration, and referral." Within the IPA definition, the nurse practitioner statute defines "collaborating physician" and "supervision." The nurse practitioner...and I'm quoting now, "the nurse practitioner and the collaborating physician shall have joint responsibility for patient care based on the scope of practice of each practitioner. The collaborating physician shall be responsible for supervision of the nurse practitioner to ensure the quality of healthcare provided to patients. For purpose of this section: Collaborating physician was defined..."and I put the bold emphasis here"...as physician or osteopathic physician licensed in Nebraska and practicing in the same geographic area and practice speciality, related specialty, or field of practice as the nurse practitioner. Supervision:" and this did get defined not by Webster's Dictionary, but defined in the statute as the ready availability, the ready availability of the collaborating physician for consultation and direction of the activities of the nurse practitioner within the nurse practitioner's defined scope of practice. The definition of "supervision" embedded in that politically expedient inclusion of the IPA has undergone some unexpected and unfortunate interpretation. A primary reason may be that the statutory definition of the "IPA" and "supervision" were not included in the APRN regulations list of definitions as they should have been. And you're familiar enough with definitions and rules and regs that the definition out of the statute comes and gets into the rules and regs. Both key terms are only tangentially mentioned on page 10 of the ARNP regulation section. I won't read you the whole section, but I've included it in there for you. I contend that the IPA has undergone misinterpretation from the inception of the rules and regulations emanating from LB414. Because of the lack of precision in leaving the predominant statutory definitions of the "IPA" and "supervision" out of those definitions, individual physicians and administrative entities have most likely used their very own personal definition of "supervision" to interpret the IPA. I can tell you that the IPA was never intended to be an impediment to access to quality, cost-effective care that NPs can provide; yet somehow it has become just that, a barrier to full authority practice by NPs that was codified in 1996. In closing, the very professional Nebraska nurse practitioners' applicant group made a very strong case for the positive Technical Review Committee report and subsequent positive Board of Health vote. And I hope your careful scrutiny of the facts will support their efforts. I respectfully ask that you support LB916 and eliminate the IPA and improve access to much needed care for Nebraskans. I must add as well, I am bringing written testimony from my former student. I was chair of her doctoral, her DNP committee. We...and this is written testimony by Terrie Spohn. She's now a DNP; she graduated from Creighton University. And we did a survey this last year and we sent it to 1,140 Nebraska-licensed nurse practitioners. We

got an incredible response rate, 54.3 percent, which is very incredible to get for a hardcopy survey. We had 619 surveys returned. I do want to point out, at the very bottom of the report that we have for a one-pager for you, that Nebraska-licensed NPs who were practicing in other states cited the top reason for leaving Nebraska was to go another state with fewer barriers to practice. And there's other data there as well. And I'm ready for your questions. [LB916]

SENATOR CAMPBELL: Okay. Any questions? Senator Krist. [LB916]

SENATOR KRIST: What's the differentiation or the definition of "supervision" versus "collaboration?" [LB916]

LINDA L. LAZURE: The definition...it's in the statute, but the supervision, the way we had crafted it, and it was with Don Wesely's help, he's going to talk about this too, was...it was ready availability. And collaboration, I believe it's defined in there as well, I didn't pull that one out for this. But it is defined in the statute. But you collaborate, I mean, you work together to make sure that the outcomes for the patient are met. [LB916]

SENATOR KRIST: So what's the most important thing: supervision or collaboration? [LB916]

LINDA L. LAZURE: I wouldn't say. I would say that collaboration would be the foundation that you predicate your practice on. The nurse practitioners are very well qualified in their practice to practice. [LB916]

SENATOR KRIST: So, not to belabor the point, but in my profession, in a collaboration, I would think, would be more important than the supervision. If you're qualified, you're qualified. [LB916]

LINDA L. LAZURE: You are, you are. [LB916]

SENATOR KRIST: You don't need to be supervised if you've come out with a, in 2015, a doctorate degree to go forward and practice. And we've already heard the transition to practice is not difficult to do based upon the local certifications, etcetera. What you need is a base to collaborate with, to go back and consult with on different issues. Would you disagree... [LB916]

LINDA L. LAZURE: And there are national standards as well. And the nurse practitioners do meet those. I'm involved in education and we do have national certification and very rigorous standards. Also there's a reason that nurses are the most trusted profession as well. We were the first with the code of ethics. Our scope of practice and our social policy statement says that a scope of practice is singular and it

depends on the depth and breadth of your education, the population you serve, and your experience. [LB916]

SENATOR KRIST: Thank you. [LB916]

LINDA L. LAZURE: Um-hum. Any other questions? [LB916]

SENATOR CAMPBELL: Any other questions? Ms. Lazure, let me ask you the question, because you served on the Board of Health and I will follow up to make sure that what I'm reading is at the end of the recommendations and not at the beginning. But I think you heard me read their ancillary recommendation. Why do you think they put that in? [LB916]

LINDA L. LAZURE: I was there. I was there. [LB916]

SENATOR CAMPBELL: Oh, okay, you can help. [LB916]

LINDA L. LAZURE: I was at just about every...I think I missed one session. And let me preface with, you know, when you are on a 407 committee, it's amazing how much information you get. [LB916]

SENATOR CAMPBELL: Oh, yes. [LB916]

LINDA L. LAZURE: And a lot of times...well, the healthcare professions pride themselves on being evidence based. But I can tell you that human nature being what it is sometimes, you go back to what you know. And so much of that at the end of the discussions was just that, it was discussions, it was more anecdotal type of discussion. I know I sat there and was a bit nervous because it wasn't evidence based what they were talking about. Being an educator, I was nervous about the fact that they...at one point the conversation was bantering about, well, how long should you be...and it's like, there was no basis for it. There was no evidence that anybody ever talked about. It was just sort of, you know, we'll talk about this and we'll talk about this and going back to, quote, what they knew. And I'm not denigrating the committee at all, because you get so much information and sometimes it's hard to filter that. And so somebody that's involved in the crafting of education and the crafting of some of those experiences, it's a little disconcerting to hear a loose conversation about it. And I think that the educators in the state are very much attuned to the education of these health professionals and want to do the very best thing they can. [LB916]

SENATOR CAMPBELL: That's helpful. Thank you. [LB916]

LINDA L. LAZURE: Um-hum. [LB916]

SENATOR CAMPBELL: Any other questions? Thank you very much for your testimony. [LB916]

LINDA L. LAZURE: Yeah, you're very welcome. [LB916]

SENATOR CAMPBELL: Our next proponent. [LB916]

LINDA L. LAZURE: See you in a couple of weeks. [LB916]

SENATOR CAMPBELL: Yes. Our next proponent. [LB916]

DON WESELY: Chairman Campbell, members of the Health and Human Services Committee, my name is Don Wesely, D-o-n W-e-s-e-l-y, I am registered lobbyist on behalf the Nebraska Nurses Association. I'm actually here as the...sort of the historical background on some of this. And you all have heard that before from me I apologize. In fact, I was in a committee yesterday dealing with the housing trust fund which was a bill I passed and was called an old curmudgeon by Senator Burke Harr, so I feel way too young to be an old curmudgeon. (Laughter) [LB916]

SENATOR KRIST: Can he spell curmudgeon? (Laughter) [LB916]

DON WESELY: I can't. But...and most of you know this history, but we go back to 407, I see Dave Buntain is here, and I became Chair of the committee back in '85. I served 14 years as Chair of the committee, 20 years on the committee and I heard many, many scope of practice issues. I mean, can you imagine as many years as you've heard this, now go to 20 and it was much more intense then. We've dealt with a lot of issues over time and narrowed down the remaining issues. So it was unbelievable how much time it took. And having sat through those, I felt...and Dave did, as well, with the medical association that there's got to be a better way. So the 407 was set up and despite it's flaws it did help a great deal to take it to be more factual and fair. And that worked, but after many years, I want to thank Senator Campbell and Senator Gloor for LB834 because you've definitely improved the process. And we saw it in action this last time with the review of the nurse practitioners' proposal over the last couple of years. And again, Dave Buntain was involved with that; Ron Jensen was involved with that; and I was as well, to try and help given our background and history on it. So, we've set up a process; I think it's worked over the years. It was improved recently by your legislation and it worked in this case. I think the answer to your question, Senator Campbell, about why did the ancillary recommendations come in, it's all about fear. I mean the whole time I was in the Legislature dealing with these issues, and you're going to hear it again later in opposition to this is fear. The opponents try to get you to be afraid that someone will get hurt, something bad will happen; and I know I felt it, maybe you don't, but I did, I was always afraid, man, if I give this expanded scope, or whatever, somebody is going to get hurt and somebody is going to look back and say, what idiot carried that bill or

voted for that bill? And here I'd be going, oh my god, and it just scared me. I honestly for many years I was very scared. But then we started to open it up and we did for different professions. In particular like the CRNAs, I remember that fight was brutal. I mean, that was really a tough fight. And anesthesia is tough. I mean, you make a mistake there somebody could die. I don't know of any case of a nurse anesthetist on this. Now there are...every profession makes mistake, maybe there are out there, but I've not heard of them. I think it's worked really well. I don't see anybody saying, well, that was a mistake. No, that was in 1992. And then we came with the nurse practitioners and it is true, this IPA came in, you know how it is, it's a close vote, you're not sure where to go and we ended up adopting this as an amendment to try to bring both sides together. So it got thrown in and it became law and it has not worked. You've heard all these wonderful nurse practitioners, and it's not working. It's not leading to collaboration. They're on the phone or they're out of, you know...it's just not working at all to help collaboration. Collaboration comes through the system. Senator Gloor, you know that. I mean, what you're trying to do with patient-based teams and that sort of...that's where the collaboration comes together. It's not this IPA piece of paper. It's not done it, it's not working, and it won't do it. It's a different approach that will get us to where we want to be. And I think that's already there. I think nurses want to cooperate and collaborate and it's in their best interest; it's in everybody on their team's best interest. It's not the IPA piece of paper. And it's not accomplishing that at all. So I think...I'm here strongly in favor of this. I think the CRNA experience with their independent practice has proven right here in Nebraska, this works. The 16 states where they have independent practice, it's working. I think it's time for us, after...I think it's been 18 years since we've pass that bill with this amendment, to take this amendment off and let the NPs go forward. And I do think that it's timely, not only because it's been so long, but also it ties in the changes with the additional coverage that's through the federal legislation, with your consideration of Medicaid. We need primary care and we need it across the state. And I know there are NPs that have left. I know there are NPs that are out there that want to come back and they're all waiting on this bill. This bill is the key to bringing back some NPs that are elsewhere. And they just won't come back until this is changed. And we may lose other NPs if it doesn't change. So in my view it all fits together with the overall system changes we're going through to pass this legislation. Happy to answer any questions. [LB916]

SENATOR CAMPBELL: Any questions? I think what's fearful for all of us is that we would be here 20 years (inaudible). (Laughter) To scope of practice only, I mean, the only thing about fearful...sorry I could not resist. [LB916]

DON WESELY: Oh my god, yeah, I don't wish that on anybody. [LB916]

SENATOR CAMPBELL: Thank you so much for your testimony. [LB916]

DON WESLEY: Thank you so much. [LB916]

SENATOR CAMPBELL: Our next proponent. Any other proponents? I just want to double...okay, because I'm going to take the proponents and then I'm going to give the committee a break. Hello. [LB916]

PAULA A. WHITTLE: Good afternoon, Senator Campbell and the rest of the committee, thank you for allowing us to speak. My name is Paula Whittle, W-h-i-t-t-l-e, and I'm a nurse practitioner. [LB916]

SENATOR CAMPBELL: Could you repeat that one more time. [LB916]

PAULA A. WHITTLE: Paula Whittle, W-h-i-t-t-l-e. [LB916]

SENATOR CAMPBELL: Thank you. [LB916]

PAULA A. WHITTLE: And I'm a nurse practitioner. I wasn't planning on speaking today and so listening to everybody else come up I thought that I should come up and offer what I have. I graduated in 2012 with my NP, so I'm the one you're scared of. (Laughter) So just to put it right out there. I'm the one you're scare of; I graduated in 2012, the spring semester from Creighton University which is an outstanding university. I attained my bachelor's degree from University of Nebraska Med Center. So I have a double allegiance to many of the women in this room. When I first graduated, I was working...in your last semester you do a preceptorship. And so that physician that I did a preceptorship asked me to come on board. And so I work in a rare field, psychiatric nurse practitioner. And it's one of the ones that you guys have also heard about being one of the ones that we really need to keep in the state. So when I first graduated, she asked me to come on board and it was kind of a--let's share our costs; you know, like you did in college. This is what the electric bill is, here's your third and everybody pay. And so that was such a great thing, you know. And I was able to get my LLC, or what we call a PC, a professional corp with being a NP. So, basically, I have my own business and all the payers that Blue Cross Blue Shield and all of them, they pay me directly, even though that I was a part of a practice I was able to bill directly, money came to me directly, and I paid my one-third of what the practice was. So as far as a new NP, that's amazing. You don't really get that. So it was a great opportunity. We were planning on leaving the state until I had that opportunity with a phenomenal M.D. who is able to give that to me. Summer of last year, through talking to other M.D.s and maybe deciding on a different business model, she decided to take what was a shared practice type of setting into a percentage. So my rent was going to double. She was going to take the percentage that I made, 30 percent of what I make. And so I was stuck, you know, what am I going to do? My rent is going to go up. I would end up making less than what I'd make in a hospital with absolutely no benefits. Trying to talk to her about that became pretty challenging so I decided to go out on my own and find a NP...or find a physician that would help support me in a collaborative care agreement.

Talking to other NPs and trying to find that other collaborative care was hard. And so I thought about, again, leaving the state. We had talked...I'm not originally from Nebraska, I raised my kids here, but I'm not from here. Thought about going back to Colorado. So anyway, long story short, I talked to many NPs, some are paying $1,500 a month but never even talk to their collaborative care person. You know, and I was able to find this physician that was going to allow me to continue my practice. And the thing that was great about it is because I love my patients. I carry a patient load about 275 patients and it's like, you know, most of them I see them either monthly, sometimes biweekly the ones that are having a hard time, sometimes every three months or so. But because it's that type of setting, I really get to know them and I care about them and I know their families and their lives and I don't want to leave my patients, you know. At the same time I was really stuck, you know. How am going to contribute. So I found that physician and now I pay $300 a month. I opened my own practice December 2 of 2013. And me and a psychologist went in together and we have another NP who, again, you know, back to college, here's your electric bill, one-third. And it's working; it's working for us. We're full, we have...we take Medicaid which most psychiatrists don't. Not only that's a problem, but psychiatry as a whole from M.D.s, it's not the specialty most M.D.s choose. It is an aging specialty even in the M.D. world. So they do need NPs to come in and fill that void. And so I've been able to do that. And love my job, wouldn't do it any other way. And love my patients and I'm glad they could all come with me. And so I just wanted to offer that up and kind of tell you my story. Even when I was with my M.D. for that year, I would barely ever talk to her about patients; once a week maybe if something came up I felt uncomfortable with. [LB916]

SENATOR CAMPBELL: Are there any questions for Ms. Whittle? Senator Gloor. [LB916]

SENATOR GLOOR: Thank you, Senator Campbell. Did you work under a RN license before you went back and became a nurse practitioner? [LB916]

PAULA A. WHITTLE: Yes. [LB916]

SENATOR GLOOR: How many years...how many clinical...how many years working had you had before you went back and... [LB916]

PAULA A. WHITTLE: Six. And I'm an oddball psych person because I was... [LB916]

SENATOR GLOOR: That's an interesting choice of words...(Laughter) [LB916]

PAULA A. WHITTLE: Yep, I am, because I spent my whole nursing career as trauma nurse so I was ICU RN at Bryan West. And I did trauma flow for one of my shifts would be trauma downstairs in the ED and the other two are in the trauma ICU. [LB916]

SENATOR GLOOR: So you came into...you're a nurse practitioner training with six years of some pretty intense clinical experience. [LB916]

PAULA A. WHITTLE: Yeah, I'm pretty strong medically. I don't...so, yes, when I have questions, it's typically more psych related and not medically related. So, yeah. [LB916]

SENATOR GLOOR: Okay, thank you. [LB916]

PAULA A. WHITTLE: Yes, sir. [LB916]

SENATOR CAMPBELL: Any other questions? Thank you for your testimony. Good luck with your practice. The next proponent. Okay. [LB916]

JENNIFER THIELLEN: Hello. [LB916]

SENATOR CAMPBELL: Good afternoon. [LB916]

JENNIFER THIELLEN: (Exhibit 31) Good afternoon, Chairman Campbell and members of the Health and Human Services committee. My name is Jenny Thiellen, it's J-e-n-n-y T-h-i-e-l-l-e-n. And I, too, wasn't going to speak today but then felt compelled. I graduated in April, 2012. I've been a primary care nurse practitioner since that time. I want to give a little bit of background too and fill in some of what I know. I've done some research on this topic. The Affordable Care Act that was enacted in 2010, basically, there's been an estimated 32 million new insured people. It's estimated by 2020 that the United States will have a physician shortage of about 91,500. The state of Nebraska is actually ranked thirty-fourth in the country as far as physician ratios. We have 219 per 100,000 people of physicians; and that's even with two medical schools. This is not new. Getting nurse practitioners independent, this has been something that had started in the 1980s. And I wanted to address your question too, Senator Gloor, about the percentage of rural and urban nurse practitioners. I actually have the article that was discussed earlier. From 2007 to 2011, the supply of primary care NPs in Nebraska grew by 33 percent. The greatest growth was in urban communities, but there were increases with rural communities as well with ages 26 through 40 and 41 through 65. And I'll make sure that this article...that you have access to it. The biggest thing that the NP work force is projected to grow by 94 percent by 2025 and that is in the state of Nebraska. That's clear that we can fill in those gaps and provide good care for our patients. Also just wanted to give you a little bit of my experience. I feel very confident as a first-year nurse practitioner. I diagnose things from myocardial infarction, which is a heart attack. I will tell you that a Harvard grad cardiologist missed it; he called it acid reflux. I've prescribed beta blockers. I treat things anywhere from sinus infections to very complex chronic medical conditions. I feel confident in my education which was from the state of Nebraska here; I graduated from the University of Nebraska Medical Center. I'm just excited to be here and just really am in full support of this bill. [LB916]

SENATOR CAMPBELL: Questions, Senators? Senator Gloor. [LB916]

SENATOR GLOOR: Thank you, Senator Campbell. And let me ask you the same question. And I didn't catch it, but had you practiced under a RN license before you went back to become a nurse practitioner? [LB916]

JENNIFER THIELLEN: I did. And what was interesting, too, about her response as well; I actually worked at the University of Nebraska, I was a floor nurse. I did that for about six years. I've done things ranging from solid organ to bone marrow transplant, oncology, but when I graduated, I went into primary care. Also some of my experience I didn't mention before is I also ran our Douglas County general assistance clinic almost solely by myself for about eight months. A physician came in about an hour a day. [LB916]

SENATOR GLOOR: And let me by way of clarification, not just for you, but for anyone else who misinterpreted me, I know there's been an increase of nurse practitioners practicing in rural Nebraska because there's been an increase in nurse practitioners. [LB916]

JENNIFER THIELLEN: Right. [LB916]

SENATOR GLOOR: My question is: Has the percentage of nurse practitioners who are moving into primary care treatment, whether it's in rural or urban areas, continued to increase or have we seen an increase in nurse practitioners who are moving in support roles? And the scribe example I gave where we're not really addressing what we see as a primary care issue, we may be, because we're increasing the numbers overall, but I'm interested in whether there is a trend away from primary care when there is practitioners because, clearly, what drives the healthcare system is specialty services and the reimbursement there. Not the reimbursement for primary care, sadly and aggravatingly. But (inaudible). [LB916]

JENNIFER THIELLEN: I think the best way to answer that, I did not go back to get a master's degree to be a scribe for somebody. I'm educated. The debate will be, somewhat, are doctors smarter than nurses? I can guarantee you not. I'm equally as smart as probably anyone who went to medical school. What has happened is because of the lack of being...kind of an independent provider, we've fallen into those roles and I think that that's unfair. There is a huge range that nurse practitioners can fulfill and I...you know, we're leaving these...being independent really opens a lot of doors. I think you'll see nurse practitioners getting out of those roles. [LB916]

SENATOR GLOOR: Okay, thank you. (Audience applause.) [LB916]

SENATOR CAMPBELL: No, really, we do not invite that in a hearing room, so we'd appreciate it if you did not. Other questions? Thank you very much for your testimony. [LB916]

JENNIFER THIELLEN: Yeah, you're welcome. [LB916]

SENATOR CAMPBELL: Our next proponent? Okay. We will take a ten-minute break. [LB916]

BREAK

SENATOR CAMPBELL: ...ask that you all find your chairs and, Mr. Clerk, are you ready to proceed? All right. We will start with our first opponent to the bill. And, Mr. Buntain, go right ahead. [LB916]

DAVID BUNTAIN: (Exhibit 32) Thank you, Senator Campbell. My name is David Buntain, it's B-u-n-t-a-i-n. I am legal counsel for the Nebraska Medical Association. I previously served for quite some time as the lobbyist for the Nebraska Medical Association. And in fact, the first year that I lobbied was the year that the original nurse practitioner bill was passed which was 30 years ago this year in 1984. At that time we had no licensed nurse practitioners. There was concern expressed after that that because of the integrated practice agreement which was a part of the original law and because of some of the other features of it, we were having difficulty with nurse practitioners finding places to practice. So, in 1995 and 1996, we revisited the issue with the task force Senator Jessie Rasmussen was involved in. Senator Wesely, by that time, was the Chair of the Health and Human Services Committee. And as a result of that, we passed LB414 which is, essentially, the current version of the law. It changed some of the provisions of the integrated practice agreement; made it more into a collaborative arrangement, encouraging a collaborative arrangement between nurse practitioners and physicians. And in response to the concern that there were certain areas in the state where it would be hard to find a supervising or...the term is actually "collaborating physician" that there would be an exception process where you could approach the board and make a showing and create an exception so you wouldn't have to have this practice agreement. And I believe I heard Dr. Lazure say earlier that there were a hundred nurse practitioners at that time. We have 1,200 nurse practitioners in the state now. Most of them are practicing under the current system. This problem comes about for two reasons. One, there have been some problems with the way the integrated practice agreement provision has been administered, and I'll come back to that. And secondly, I think this is a symbolic issue for the nursing profession. It's an issue nationally. For many, if not most, nurse practitioners, whether this bill passes or not, will not affect their employment situation because they are already practicing in situations where they have a variety of formal relationships, including the integrated practice agreement. So the...looking at this with a 30-year perspective, it seems to be

that the real issue is not black and white; should there be a practice agreement or shouldn't there be a practice agreement? But rather, isn't there...are there problems under the current situation and shouldn't they be addressed? Those problems include: Number one, the practice agreement itself. I agree, the integrated practice agreement is problematic. As Dr. Lazure indicated, the way it's been interpreted, the regulations, there are problems with that. Frankly, the nursing board, the Advance Practice Nursing Board does not have an incentive to make the system work because nurse practitioners are opposed to practice agreements. So part of the fault lies, I think, with the way it's been administered; part of the fault, as Dr. Acierno pointed out in his report, is that the physicians have not met their responsibility in all instances as far as being collaborating physicians. And we acknowledge a need to do that. The medical profession would like to work with the nursing profession to promote collaborative care. We think that requiring a collaborative relationship between nurse practitioners and physicians is essential. Again, the issue of newly minted or new nurse practitioners and the way they are integrated into the system, I think, is a very key issue. The biggest concern is with practitioners who are going out on their own in rural areas without any kind of requirement of being involved with other kinds of practitioners. Licensure laws are there to protect the public; not from the people that you see here today who are responsible practitioners. But from persons who have the license, don't know the limits of the license, and can create real threats to the health of the citizens of the state. So, you'll hear from some physicians who follow me. Dr. Acierno is here to talk about what happened at the department. But I would just encourage you from the medical association's standpoint to think about how to get the two professions together to work on this rather than saying it's a black-and-white issue, which is the way it's being presented to you. [LB916]

SENATOR CAMPBELL: Questions? Senator Gloor. [LB916]

SENATOR GLOOR: Thank you, Senator Campbell. So, Dave, does the NMA have a deal to put in front of us today? Because we've got to make a decision based upon on what we know, not based upon what we hope gets worked out. I mean, and that's what I heard you say is a recognition that the physicians in the state own a part of this problem and we can work on that or it can get worked out. But are you proposing it gets worked out before (inaudible)... [LB916]

DAVID BUNTAIN: And I don't know that it can get worked out between now and the fifteenth of April. Part of the problem...there have been, from time to time, discussions; a lot of the process ended up getting directed toward the 407 process rather than discussions outside of that. I think the physician leadership is more than willing to sit down and find out. But if it's...if the starting point is we'll get rid of the independent practice agreement, I...you know, that makes it a pretty short conversation. There has to be good-faith negotiation on both sides. [LB916]

SENATOR GLOOR: Okay, thank you. [LB916]

SENATOR CAMPBELL: Senator Krist. [LB916]

SENATOR KRIST: I'm going to ask this question of opposition, so I'll just start with you. We've heard a 30-year perspective from Don Wesely. We're hearing a 30-year perspective from you. They're on different sides of the fence. So I'll say that 30 years of dealing with the issue, or 20-plus, both your cases, have given you different perspectives. So that gives me cause for pause in terms of where we are. And, obviously, and I'm not rating either one of you any better than the other, we're just saying there's two different opinions and I respect them both. But did you give opposing testimony at any point during this process for the board or...? [LB916]

DAVID BUNTAIN: Did I personally? [LB916]

SENATOR KRIST: Well, I guess I...the question would be...yeah. [LB916]

DAVID BUNTAIN: The Medical Association was involved in monitoring the 407 process. We had physicians who attended and gave input during the 407 process. I mean, we've been involved in this issue really, you know, for 30 years. [LB916]

SENATOR KRIST: So, back to Senator Gloor's point, was there some suggestion given as to how to get to this point? I mean, it seems to me that if you were involved in this process and if you provided...if...if physicians provided that testimony, we'd be further down this discussion point. Yet what I'm hearing is that if the IPA is the issue, then there's no compromise. Is that fair or no? [LB916]

DAVID BUNTAIN: Well, I think...there's a...it has come down to this one issue. There is a whole, kind of, penumbra of issues around that that need to be discussed. That the focus of the 407 process was really on do we eliminate the practice agreement or not? You know, one of the concerns that I think this committee should have is the affect of this is to eliminate physician involvement in prescribing by nurse practitioners. They're only...there's less...or I would say there's about a third of the states that have truly independent nurse practice now. Even those that have some form of independent practice, a lot of them still require physician involvement in prescribing. That issue really wasn't addressed in this report. It's...there's a lot more to it than do we have a practice agreement or not on both sides. [LB916]

SENATOR KRIST: I saw the 407 when I first arrived, which was a product of years past. I've seen the changes that came into the 407 process. I don't think there would have been a limitation to carry that discussion to the next level and not be about just the IPA. But maybe I'm missing something out of the process. You know, that's all that I'm suggesting. [LB916]

DAVID BUNTAIN: You're right. I think you're correct, it could have been made a part of that process. [LB916]

SENATOR KRIST: Okay. Well, thank you for coming. [LB916]

SENATOR CAMPBELL: Mr. Buntain, it seems to me...you know, we keep talking about this is a 30-year process...oh, I'm sorry, Senator Howard. [LB916]

SENATOR HOWARD: I did have a question, but I can go after you. [LB916]

SENATOR CAMPBELL: No, you go right ahead because mine is longer probably. [LB916]

SENATOR HOWARD: Oh, okay (laughter). [LB916]

SENATOR CAMPBELL: Just as a warning. [LB916]

SENATOR KRIST: I don't know, she rapid fires. [LB916]

SENATOR HOWARD: Can you help me remember a time when the Nebraska Medical Association has come to this committee as a proponent of a change in scope? [LB916]

DAVID BUNTAIN: I would have to rack my brain. I can't say offhand that I can. It's the nature of the process that physicians are trained, and you'll hear some physicians talk about that, to practice at a very high level. And what you are seeing is a number of more limited scope professions which without the necessary education and training that we think that you need to practice medicine or wanting to do things that are medical practice. So, I mean that...I suppose I've given you the answer with a rationale, but, generally, there have not been those situations. [LB916]

SENATOR HOWARD: And then, just to follow up on Senator Gloor's sort of compromise question: can you remind me of a time when the Nebraska Medical Association worked with another group and came up with a compromise and brought that to this committee? [LB916]

DAVID BUNTAIN: You're catching me at the end of a Friday. [LB916]

SENATOR HOWARD: I apologize. [LB916]

DAVID BUNTAIN: No, that's all right. [LB916]

SENATOR HOWARD: I completely understand. [LB916]

DAVID BUNTAIN: We've been involved, probably, in, you know, 20 or so...and there have been a lot more than that. I mean, we've worked with groups such as the physical therapists, for example, where there were some issues. You know, I would have to...I can get you a more specific answer to that. [LB916]

SENATOR HOWARD: That would be wonderful. Thank you. [LB916]

SENATOR CAMPBELL: I think in response from Senator Howard's question, with all due respect to everyone that is in this room, you have to realize that the old 407 was really very adversarial. And it was, to some extent, it might have not been at the beginning, but it evolved to that point. And people saw it as that. And they saw it as, you ought to pick a side. You're either on our side or you're on the other side. And I don't know if Senator Gloor agrees with me. But his legislation, it seems to me, tried to take some of that out and put things forward. And so that's kind of the dilemma, I think, is that we now have a new system and the point being, I'm sort of with Senator Gloor. I mean, what would you like to put on the table after 30 years of looking at this issue? I mean, if we're...we're at that point, if I were some of the people who spent a lot of time...the nurse practitioners, I'd say we've spent a lot of time on this issue. We've studied it; we've looked at it. We should be ready to come to that point. And they're saying: I don't think we need more study. On the other hand, you're saying: well, we should sit down and talk. How do we balance all that in a new system, I guess? [LB916]

DAVID BUNTAIN: I don't know. I mean it's a matter of taking the various issues that have been raised such as the inadequacies of the practice agreement; such as the need for physicians to step up. We have concerns, as do the nurse practitioners about some of the reimbursement practices the physicians have insisted on. We had a hearing similar to this four years ago where we said, if you're aware of instances where this is going on, let us know or report it to the board of examiners. To my knowledge, that has never happened. You know, one of the things that I think is very puzzling to us is that there's been this constant argument about we can't...this is a barrier to entry in rural areas. Well, there is an option to go through he board to practice without a practice agreement which has been exercised, according to Dr. Acierno's report, six times in 18 years. So, there's kind...there's a disconnect in a lot of the information. We think that it's important to encourage nurse practitioners to work in a collaborative relationship with physicians and that healthcare delivery will be improved if you encourage that through the laws. And that's what our position is. [LB916]

SENATOR CAMPBELL: You alluded earlier to the fact that the administration of it and, you know, we've certainly...and I think you were here and heard the testimony where she did apply for a waiver and she got six months or whatever... [LB916]

SENATOR KRIST: Three months. [LB916]

SENATOR CAMPBELL: Three months to do it. Well, that's not sufficient if you're trying to put a business together. So that...it backs up what you're saying on the administrative part of it. [LB916]

DAVID BUNTAIN: We're not involved in that at all. [LB916]

SENATOR CAMPBELL: You are not. You know this issue before the committee is exactly what you're talking about four years ago when we had the hearing. And many of us sat here, not the new people, I realize that. But, you know, it was the nurse practitioner in the north central part of the state in a very, you know, rural setting and she paid $10,000 a year and she never saw the doctor. And I think that's when a number of us starting saying, you know, we've got to change the system in terms of how do we get at those issues. And apparently, even through this 407 process, we didn't get, perhaps, a suggestion from the medical side as to how they would change it. And I think that's Senator Gloor's question. Any other comments? [LB916]

DAVID BUNTAIN: Thank you. [LB916]

SENATOR CAMPBELL: Thank you, Mr. Buntain. Our next opponent. Good afternoon. [LB916]

JOSEPH ACIERNO: (Exhibit 33) Good afternoon. Good afternoon, Senator Campbell and members of the Health and Human Services Committee. My name is Dr. Joseph Acierno, that's J-o-s-e-p-h A-c-i-e-r-n-o. I'm the Chief Medical Officer and Director of the Public Health Division in the Nebraska Department of Health and Human Services. I am testifying on behalf of the department in opposition to LB916. LB916 makes revisions to the Nurse Practitioner Act. This bill will allow a nurse practitioner to practice without an integrated practice agreement with a collaborating physician. Currently, there is a requirement for an integrated practice agreement to ensure that there is written agreement between a nurse practitioner and a collaborating physician to provide for the deliver of healthcare through an integrated practice. Currently, the newly licensed nurse practitioners are required to have 2,000 hours of supervised practice. This bill does not provide for any supervision or mentorship for new, inexperienced nurse practitioners. There should be some form of supervision or mentorship for new nurse practitioners. Not only are they lacking experience as a nurse practitioner, but in some cases they may have graduated as a nurse practitioner without having first practiced as an RN. It is not in the best interest of the public to eliminate the requirement for the integrated practice agreement for new nurse practitioners. Eliminating the practice agreement with a physician removes the assurance that the nurse practitioner has at least one physician on file who has agreed to serve in a collaborative capacity. Currently, there is a provision in the statute for the Advanced Practice Registered Nurse Board to waive the requirement for an integrated agreement under certain circumstances. We believe

this provision provides a sufficient avenue for nurse practitioners who are practicing in an area where there is a shortage of healthcare services, or are unable to find a collaborating physician to sign a practice agreement, and who meet the requirements to practice without the protocols. We recognize there is an increase in nurse practitioners who report having difficulty obtaining these practice agreements. To date, there have been ten nurse practitioners who have requested and been granted waivers. The department regards it to be in the best interests of the public to retain the requirement for an integrated practice agreement. My Credentials Review Process Report, commonly known as the 407 report, provides additional information on this matter and copies of the report have been provided to all of you electronically. I'll be happy to answer any questions you have. And I'm sure you have a few. [LB916]

SENATOR CAMPBELL: Well, we do. (Laughter) I can see that. We'll start with Senator Gloor and we'll work our way around. [LB916]

SENATOR GLOOR: Thank you, Senator Campbell. And thank you, Dr. Acierno. [LB916]

JOSEPH ACIERNO: Sure. [LB916]

SENATOR GLOOR: Did you say that there have been ten requests that have been granted? [LB916]

JOSEPH ACIERNO: Yeah, I think that's the final up to date, yeah, is ten. [LB916]

SENATOR GLOOR: And that's over...since we were last here. [LB916]

JOSEPH ACIERNO: I don't know for sure, but for a number of years. [LB916]

SENATOR GLOOR: But that doesn't necessarily represent how many requests there were, it represents how many requests we're going to... [LB916]

JOSEPH ACIERNO: No, but I could tell you, that's pretty close to the number. And when you talk about that waiver, and you were talking about the length, Senator Campbell, that's up to the board. The board determines the length. The regulation says the board shall determine the length of that waiver. That's the APRN board, that's peers. So depending on, they can...they can adjust whatever their judgment is. I have the regulation. It says that a waiver granted by the board will be for a time specified by the board. But just so you, you know, kind of get an idea of that. [LB916]

SENATOR GLOOR: That's helpful. [LB916]

JOSEPH ACIERNO: Yeah. [LB916]

SENATOR GLOOR: Would you think a nurse practitioner who came in and said I can get a practice agreement, but it's going to cost me $24,000 a year for that, is that justification to issue a waiver? [LB916]

JOSEPH ACIERNO: I can only give you my opinion; I don't know how the board would view that, but I would assume that's probably a fairly hefty price to be paid. [LB916]

SENATOR GLOOR: (Laugh) Yes, and it has been, I think. [LB916]

JOSEPH ACIERNO: So, and...I'm not disagreeing with the fact, and I think you've heard from everybody and my report says: I don't think the system is perfect as it...as the evidence I saw as it was brought to me. I do think there's issues with this relationship. But the issue, ultimately, I look at it from a regulatory standpoint and safety. I'm not trying to pick the profession. I know it's been discussed that I'm against the profession or I'm for a profession. I'm not for or against anyone. I'm for the citizens. And all I look at is what, objectively, what's in front of me and to protect safety. I think it's fairly clear from my report that my...I looked at the situation as it is, it has some issues with it, need to be worked out clearly. And I also think there's quite competent nurse practitioners out there doing great work every day. My biggest concern is really the young graduates coming in and how they are prepared to enter practice, how much experience they have. You've heard testimony about 2,000 hours; but what I heard was 2,000 hours was (inaudible), not that big a deal. Two thousand, it really didn't really mean anything. Well, it's there for a reason. Two thousand hours is still two thousand hours working with somebody. But yet that's still...compared to a physician who has tens of thousands of hours, there is a difference. [LB916]

SENATOR GLOOR: What finds its way to our doorstep though, in this case, is a technical committee who we assume, and I think rightfully so, are also concerned about safety, and a Board of Health that's also concerned about safety, and yet they brought forward a recommendation that they were comfortable with this. And that's not to discount your belief in safety either. [LB916]

JOSEPH ACIERNO: That's fine. [LB916]

SENATOR GLOOR: But...well, everybody, I think, is interested in safety, but it...not everybody has come to the same conclusion. [LB916]

JOSEPH ACIERNO: And I understand that. And I would say that with the Board of Health and the Technical Review Committee, they expressed the same concern I have. The difference is, I think their recommendation is to terminate the agreement and then look at...to make sure the younger nurse practitioners have some form of training. I'm saying before you terminate that relationship...or by law terminate that relationship you

should have something in place prior to terminating the practice agreement provision. [LB916]

SENATOR GLOOR: But by way of clarification, I don't think you mean age, I think you mean experience. [LB916]

JOSEPH ACIERNO: Yes, I do. This is true. I don't mean to offend anyone, I'm getting older by the day, so I don't know what that means, but...as far as, I just think we look at it...but I believe, actually, the change should...or how to view that training aspect should be done before there is a termination or we do away with integrated practice agreement. I think that's really the difference between my report and the Board of Health and the Technical Review Committee, but they can speak for themselves on that. [LB916]

SENATOR CAMPBELL: Okay. Senator Krist, did you have a question? I'm going to work around. [LB916]

SENATOR KRIST: Yeah, that's fine. You're a licensed physician, okay, so they come to you and ask you to be their guy. What do you charge? And what is the ethics involved with $10,000, $15,000, $20,000? [LB916]

JOSEPH ACIERNO: You know, I...it's unfair because I was never in that position, so I can't say what I think is fair and what isn't fair. But, clearly, what we're hearing, I think, there's reasons to...that we should all question when you have numbers that you're tossing around to say: what is that physician getting? Why is it that amount of money that's being charged? And I do think that if somebody thinks it's an unethical practice, and I agree with Mr. Buntain, that is something, I think, if we're looking at unethical behavior, that is something that should be looked at by the Board of Medicine and the department for these practitioners, frankly. [LB916]

SENATOR KRIST: Okay. And I make that point only to say: you said, clearly, that the system is not working. I don't want to put words in your mouth, but it's not working. [LB916]

JOSEPH ACIERNO: No, and it's written there, so. [LB916]

SENATOR KRIST: So, it's broken. So how do we fix it? Well, one of the things, to me, seems to be an ethical approach to providing, potentially, the supervision. And then what has come up in here today is, you know, in my business, you need 1,700 hours to qualify to be a commercial pilot on an airliner. That's not 1,700 hours of good time, that's 1,700 hours of punching an autopilot off and on. So I would say, it's 1,700 hours minimum and then there's a qualification that follows in that. But, certainly, a pilot doesn't start out with a doctorate degree or a master's degree and six years of trauma and all those kind of things. And so another part of it that I would point to, I think, in the

system being broken is...three months...three months and...and this...so this is...you brought it up, it's the board that's making that decision. That seems to be not a very long time for someone who has 20 years of experience in the field or 10 years. So another part of the system that might be broken that we could look at. But I go back to my point before, I saw 407 when I first got here; I see 407 now, and every time we have one of these hearings somebody comes up and says, well, just give us some more time to work on it. Really. When are we finally going to get to a point where somebody comes in a says: okay, here's the deal...and this is the point I would make to anybody who is coming up in opposition, it's bad, it's bad, it's bad. Great, it's bad, it's broken, now what do we do about it? So let's deal with the training...the supervision issue on the front side. If you have more than six years of experience as a nurse, do you need to have this process in place? I don't know. You know, all of that, I think, should have washed out within the 407 to some extent and we would have some recommendations about how to adjust. And I've hammered on long enough. (Inaudible) comment. [LB916]

JOSEPH ACIERNO: No, and I understand exactly what you're saying. I think the 407 has improved in the respect...I agree with Senator Campbell, completely. I think this 407 shows that if you actually...if you go read...anyone who reads the Technical Review Committee, I think it was more of a fact-finding mission than adversarial as we've had in the past. So I think that is good. Now how all that worked out, whether it was sufficient to answer all the questions, well, that's in the eye of the reader and the committee to determine whether there was enough uncovered in this 407. And then my responsibility is not necessarily to come up with the answer, the ultimate answer because, as I put in my report, there are many learned minds who can look at this. I don't think I wave a magic wand and say, tomorrow all nurse practitioners should be trained as X. I think what I look at is how that...what evidence is through that 407 and how do I view it. Has somebody met whatever standard; or what arguments have been made, and what do I find to be the still-standing questions involved in it? And my report shows what I still think are standing questions which I think, to some extent, are the same questions you have at this point. And that's why I'm saying before you do away with the integrated practice agreement, I think you just need to be cautious with the implication of that is. But, clearly, that is going to be up to your body to determine. [LB916]

SENATOR KRIST: So, your report is your report. Can I have one... [LB916]

SENATOR CAMPBELL: Yes. [LB916]

SENATOR KRIST: The report is your report; yet, I'd be curious, can you talk about some of the evidence that you used to get to that point? [LB916]

JOSEPH ACIERNO: Well, what I look at is I...I actually look at public hearing. I look at things that may be cited into the articles. I look at all the things that were provided because, frankly, the parties brought a lot to the table. So I go through all of that. I

actually have in front of me, as well, I have the Board of Health and the Technical Review Committee reports. So I kind of synthesize all of that. And I may ask other questions, too, that I may want to know something about. Frankly, I go to the law itself or I may go to the regulations, I want to see for myself. I'm not limited, nor is any...to anything in particular; it's not like a trial where I can only look at what's in front of me. But I will go to articles and I will do that, depending on the 407, what I need to do at that point. So that's how it's done. [LB916]

SENATOR KRIST: Okay. Thank you. [LB916]

JOSEPH ACIERNO: Sure. [LB916]

SENATOR CAMPBELL: Senator Howard. [LB916]

SENATOR HOWARD: Thank you. And thank you for your testimony, Dr. Acierno. [LB916]

JOSEPH ACIERNO: Sure. [LB916]

SENATOR HOWARD: Does the APRN Board have physicians on it? [LB916]

JOSEPH ACIERNO: I believe, but I can't...I don't remember it's configuration. I don't off the top of my head. [LB916]

SENATOR HOWARD: Okay, so you don't remember how many... [LB916]

JOSEPH ACIERNO: I don't remember...I could get you that configuration. [LB916]

SENATOR HOWARD: That would be wonderful. Thank you. [LB916]

JOSEPH ACIERNO: Yeah, that's easy to do. [LB916]

SENATOR HOWARD: Okay. And then... [LB916]

JOSEPH ACIERNO: I just don't remember its configuration. [LB916]

SENATOR HOWARD: I only have one more. [LB916]

JOSEPH ACIERNO: Sure. [LB916]

SENATOR HOWARD: In your memory of working for the state, can you remember a time when a Chief Medical Officer, even in the new and the old 407, approved a change in scope? [LB916]

JOSEPH ACIERNO: Oh, wow, I haven't been involved in that many. I don't know the answer to that actually. I just look at them independently, one to the next. So I don't...I don't recall one way or another, actually, Senator, I don't. [LB916]

SENATOR HOWARD: Thank you. [LB916]

JOSEPH ACIERNO: But, obviously, those reports are available. And if you want to know how the...how things have been viewed, we can get those reports to you. [LB916]

SENATOR HOWARD: Thank you. [LB916]

SENATOR CAMPBELL: Senator Howard, when Mr. Montgomery used to come, and I think he came last year and gave an orientation with several members from the Board of Health, he used to have a chart. [LB916]

JOSEPH ACIERNO: Yes. [LB916]

SENATOR CAMPBELL: And that chart sort of listed all the 407 process and it was like, if I remember right, the technical committee said yes; the Board of Health said, no; the director said...and there was a whole chart so that you could look at the 407 process. Now you have to realize that's under the old system, not necessarily the new. And I tried to find it and I have so many pieces of paper in my office that I could not find the chart. But... [LB916]

JOSEPH ACIERNO: So you're saying you'd like me to find that chart for you again? [LB916]

SENATOR CAMPBELL: You know, Dr. Acierno, whichever one of us gets to it first. But it might help to answer Senator Howard's question. [LB916]

JOSEPH ACIERNO: Sure. [LB916]

SENATOR CAMPBELL: Because, you know, one of the things that I think is very important, and I recognize that we are in a 60-day session, and so therefore we do have to speed up our reading and speed up our whatever. But I have told the committee members that they...they are responsible for reading the materials that are sent to them and that we will discuss the reports because that's what the statute requires. I mean, we really do...you advise all...we have three advisory reports, but now in order for our colleagues to know that we're doing the due diligence, we need to read all of this material because otherwise you just don't make a snap decision in my estimation on scope of practice no matter how you feel on either side of the issue. And I think that's important. I did want to go back and discuss what...I keep bringing up is the ancillary

recommendation. And one of the testifiers thought that perhaps I was reading something and the minutes would show that there was a different recommendation at the end. But I thought that the material we got in the mail had their final report and ancillary recommendation. [LB916]

JOSEPH ACIERNO: That's correct. Normally how it works is, with the Board of Health, I think, is...there was some discussion of the Board of Health. Normally, the report is finalized after public hearing, because that's...that's part of the process, that takes it into account, and then they write the report. [LB916]

SENATOR CAMPBELL: Right. [LB916]

JOSEPH ACIERNO: So I have no knowledge of the fact that there may have been a public hearing after a report was written. I would assume it was the way it should have been. [LB916]

SENATOR CAMPBELL: And I have to say, I thought what was interesting is that the technical committee basically had one ancillary recommendation and the Board of Health had two. But the Board of Health also listed a number of discussions upon which they could...they threw out what they discussed. But apparently they didn't have enough consensus to make it a recommendation. Am I saying that correctly? [LB916]

JOSEPH ACIERNO: Right, and that's how I viewed it as well. [LB916]

SENATOR CAMPBELL: Okay. Over the course of the time, does the department keep track of complaints from a nurse practitioner or a physician, on these agreements? [LB916]

JOSEPH ACIERNO: Sure, I would assume. We know various categories... [LB916]

SENATOR CAMPBELL: And so people have... [LB916]

JOSEPH ACIERNO: ...of how many complaints there may have been. [LB916]

SENATOR CAMPBELL: And so people have complained and said, this isn't working. [LB916]

JOSEPH ACIERNO: Yes. It could be...and I have to say, in my time...but I don't know every investigation that goes on. But in my time--and I've been with the regulatory portion of the division for seven years now, the last year as Chief Medical Officer--I've not encountered a case dealing with it. [LB916]

SENATOR CAMPBELL: Oh, okay. [LB916]

JOSEPH ACIERNO: I have not. [LB916]

SENATOR CAMPBELL: So the Board of Health or the Board of APRNs has not specifically dealt with a complaint... [LB916]

JOSEPH ACIERNO: I don't know if the board hasn't, but it hasn't made it to where I knew about it. [LB916]

SENATOR CAMPBELL: Oh, okay. [LB916]

JOSEPH ACIERNO: Where there was a disciplinary matter it may not even make it to me. [LB916]

SENATOR CAMPBELL: Either from a complaint from a physician... [LB916]

JOSEPH ACIERNO: Right. [LB916]

SENATOR CAMPBELL: ...or a complaint from a nurse practitioner. [LB916]

JOSEPH ACIERNO: Right. Right. [LB916]

SENATOR CAMPBELL: Dr. Acierno, is there a way to find out if there has been? [LB916]

JOSEPH ACIERNO: Sure. [LB916]

SENATOR CAMPBELL: Because it may give us some idea what was the nature of those complaints... [LB916]

JOSEPH ACIERNO: Right. [LB916]

SENATOR CAMPBELL: ...and does this legislation meet those. [LB916]

JOSEPH ACIERNO: We could take a look at... [LB916]

SENATOR CAMPBELL: Would you? [LB916]

JOSEPH ACIERNO: ...whether we've had any complaints on that. [LB916]

SENATOR CAMPBELL: That would be helpful. [LB916]

JOSEPH ACIERNO: Sure. [LB916]

SENATOR CAMPBELL: I have to say that four years ago when we talked about this and I related about the nurse practitioner that was in north-central Nebraska, I called over to your department--and you were not, of course, the director at that point--but I talked to I think it was Helen Meeks at licensure, and she said to me, boy, nobody has asked that question. And so she said, let me go back. And she actually went through old records and old boxes. And at that point, four years ago, there had only been five or six...asking for a waiver. [LB916]

JOSEPH ACIERNO: Waiver. [LB916]

SENATOR CAMPBELL: And so at least there's been a few more. But that...Senator Howard, I wanted you to know that they really had to go through the boxes to find that. So it's not...it's not been utilized very much. [LB916]

JOSEPH ACIERNO: Correct. [LB916]

SENATOR CAMPBELL: And that in and of itself, I think, also makes some statement in terms of how people perceived whether it was valid or not. Any other questions that you want to ask Dr. Acierno at this point? Okay. Thank you. [LB916]

JOSEPH ACIERNO: Thank you. [LB916]

SENATOR CAMPBELL: And if you wouldn't mind getting that information, that would be helpful. [LB916]

JOSEPH ACIERNO: That's fine. I will. Have a good weekend. [LB916]

SENATOR CAMPBELL: Thank you. [LB916]

JOSEPH ACIERNO: Thanks. [LB916]

SENATOR CAMPBELL: All right. Our next opponent. [LB916]

CASSIE KRAUSE: Good afternoon. [LB916]

SENATOR CAMPBELL: Good afternoon. [LB916]

CASSIE KRAUSE: (Exhibit 34) My name is Cassie Krause, C-a-s-s-i-e K-r-a-u-s-e. I am a family nurse practitioner and have been practicing in primary care since I graduated with my degree in June of 2012; I have been practicing now for a year and a half. I work with Dr. Brian Finley, who is my collaborating physician. When I graduated from my master's program, I had completed approximately 540 clinical hours. I also worked as a

nurse five years prior to completing my nurse practitioner degree. When I started my job as a nurse practitioner, I felt equipped to practice with basic knowledge but relied heavily upon Dr. Finley's wisdom, experience, guidance, and teaching. In the beginning, I consulted with him, on average, between 50 percent to 75 percent of the time by either consultation or having him directly evaluate the patient himself. Eighteen months later, I can tell you my skills and knowledge have grown by leaps and bounds. I would estimate 80 percent of the time I am able to assess, diagnose, and treat my patients without his direct supervision. Twenty percent of the time I still ask him for help. I need help with complex patients who have many co-morbidities, complex medical diagnoses, or even when I am unsure of the diagnosis altogether. I rely on him being immediately available for my questions and sometimes for him to come assess the patient himself so I can be confident I am not missing something. I want to give you an example of a time when I relied upon his help. I had a patient present with a one-day history of redness and pain in her right lower leg. It was red, swollen, tender to touch, and slightly fluctuant in nature. The patient denied having any fevers; there was no break in the skin. So many possible diagnoses are running through my head. Could this be a cellulitis, an infection of the skin? Could there be an abscess underneath that needs to be drained? Does she have a DVT in her leg that would put her at risk for a pulmonary embolism, stroke, or heart attack? I really wasn't sure. So I went to get Dr. Finley, explained to him the situation; he came to assess her leg. He felt it was appropriate at that time to do some imaging. He ordered an ultrasound of her leg, which showed phlebitis. It was a superficial blood clot in the vein in her leg. I looked it up. Treatment recommended NSAIDs and warm compresses and the clot would dissolve on its own, in time. She came back one week later. The redness had spread, and the tenderness was much worse. My treatment wasn't working. What do I do now? I went to get Dr. Finley, who again evaluated the patient, reviewed her ultrasound report, and decided to put her on three weeks of anticoagulation, Xarelto, and continue warm packs. She came back two weeks later, and the redness, swelling, and tenderness had resolved. This is just one of many examples of how I rely on Dr. Finley to back me up when I am unsure, or if my treatment fails. I have a lot of security and comfort that I have a written agreement between myself and Dr. Finley, so that together we can deliver quality, cost-efficient healthcare to our patients. I am not limited by our agreement. I can practice to the full extent of my training with confidence that someone has my back when I need it. I also want to briefly touch on the differences in training between physicians and nurse practitioners; however, I want to focus on their four years of medical school, in which they graduate with their medical doctorate degree. They complete, on average, 6,000 clinical hours in medical school, which, again, is more than my 540 hours. And if you ask any nurse who works with a brand-new doctor in residency if they think they could practice medicine on their own at that time independently, I am confident you will not find any. We often remind each other come July of each year, when brand-new residents start, to watch our charts carefully, because occasionally we would find an unsafe order. Physicians need residency; it's a structured learning environment where they can gain clinical experience, research, and in-depth training. Nothing like this exists

for nurse practitioners. Therefore, for the protection of the nurse practitioner and the safety of our patients, I urge you not to get rid of the integrated practice agreement. [LB916]

SENATOR CAMPBELL: Questions? Senator Gloor. [LB916]

SENATOR GLOOR: Yes, Senator Campbell. Thank you for your testimony, and thanks for taking the time to come in, Ms. Krause. Here's what I...where I don't connect the dots. And that is, you look like a bright, intelligent practitioner; I don't understand why, if this bill went through, you wouldn't still try and refer appropriately to a practitioner, a physician, if you felt that the care you had provided wasn't making a difference. [LB916]

CASSIE KRAUSE: I don't think...if this bill passed, this would not affect how I practiced at all. I would still continue my collaborative agreement with Dr. Finley. He sees so many complex patients that if I were to go out in rural Nebraska and practice independently, by myself, and not have a written agreement with a physician, I would be fearful that I would come across a problem and want to call a collaborating physician or want to call a network, so to speak, and somebody may not answer my phone call. [LB916]

SENATOR GLOOR: But even physicians in those rural settings, if they feel like they've got a patient that they can't handle, faced with the same situation, pick up the phone and call somebody. I mean, we've talked about the need for collaboration; we've talked about teamwork. People call people. Or if they can't get anybody to take a patient, they make sure they get transported to an emergency room, which has to take that patient, by federal law. So I understand, and your relationship seems to be a great one, a healthy one; certainly resulted in better patient care. I'm just not sure that this bill, if it passed, is going to change your wise decision making when it comes to what you can handle and what you can't handle. [LB916]

CASSIE KRAUSE: If I may... [LB916]

SENATOR GLOOR: It's not going to force you to have to take care of those patients you're not comfortable taking care of. [LB916]

CASSIE KRAUSE: Right. If I may respond... [LB916]

SENATOR GLOOR: Sure. [LB916]

CASSIE KRAUSE: ...real quick, let's take this example of this patient. If I was practicing in rural Nebraska and this patient came in with redness in their leg, warmth, honestly, I thought it was a cellulitis, to begin with. And it was fluctuant; I was worried it was an abscess. I would have...if I was by myself and didn't have a physician, I could have

called a physician to collaborate with. This was something that I felt needed to be assessed in person. I would have called and said, hey, this is what I'm thinking; this is what I'm going to do. I would have put her on antibiotics, thinking it was an infection. And that wouldn't have gotten better. So she would have come back to me and said, "It's not better; it's worsening," just like she did. And what would I have done next? I would have consulted a surgeon, probably, in case it was an abscess that I felt needed to be drained. So right there is an example of a consultation that would have had to take place, an expensive consultation, had I not had Dr. Finley right there, who were to say, "Nah, let's get an ultra now; I feel I know what this is." And even when we knew what it was, she didn't get better. And we were treating it with what we thought was appropriate treatment. So we actually utilized some medical resources to figure out a Plan B. [LB916]

SENATOR GLOOR: Well, you're not convincing me that your wise decision, with the practice agreement, won't continue to be a wise decision if you don't have to have a practice agreement. That's where we may disagree. And take that as a compliment, by the way. [LB916]

CASSIE KRAUSE: Thank you. I'm not worried about myself; I'm worried about the brand-new nurse practitioners who may feel like they can take on rural Nebraska by themselves. And if you ask many of my colleagues, who are brand-new, similar to myself, or even a student that I have in my office at this time, "Would you want to go out and practice by yourself right now?" And I have not heard one person say yes. And we may be bright and able to handle a lot of things, but when...there's a difference. There's a difference, bottom line, between physician training and nurse practitioner training. [LB916]

SENATOR GLOOR: Okay. Thank you. [LB916]

SENATOR CAMPBELL: Other questions? Ms. Krause, I just have one. And maybe it's in your testimony and I missed it, but were you a practicing RN before; and how long did you practice as an...? [LB916]

CASSIE KRAUSE: For five years. [LB916]

SENATOR CAMPBELL: For five years. In what particular field or...? [LB916]

CASSIE KRAUSE: I practiced for two years in cardiac. So I was working in a cardiac step-down unit at the Nebraska Medical Center. And then I worked for three years down in the recovery room at the Nebraska Medical Center. So I feel, like, definitely that experience played a role in my knowledge. And when I started my master's program, I was able to build upon that knowledge. However, I feel like they're different entities. Being a nurse and being a nurse practitioner are different entities. As a nurse, you're

taught to assess your patients just like you are as a nurse practitioner; however, there's a diagnostic piece. As a nurse, you don't do any diagnosing. And even if you have an idea of, hey, this is...something is wrong, and...and as a nurse, you know when to call the doctor. You know when, hey, this can wait till the morning; and this is an emergency phone call, it needs to be...he needs to know about this at 2:00 in the morning. So you know that. However, what are they going to do about it? And a lot of times as a nurse you may have an idea, and that's experience. I worked on a cardiac floor two years. I could tell you, if somebody went into A-fib and their heart rate is 150, they're probably going to give them 5 milligrams of metoprolol IV. But I don't have the in-depth training to know why you would do that, why would you do amioderone, why wouldn't you cardiovert the patient, what are the risks and benefits of both. That's the difference of the in-depth training between physicians and nurse practitioners. So, yes, my education was valuable, but it is different. [LB916]

SENATOR CAMPBELL: Okay. Any others? Thank you for your testimony. [LB916]

CASSIE KRAUSE: Thanks. [LB916]

SENATOR CAMPBELL: Our next opponent. Good afternoon. [LB916]

RICHARD BLATNY, SR.: Just in case. [LB916]

SENATOR CAMPBELL: You're fine. [LB916]

RICHARD BLATNY, SR.: (Exhibits 35 and 36) Good afternoon, Senator Campbell and the rest of the committee. Go ahead? My name is Richard Blatny, R-i-c-h-a-r-d B-l-a-t-n-y, Senior. And I'm speaking against the elimination of the collaborative agreement. I am currently president-elect of the Nebraska Medical Association and, therefore, speaking for the Nebraska Medical Association. I am a board-certified family physician practicing in Fairbury, Nebraska. Our clinic has three other board-certified family physicians and currently three physician's assistants. A physician is always available for consultation if one of the non-physician providers needs help with a more complicated patient. This happens several times a day. One of our physician's assistants was a medic in Vietnam, has been with us 34 years, and still appreciates our help with more-complicated patients. If at all in doubt, they are to request our help. This assures quality care for our patients. As in most small towns...small rural towns, we also cover the emergency room in our hospital. If a physician's assistant is on call, a physician is also on call to back him or her up. I feel this is an ideal working relationship for both the physicians and the physician's assistants. We have had non-physician providers working with us in our clinic since 1980. Our patients are comfortable accepting their services because they know we're all working together as a team providing quality care. Eliminating the collaborative agreement will put the citizens of Nebraska at increased risk. One assumes the nurse practitioner will recognize that they

are dealing with a problem patient, but this is not always the case. The training of a nurse practitioner is far different from that of a physician. A physician has seven years postgraduate education; a nurse practitioner, two and a half years. A physician has 12,000 to 16,000 hours of clinical experience on completing his residency...his or her residency, versus 500 to 550 clinical hours for a nurse practitioner. This is less than 4 percent of the total clinical hours that a physician has at the time they start practicing. If you were boarding an airplane and one pilot had 4 percent of the training of the other pilot, which pilot would you want to have in control of your plane? Five hundred clinical hours is equivalent to working a 40-hour week for 3 months. A nurse practitioner practicing without a collaborative agreement would not have the luxury of only allowing patients with simple problems to walk into the office. Many patients, especially rural patients, are elderly and have complex illnesses with multiple co-morbidities. Giving one medication may upset the delicate balance of their often multiple other medications. If a nurse practitioner does recognize a complex problem and needs help, without a collaborative agreement who will they call? All physicians are busy. The physician would have to stop, leave his patients waiting, spend time listening to concerns regarding the patient, and then give advice. After a couple of these consultations, a physician may not be available the next time the nurse practitioner calls and needs assistance. Also, in providing advice regarding the care of the nurse practitioner's patients, a physician is assuming liability. The other alternative a nurse practitioner has is to order more tests, which may be unnecessary because he or she doesn't really understand the patient's illness. This drives up unnecessary costs. Anyone with minimal training can diagnose a tonsillitis or acute ear infection and treat appropriately. Likewise, it's obvious a referral is needed if a patient has a fractured leg with the bone sticking out. It's all the gray in between. Not recognizing a more serious problem may result in delay of treatment, increased morbidity, and possibly even death. By eliminating the collaborative agreement, the nurse practitioners state they'll provide better access to care in rural areas. This does not prove to be the case in states where independent practice has been allowed. Oregon, Washington, and Arizona maps, which you have, reveal the nurse practitioners settle in more densely populated areas. This is the case now in Nebraska, and there's no reason to expect it to change. Only six, but we heard today ten, nurse practitioners have applied for waivers in 18 years. Dr. Kevin Nohner, president of the Nebraska Medical Association, has submitted written testimony describing patient-centered medical homes, with physicians, nurse practitioners, and physician's assistants working together to provide quality, efficient, and evidence-based medical care. This is the wave of the future. Finally, with regard to the collaborative agreement itself, it's a win-win situation. For the nurse practitioners, there's the security of knowing that someone is there for a consultation whenever they need it. For the physician, there's the comfort of knowing the capabilities of the nurse practitioner and knowing that they will be able to carry out our recommendations. The collaborative agreement is not just a piece of paper, it's working for the vast majority of nurse practitioners in our state. If there are some instances where it's not working as intended, we need to fix the problem, not throw away the one thing we have to ensure safe,

quality care for the citizens of Nebraska. The NMA is willing to work with nurse practitioners to help solve the problems in instances where the collaborative agreement is not working properly. Also, a fee schedule should be developed to fairly compensate a physician for the time away from his or her patients and the increased liability when the physician agrees to be a collaborating physician. The future of medicine in developing cost-effective care will be through us all working together. We strongly oppose the elimination of the collaborative agreement. Thank you. [LB916]

SENATOR CAMPBELL: Thank you very much. Questions? Senator Krist. [LB916]

SENATOR KRIST: I like your aviation reference (laughter), for the record. [LB916]

RICHARD BLATNY: Thank you. [LB916]

SENATOR KRIST: You kind of touched on it at the end, but, just briefly, are you taken aback at all by the numbers you see when you see that a doctor is charging what, to me, is an exorbitant rate? [LB916]

RICHARD BLATNY, SR.: Yes, sir. But what I've heard today is that...I've heard $300 on one end and $24,000 or something like that on the other. [LB916]

SENATOR KRIST: Well, I think Senator Gloor said $24,000; I don't know where...what that...but I did hear $10,000, I think. [LB916]

RICHARD BLATNY, SR.: Ten. Yes. [LB916]

SENATOR KRIST: So... [LB916]

RICHARD BLATNY, SR.: Yes. I...I... [LB916]

SENATOR KRIST: Yeah. [LB916]

RICHARD BLATNY, SR.: The only thing I wanted to bring up is that the point I'm making, that everyone being busy, I don't know if people out there think about if there's no collaborative agreement, then the nurse practitioner calls a physician; I don't have any breaks in my day, so if I were to do this, I stop, my patients have to wait. Everyone down the line has to wait the rest of the day. And also the increased liability of taking that on, when you really don't have any control...without a collaborating agreement, you have no control to really say that...are they really going to do what you say; or is something else going to happen? So there is a liability. So, yes. But I, you know, no one has ever...I've been involved with this as long as Dr. Lazure. We've known one another...no one, to my knowledge, has even come to us and said, hey, why don't we get together and try to work on a fee schedule to do this? We're willing to do this. Just

like why aren't there complaints lodged with their own nurse practitioner board or all the other possibilities? So, yes, I think something should be done with that. [LB916]

SENATOR KRIST: Okay. Good points. Thank you. Thanks for your testimony. [LB916]

RICHARD BLATNY, SR.: Um-hum. [LB916]

SENATOR CAMPBELL: Any questions? Okay. Thank you, Doctor. [LB916]

RICHARD BLATNY, SR.: Thank you. [LB916]

SENATOR CAMPBELL: Our next opponent. [LB916]

SENATOR KRIST: How many more (inaudible)? [LB916]

SENATOR CAMPBELL: I don't think that many, but I'll ask. [LB916]

SENATOR KRIST: Just curious. [LB916]

SENATOR CAMPBELL: Good afternoon. [LB916]

ROBERT WERGIN: Good afternoon, Senator Campbell. And thank you for the committee to allow me to share my views on LB916. I'm Robert Wergin, R-o-b-e-r-t, Wergin, W-e-r-g-i-n. I'm a practicing rural physician in Milford, Nebraska. I also currently serve as president-elect of the American Academy of Family Physicians for...nationally. They represent 111,000 practicing family physicians and medical students across the United States. And I serve on the board of directors of the Nebraska Academy of Family Physicians. I want to state personally right up-front, and I can say this on behalf of the American Academy of Family Physicians and the Nebraska Academy, that we support nurse practitioners. And we they're a important part of a healthcare team delivery of care. On the other hand, I have to say strongly, we don't support creating another class of providers that further fragments care, with the resulting increased costs and reduced quality of care delivered to the patients, not just here in Nebraska but across our country. We know from studies and proprietary data that having less-qualified providers see patients in first contact generally, if you look at all costs, total cost of care, generates more tests, more imaging, and more referrals. In other words, I pride myself on being comprehensive: every fracture doesn't have to go to the orthopedist; I can care for some of those. Collaboratively, that works. I would put to you, if you look at national trends as well, the team approach of care is a trend, both with CMS...I would refer to your packet. The PCPCC, which is the Patient-Centered Primary Care Collaborative that was started by Paul Grundy...a group of leading businesspeople in the country came together and proposed and supported patient-centered care, and their recent report, which is in your packet, was just released this last fall, and the one previously,

and I think you'll see one trend in there across the board. Team-based care, almost in every instance, reduced the cost and, yet, improved the quality of care. I also had the honor to be on the Governor's task force for our own state's patient-centered medical home, along with Senator Gloor, which I'm happy to see here, who found similar data, that our two rural practices that we facilitate becoming PCMHs, flattened the healthcare cost, lowering it, and improve the quality indicators. So we believe in team-based care and a nurse practitioner being part of that, working collaboratively with physicians. Also in the academy, I wanted to point out, we've done a recent study--University of Texas at San Antonio, evidence-based--looking at the complexity of patients that family physicians see. And we found, even compared to our subspecialty colleagues, that we see the highest complex patients, of providers, due to the multitude of problems we see, even compared to our peers. With the aging baby boomers, the complexity of patients are going up, not less. And the extra experience and training we have as family physicians, I think, prepares us for that, and can give guidance to someone with less training and background maybe feeling less comfortable. We feel getting it right the first time is the answer to better quality and less cost, and that's what we see at the academy. One other thing I'd say, being a rural family physician, as you talk to rural hospital administrators--and I know Senator Gloor is going through his 12-step program from...as a former hospital administrator (laughter)--what you'll find...and they ask me: If you come to here, what day are you going to cover the emergency room? Who are you going to admit to my hospital in rural Seward, Nebraska, where I practice? And I don't know if that's a role that would be fulfilled, that you would salvage these rural access points, in care in these rural areas. And I can tell you, working there, you do see high complex problems. I want to close by reiterating I support nurse practitioners as part of a healthcare team. We at the academy always...kind of our mantra as we walk down the hall is: The right provider, the right care, at the right time. Thank you for listening to my remarks. I kind of... [LB916]

SENATOR CAMPBELL: Senator Gloor. [LB916]

ROBERT WERGIN: ...thought I'd get a question here. [LB916]

SENATOR GLOOR: (Laugh) Thank you, Senator Campbell. And we should put people at ease that your reference to my 12-step program is you're only repeating what I've told you... [LB916]

ROBERT WERGIN: (Laugh) I know. [LB916]

SENATOR GLOOR: ...at our meetings. I'm sure the members appreciate your participation in the establishment of our pilot projects for patient-centered medical home, which, regardless of the outcome of these discussions, is still something that's going to be important to all practitioners in this state eventually. But let me lighten this up a little bit by telling you that if we get out of here in time, I'm going to hop in my car

and drive back to Grand Island, and I'm going to have dinner tonight with some friends, a married couple: he's a physician; she's a nurse practitioner. And they are wise enough not to practice together (laughter). But I've been struggling with whether I tell them what I'm doing today, and...because they've not been married for a full year yet, and (laughter) thinking, do I want to be responsible for causing some sort of a rift here, except I know I can do that because they know each other well enough and are comfortable with each other enough that not only can they have that conversation, the nurse practitioner would be completely comfortable referring to the doctor and the doctor would be completely comfortable allowing that nurse practitioner to practice independently because they know each other so well, and they have that trusting relationship. And the problem here is how do we force people into those relationships without legislating it and putting it into some kind of statute, with an independent practice agreement, because I would imagine every physician and every nurse practitioner knows somebody on the other side of this that they know they can work that way with. And how do you get an agreement to do that so that the world moves along nicely here in those trusting relationships? It's a predicament. And, unfortunately, we find ourselves now wrestling with... [LB916]

ROBERT WERGIN: Yes. [LB916]

SENATOR GLOOR: ...with issues around 407 reviews and changing legislation, when that collaborative, cooperative relationship that I know exists in at least that married relationship is a hard one to bring out into the field. [LB916]

ROBERT WERGIN: Yes. [LB916]

SENATOR GLOOR: And it's...that's probably more of a statement than a...but a comment. But it's the frustration I know we feel as we sit down and listen to all this. [LB916]

ROBERT WERGIN: I would say I was...in response to that comment, is, I was surprised to hear that the collaborative agreement was interpreted differently by different physicians. I work with a PA, same office; I consult with her every day. That's what I am comfortable with, and I think that's my responsibility: I sign her charts. And I would hope that...it was a surprise to me that some of the nurse practitioners had never met their...or they don't come by and that. And so I don't know if that means all are that way; we certainly heard some anecdotal evidence that there's problems. But I certainly think that could be addressed in fostering that team-based relationship. And you know as well as I do, moving to a team-based when I would say most practices are doctor-centered: it's about me getting home at 5:00. I don't get home at 5:00. If you're patient-centered, you think about your patient and their needs; and that's, really, your responsibility too. And I think that can be accomplished with some revisions in the IPA; I could give you some suggestions, but it's not my role. [LB916]

SENATOR CAMPBELL: And I just want to make sure that we clarify. In your practice, do you work with nurse practitioners or physician's assistants? [LB916]

ROBERT WERGIN: My...I'm in a rural health clinic, so by federal statute I have to have a mid-level non-physician provider. We have physician's assistants. We have three physician's assistants that I work with, all three, one on one. And I'm the primary supervisor of the one in Milford, so I sign off on all her charts. [LB916]

SENATOR CAMPBELL: And, Doctor, I could be wrong, but in the conversations I've had with some of the nurse practitioners, they give me the list of what they...their qualifications and what they've had to go through; and in a number of cases, that's more extensive than a physician's assistant. [LB916]

ROBERT WERGIN: I'd refer you to your wheel. I would disagree with that, respectfully. The physician's assistants I work with, having trained next to them, are more allopathic-trained--not in nursing--diagnostic. When I was on call at night at the University of Nebraska, they were in the bed next to me. They came down and saw patients with me, worked with me, one on one, in that parameter. They did go through their four years of college...not in nursing, and that may be where they're saying, we have this clinical experience, nondiagnostic, that they have in that background. But I would say, if you look at the wheel, they have more clinical hours, in training, by the time they're regulated. One other point I'd make, as a family physician, I have to be recertified every ten years. It requires more than just CME, practice improvement. I have to take a didactic test on-line three years, at the end of ten years take a national exam and pass it and go on. And I'm not aware of a standardized recertification curriculum for nurse practitioners in this country. I know they're working towards a standardized curriculum to be an NP. I would just say, when you see an M.D., you see an M.D.; we have one standard. [LB916]

SENATOR CAMPBELL: And with all due respect, Doctor, I think that for some of the nurse practitioners, and certainly not all of them, but some of them, I think they feel that they're not considered as a part of the team, because they're having to deal with this agreement that in many cases is not functioning well. I mean, if we take a balance, on both sides of this issue. So... [LB916]

ROBERT WERGIN: Thank you. [LB916]

SENATOR CAMPBELL: ...I would appreciate, with your national connections, if there are some other states that are looking at...we all know that team-based, patient-centered medical homes are the future. I mean, we are not going to have sole people out there; we know that we need everybody on that team. So it's almost as if we're looking for something different than the traditional agreement. [LB916]

ROBERT WERGIN: I would say you're the preacher preaching to the choir. Couldn't agree more. And one of our focuses is to have high-functioning teams that include those nurse practitioners break down those barriers. [LB916]

SENATOR CAMPBELL: And as a valued member of the team. [LB916]

ROBERT WERGIN: Yes. [LB916]

SENATOR CAMPBELL: So... [LB916]

ROBERT WERGIN: I would say that's true. [LB916]

SENATOR CAMPBELL: ...I'm looking for that. [LB916]

ROBERT WERGIN: We'll get there. [LB916]

SENATOR CAMPBELL: Okay. [LB916]

ROBERT WERGIN: Next year I'll be president. One year. [LB916]

SENATOR CAMPBELL: One year, okay. Thank you. Our next opponent. And just so that we have some idea of time, how many others wish to testify in opposition? [LB916]

SENATOR KRIST: 2? [LB916]

SENATOR CAMPBELL: 2. Okay. Do we have...? Yes, thank you. [LB916]

SENATOR KRIST: 3. Bruce. [LB916]

SENATOR CAMPBELL: Oh, three? [LB916]

SENATOR KRIST: Bruce as well. [LB916]

SENATOR CAMPBELL: Oh, neutral. Yes, I was going to ask neutral. A hand in the back was neutral. Good afternoon. [LB916]

CHRISTINE JEFFREY: (Exhibit 37) Good afternoon, Senators. Thank you for the opportunity to talk with you today. And I'm here in...I'm...my name is Christine Jeffrey. Christine is C-h-r-i-s-t-i-n-e; Jeffrey is J-e-f-f-r-e-y. I'm a practicing family physician in Omaha, Nebraska. And I...you're being provided with the wheel that Dr. Wergin discussed. And it goes through the various medical providers and their length of training; their residencies, if that's applicable; and their initial schooling. So that might be

something that would be of interest to you. The other thing that I brought today are three maps that you have, and these deal specifically with Nebraska. These statistics are from the Health Professions Tracking Service done by the University of Nebraska Medical Center. And this particular map is a map of all the active nurse practitioners. According to this map, there are 795 active nurse practitioners. The vast majority of them...or not the majority, but a significant amount are in Douglas and Lancaster County. So of those 795, 528 are in those two counties alone. And if you look at the western counties, there's very few nurse practitioners. The second map that I would refer you to is the one with the pink. And of the initials of that 795 nurse practitioners, 340 of them are in primary care. And of those 340 in primary care, 163 are in Douglas and Lancaster County. So access, I think, is not going to be solved by doing away with this agreement. The third map is a map of all the primary care physicians in Nebraska. And as you can see by that, they are also in the major metropolitan areas. The other thing that I would like to say, I have been a practicing...or I have been a preceptor for nurse practitioners for the past five years. I volunteer to do this; I don't get paid to do this. And the nurses that have all worked with me have been very good. Their experiences have been very different. Some have come from the emergency room; some have come from the intensive care unit; some have...one person came from OB/GYN. So their background experience is all different. They also have to call their preceptor individually. They don't have a list of assigned preceptors for certain things that they need to learn; they have to call those providers. And so you're not always going to get an established or, I guess, a consistent, maybe, level of what they need to learn. The nurse practitioners that I have worked with, I've been with them from the beginning of their training to the end, and that's anywhere from 500 to 600 hours. They're usually with me one to two days a week. And during that time, I try as hard as I can to get them as broad an experience as they can, especially if they're going to go out in primary care. But the problem is, is that when I did my residency, I do it over, you know, 12,000 hours in a residency, and I...that length of time gives us the opportunity to see multiple things and experience multiple presentations of the same illnesses that...I can't possibly give that to a nurse practitioner in the limited time that I have. The other thing, if they're only required to do 2,000 hours in that first year, and at the end of that there's no examination so that I know what they know, to be then as a collaborating physician, at the end, I have no way of knowing if they're adequately trained. I'm hoping that they are, but I have no way of knowing that. And patients know that I have to pass medical school; I have to go through residency; I have United States medical licensing exam, which is three parts; I have my board certification. So there's a lot of testing so patients know that they are getting a physician and they know what their qualifications are. [LB916]

SENATOR CAMPBELL: Questions or follow-up? Thank you, Doctor, for coming today. [LB916]

CHRISTINE JEFFREY: Thank you. [LB916]

SENATOR KRIST: Thank you. [LB916]

SENATOR CAMPBELL: Our next opponent. Good afternoon. [LB916]

DALE HANSEN: (Exhibit 38) Good afternoon. We're getting close to the end. [LB916]

SENATOR CAMPBELL: That we are. [LB916]

DALE HANSEN: I have a new empathy for what you all do here. My name is Dale Hansen, and I have practiced cardiology for nearly 30 years. I guess Dave Buntain and Don Wesely and I all can be thrown in the same group here. The last 25 years of my practice have been in Lincoln, Nebraska, first at the Nebraska Heart Institute, then most recently, the last 13 years, at Bryan Heart. I also have a clinical appointment at the University of Nebraska Medical Center. And I'm the governor for Nebraska for the American College of Cardiology. I have worked very closely with nurse practitioners, who have been a very integral part of my practice for the last 20 years, starting in 1990. In addition, I'm involved in the educational process of nurse practitioners as they rotate with our group during their training process. My practice consists of 15 cardiologists, and we have 8 nurse practitioners who work with us. Some of these nurse practitioners have been with us nearly 20 years. As I mentioned, nurse practitioners are an integral part of our practice. They function in several ways. First, they gather information as part of the history and physical process, which is then presented to the cardiologist to formulate a diagnosis and treatment plan. Secondly, after the treatment plan is developed, the nurse practitioners are utilized to explain and discuss with patients what the diagnosis and treatment plan is. Thirdly, our nurse practitioners longitudinally follow the patients, both as inpatients and, in some specific disease processes, as outpatients, such as with congestive heart failure, under the tutelage of a cardiologist. The patients are followed to determine the effectiveness of the treatment plan, to modify the treatment plan, and to provide information to the cardiologists on the ongoing state of the patient. This is done through treatment protocols that have been developed for the individual disease processes. Lastly, our nurse practitioners are an invaluable resource in the completion of the mountainous volume of paperwork that is now part of any medical practice. We specifically do not utilize nurse practitioners independently in the role of diagnosis and development of a treatment plan. I've observed repeatedly over the years that the training provided to nurse practitioners has not given them, in some cases, the needed fund of knowledge to independently evaluate a patient, especially patients with more complex disease processes. That is not to say that there are not very well-trained nurse practitioners who come out, but it is the disparity of the training that concerns me. I do have grave concerns with LB916 and the development of independent practice of nurse practitioners. This concern is more marked in recent graduates. I do believe the best approach, as you've already heard several times, to the practice of medicine is the development of the team concept: physician, nurse

practitioner, and other team members can work together to utilize the strengths of each. I believe the strengths of the nurse practitioners are that they are especially effective in communicating and developing a strong rapport with their patients, which is invaluable in the long-term treatment plan. My wife was a nurse. I...even in remote areas of the state, I think the team concept, with the collaboration, can be utilized, possibly through telecommunications, to ensure optimal care of these patients. We've heard of anecdotal cases of difficulty, and we certainly want to solve them. I would ask you how prevalent are those cases really; do we really have information that there are a number of these cases going on? Lastly, I think you have a letter from Dr. Les Spry, who unfortunately couldn't be here today. I agree wholeheartedly with Dr. Spry, who in his letter has advocated the development of a task force of the Board of Medicine and Surgery and the Board of Nursing to resolve these issues that have become quite apparent. I strongly believe that this should be done, with the goal of maintaining collaboration and utilizing the team concept. I do not believe that pursuing independent practice pathways would be optimal for the citizens of our state. [LB916]

SENATOR CAMPBELL: Thank you, Dr. Hansen. [LB916]

DALE HANSEN: Sure. [LB916]

SENATOR CAMPBELL: Questions? Thank you very much for your testimony today. [LB916]

DALE HANSEN: Okay. Thank you. [LB916]

SENATOR CAMPBELL: Our next opponent. Good afternoon. [LB916]

ANN FROHMAN: (Exhibit 39) Good late afternoon, Madam Chair, members of the committee. My name is Ann Frohman; for the record, that's spelled A-n-n F-r-o-h-m-a-n. I am a registered lobbyist, here on behalf of the Nebraska Medical Association. And I hope, Senator Campbell, I can answer maybe some of your questions you posed to David Buntain in the beginning of the session regarding where we go from here, where we've been, and are we kind of at gridlock and an impasse. But before I get to that, I want to just point out a few things, and I handed out something I want to address. And what I've heard today here, and starting with Senator Crawford, the concerns are, you know, we have a shortage, particularly in the rural area; we have education and training that we think is sufficient to do no harm to patients and the citizens of Nebraska; and the current agreement isn't working. With regard to the education and training, what I have handed out is a perspective that I always fall back on, is insurance, because in the world of insurance, they can quantify things, like harm: is there harm? And I looked for reports with respect to the collaborative agreements and without...and very difficult, because you can't find a whole lot out there. But what I did find...I didn't burn a tree and print off the 65 pages. I went through the report; I put the Web site on the front page,

trying to be in the electronic world, if you want to read the full report. But there were a couple of interesting pieces of information from CNA; they are a nationwide insurance carrier that provides medical malpractice liability insurance to medical providers, physicians, as well as nurse practitioners. And they provided a report on closed claims, so not on any open, pending claims, but 2012, as of that time, claims that were closed within their policyholder membership on nurse practitioners. And in the report I found a couple of pages that were interesting. And I'm laying it all out: the good, the bad; it's both. On the first page that I provided, on page 70 of the report, they talked about the...in the environment of their policyholder base, you have those that did not have any claims, those that did. And under 32, for instance, they talked about the breakdown of, you know, did they have oversight; did they have direct supervision; collaborative practice agreements; and the payouts. So, to me, it's like, okay, if we're going to talk about harm, we're going to talk about severity of the payouts. And in this instance, when there was no physician oversight, the payouts were higher than when there was a collaborative agreement. But on the next one, it appears that having a physician on site doesn't provide any magical, you know, benefit, in the sense of how the claims are paid, because the claims were higher when the physician was on site than off. Okay, so, you know, supervision doesn't have to necessarily be physical and in the location, maybe not. But the next page is what is telling to me, that I think you ought to maybe pause and think about this in your direction forward. And it's this. For those that had claims, nurse practitioners, closed claims, that were not supervised at all--that's the bill today, not supervised at all--the average total paid was significantly higher, $293,000, versus those that had direct supervision, $4,000. I think where we're at today, in today's environment, that isn't necessarily working as well as we'd like it; clearly, we need to do more. But "Available if needed" is maybe what I heard, you know, $83,000 in average claim payout of CNA. When you get down to the next section, this is where I think maybe we can do more, because this is really telling to me, and I would suggest we move into looking into doing something here. This is a real recommendation on the part of the Med Association. "As needed"..."Frequency of Clinical Chart Reviews." Why do we not really focus on this? Because "As needed," look at the payout; "Once a year: $152,000"; "Never: $191,000." It just goes up the less touch points you have with a supervising physician. You know, look at it, think about. It's says something to me about the value of collaboration. If we go without the agreement, I hear that we still have collaboration. It's unilateral; it's not bilateral. You're going to catch the physician if you can? I mean that is what I heard today. On the shortage issue, you heard from Dr. Blatny; you have your charts. Three states. They're not moving to Bridgeport, Nebraska, if this bill passes. It's not going to happen. It isn't going to deal with the shortage. On the problems that we have...and, Senator Campbell, if I may answer your question earlier that you asked David Buntain, I know I'm out of time, but we do have some ideas there. I don't think it's systemic. And legislatures, as I view the rule that you have as this body, is you legislate systemic. What we have here are outliers. We have problems on some occasions with fees. We had members of our legislative committee that were embarrassed and ashamed when they heard of the fees. And they thought that, you

know, we had some physicians that were doing this wrong, clearly. And so we need to fix that. And we have recommendations. What do we do there? But something. We need to have a fee schedule or something, look at something. Clearly the nurse practitioners are frustrated in those instances. And I wonder if they are getting the right avenue for relief. They have waivers, but that's not going to solve the fee, you know, the fee problem. But they need an answer. I don't think the answer is tossing the agreement for everybody, but the answer is let's give them an avenue where they can vent their frustrations and get some relief on their problems and deal with it tactically, surgically, and not throw the baby out with the bathwater. [LB916]

SENATOR CAMPBELL: Questions? Senator Gloor. [LB916]

SENATOR GLOOR: Thank you, Senator Campbell. I'm looking at this information just a little differently, because, as you know, Ann, providers don't make the decisions on settling; the insurance company makes that decision. And what this may tell us is that the insurers get cold feet going to the mat when they're representing a nurse practitioner versus an M.D. I mean, if you were to compare this information, as an example, when it came to cardiac diagnosis with FPs compared to cardiologists, the quality of Dr. Hansen is an example. My guess is an insurer would be more likely to say, on an incident involving...a cardiology incident, that they'd settle with the FP, or maybe even the internist, but they'd go to the mat if they were representing Dr. Hansen. And so I think there are other variables that enter into that. Nonetheless, it may be significant as it relates to what a nurse practitioner might have to pay in terms of malpractice insurance. I mean, it may be representative of the cost of malpractice. But I'm not sure it's a...I'm not sure it's a true measure of quality. [LB916]

ANN FROHMAN: It's an interesting report, interesting data. We don't know what it means other than what the payouts are. And they are different when they're in a collaborative under direct supervision than when they're not. But you're right; there's probably much that goes into it. [LB916]

SENATOR GLOOR: And the insurer may say: A collaborative agreement, we're more comfortable fighting this, rather than settling, if there isn't a collaborative. Again, I'm not saying the numbers don't show something at work here, but... [LB916]

ANN FROHMAN: And you wonder why they are more comfortable. [LB916]

SENATOR CAMPBELL: Any other questions? Ms. Frohman, I think I heard you say that there has been discussion in the NMA about some recommendations or some areas that you think, you know, going back to my very first question to Mr. Buntain. Would you be willing to sit down with Senator Crawford and at least discuss those with her so that she has some idea about what those recommendations might be? [LB916]

ANN FROHMAN: Absolutely, yes. In fact, we've been talking within the medical association, we'd love to see an interim study. I've heard it studied to death. Well, I asked...I'm new to this in the last couple years, and I asked Dale Mahlman, I said, has this been studied to death? And he said, well, you know, we clearly are at an impasse; they want out; they wanted out 20 years ago. You know, they want out. And so it is a different dynamic, I understand that. But that's what we're working with. But, absolutely; we have some ideas. And you heard the physicians testify today that, yes, we need to do something. But, you know, let's be careful here; this is a radical decision we're making if we're going to toss the agreements. [LB916]

SENATOR CAMPBELL: I think it would be helpful to Senator Crawford to have a conversation with you, because at least we need to know what that is. To wait indefinitely, I don't know about that. But I do think Senator Crawford needs to weigh those recommendations. And I know she will, because she's nodding; she would be interested in talking to you. Thank you. I believe we are down to the neutral testimony. Is that correct? [LB916]

BRUCE RIEKER: This is what we're down to? [LB916]

SENATOR CRAWFORD: This is what we're down to. [LB916]

SENATOR CAMPBELL: I didn't mean that literally. With respect to the testifier, I should say. Good afternoon. [LB916]

BRUCE RIEKER: (Exhibit 40) Good afternoon, Chairwoman Campbell, members of the committee. My name is Bruce Rieker; it's B-r-u-c-e R-i-e-k-e-r. I'm vice president of advocacy for the Nebraska Hospital Association, here in a neutral capacity with regard to LB916. It's been very educational to hear all the testimony so far. I don't know if...as I was listening to all the testimony, maybe it was specific to some the trending, Senator Gloor, I don't have trends before me yet, but I was looking at some of the tracking service maps that were done by...health professional tracking by UNMC. And one of the previous testifiers had talked about there are 795 active nurse practitioners; 43 percent, or 340, of those are in primary care specialties across the state. Of those 340, two-thirds of them, or 230, are in 7 counties, those being Douglas with 103; Lancaster, 60; all the way down to Madison, Hall, Scotts Bluff, ranging between 10 and 18. There's 110 in rural areas, with 6 of them being in the Panhandle and then the rest of them are evenly split north of the interstate and south of the interstate. So just a little bit of a idea where they are--but I didn't find previous maps--that was as of February of last year. Like I said, we're here in a neutral position. We...this proposal moves the discussion in a positive direction, toward the future of more-collaborative models of healthcare delivery that ensure access and quality and affordability. I think that it's interesting that the conversation that I've heard about the importance of collaboration...absolutely, and we're headed that way through patient-centered medical homes and many other

models. But I think it's a question that we have to ask, is: How...what's the value of the integrated practice agreement to those collaborative arrangements? As we look at this, we as hospitals see nurse practitioners as vital members of the healthcare provider continuum. They function in numerous specialty and general practice roles. With appropriate education and training, with emphasis on "prior to licensure," the need for the IPAs would be eliminated. And so where I'm going with this testimony is, if there are provisions of a residency requirement or education required before the licensure takes place, that is where our membership thinks that we need to go with this particular issue. There are 17 "full practice" states; we could look at those as to how they handle the situations already. A couple of those are close to us, Colorado and Iowa; in fact, they border with us. And one of the issues that we look at as employers and changing the way we deliver care is, if there are no practice agreements required in our neighboring states, it makes it a little bit more difficult to recruit those individuals, to employ them in our state. Our hospitals look at...there are several situations that, you know, or venues that we assessed as we went through this very deliberately a couple weeks ago. When it comes to nurse practitioners that would be credentialed or privileged with our hospitals, we feel very comfortable that we could handle that situation without an integrated practice agreement. As we see the trend where we employ more and more physicians, a trend that is escalating in its pace, but also we as hospitals are now starting to own more of their clinics, we also see that as an environment where we can adequately handle the situation and develop these collaborative relationships without the need for the IPA. The area where we're concerned are the nurse practitioners that may be new or inexperienced, without this residency requirement--if we go that path--but they have no affiliation with us or some other providers. That's the area where our members came down to still having some sort of concern or a concern as to what we do in those areas. I think that that pretty much summarizes the rationale for our neutral position and where we stand. [LB916]

SENATOR CAMPBELL: Senator Krist. [LB916]

SENATOR KRIST: To your statistics and also to doctors maps, when they brought it up here, let's...in terms of looking at those, solving a rural problem... [LB916]

BRUCE RIEKER: Um-hum. [LB916]

SENATOR KRIST: Remember that the population is on the eastern side of the state. [LB916]

BRUCE RIEKER: Absolutely. [LB916]

SENATOR KRIST: And the counties that you're talking about, if we look at a per-population number, I'll bet they're pretty close, because a couple of those that are out there that have 2 or 3, in Scotts Bluff and there, would be 10 to 12 in Sarpy. So you

know what I'm...you know where I'm getting at here... [LB916]

BRUCE RIEKER: Absolutely. [LB916]

SENATOR KRIST: So... [LB916]

BRUCE RIEKER: Yeah, I...I... [LB916]

SENATOR KRIST: ..as we break it... [LB916]

BRUCE RIEKER: It's relative to the population. [LB916]

SENATOR KRIST: If we break it down, I think we see...I...I'm...just by superfluously looking at it, there's a real need for a team approach, that nurse practitioners are part of that team and where the population is, you're going to see a lot of them there. The trick is always, as Senator Gloor says, to get medical care into a rural community. But I think this is part of the answer. So I just don't want to...I didn't want to leave everybody with the fact that they're all over in Sarpy and Douglas and everything else. I think, per population base, it could be statistically significant to look at where they are, so anyway, thank you. Thanks, Bruce. [LB916]

SENATOR CAMPBELL: And, you know, just to reflect, this week we heard some really good testimony about BHECN and how, from a behavioral health standpoint, they are reaching out across the state and using telehealth and lots of technology. So, you know, the point being, is we don't want to get ourselves in any situation in which we lock ourselves away from the future. [LB916]

BRUCE RIEKER: Um-hum. [LB916]

SENATOR CAMPBELL: And I think that's what we're hearing: there's very talented people here, and how is the best way that we create that team for them? Thank you, Mr. Rieker. [LB916]

BRUCE RIEKER: You're welcome. [LB916]

SENATOR CAMPBELL: We appreciate you being last. (Laughter) [LB916]

SENATOR CAMPBELL: Senator Crawford, would you like to close... [LB916]

SENATOR CRAWFORD: I would. [LB916]

SENATOR CAMPBELL: ...on your bill? [LB916]

SENATOR CRAWFORD: Thank you. I seem to have marked in a few spots here. Thank you so much to the committee for your good questions and time and attention. I would like to just come back to a few of the points and answer a few of the questions that I think have arisen while we were going through the testimony. And first I'm going to come right to your question, Senator Campbell, about why didn't we decide to draft this with attention to the ancillary recommendations. And my answer to that is twofold, but the main point is that the ancillary recommendations are just that: they are ancillary recommendations. The key evidence-based focus of their task was: should we get rid of the IPA? And the answer of the technical review board and the answer of the Board of Health was: yes. And that was the evidence-based focus of their discussion. Now...so there are two reasons...so that is their recommendation, and that's what's reflected in the bill. Now there are two other reasons why I didn't include those recommendations in the bill itself. The first is because of that nature of the ancillary recommendation discussion. And you heard a bit of it today. But I also heard it in talking to people who are observing another process. Sometimes in that ancillary part you can get a bit into the "Gee, whiz, wouldn't this be nice" discussion. Right? And again, the focus of the study, with the evidence and hearings, was: should we get rid of the IPA? And the answer was: yes. The second thing is, even if we were to say that the issue about hours/mentoring/readiness was key recommendations for us to consider as a Health and Human Services Committee, the proper place to discuss that is in discussions of licensure, board certification, nursing education. And the nurses are right now involved in a process to review their education and compare it to the Institute of Medicine recommendations to make sure they're bringing their education standards up to those Institute of Medicine recommendations. So those questions about mentoring, hours, etcetera, those are questions that are questions about licensure and board. And we, in my understanding, we do not, in general practice, put those policies into statute; but, instead, they're handled there. And on that front, let me just clarify...somebody asked questions about, do they need continuing education or...and it is...in order to have a nurse practitioner license, you must be board-certified. And so there's licensure and board certification before you practice as a nurse practitioner. And if there are discussions about those policies and questions, that's a different bill...or a different process than this, particularly aimed at asking about the IPA. I also want to clarify...there were some questions about the waiver and the waiver process and about whether or not the advanced-practice nurses were trying to keep the process from working, to try to manipulate it and make us decide to get rid of it. Actually, the waivers must go to the Board of Advanced-Practice Nurses. And if you hear that name, you think, that must just be advanced-practice nurses. But, actually...you asked a good question, Senator Howard: Who is on the Board of Advanced-Practice Nurses? Actually, advanced-practice nurses are a minority on the Board of Advanced-Practice Nurses. It is five advanced-practice nurses, five doctors, a pharmacist, and three consumers. So this is not a friendly board of peers that decides whether or not to issue the waiver. I'll also say there are strict criteria, as well, to even apply, is what the nurses have told me. And I think if you look at Acierno's report, he mentions something about

trying to get a practice agreement for two years. So we're talking about a difficult process. So the fact that there have not been a lot of requests for waivers does not mean that there's not a need or there's not a problem existing with the existing process. And also, in terms of ethics complaints...I'm a political scientist, but I know you all also understand power. And you have to recognize that nurse practitioners would be in a very vulnerable situation to pose an ethics complaint against a physician, when their livelihood depends on getting a physician to sign a practice agreement. So, I mean, that is also an issue. Whether or not physicians would ever retaliate, I mean, I'm not saying that they would; I'm saying a person in that position of deciding whether or not to pose the ethics complaint may feel, in that situation, very vulnerable in terms of offering that complaint. We've also talked a lot about the importance of collaboration. And I think I'm hearing...I'm hearing "shared agreement" on that point. (Laugh) The nurse practitioners and the physicians are both talking about the importance of collaboration and team-based care. And I want to stress that if...again, the point I made at the very beginning of my opening: in our nurse practitioner statutes page 3, line 5, the copy you have in front of you, our statutes say, "A nurse practitioner shall function by establishing collaborative, consultative, and referral networks as appropriate with other health care professionals. Patients who require care beyond the scope of practice of a nurse practitioner shall be referred to an appropriate health care provider." So I did talk to Ann a bit before the hearing, and she did say they had a concern about wanting additional study. This is what the interim study should be about. We have language for collaboration in the statute. We could talk more about how to make that collaboration work that's in the statutes now. We have had decades and decades of study, in our state and other states, about an independent practice agreement. And that does not need any more study. So I think it is very appropriate for us to move forward and make the change, for which we have decades of evidence, and to say, yes, let's talk some more about how physicians, doctors, and other providers can work together to make sure we're...we are providing collaborative, consultative, and referral networks. How are those created...because another important point that I think you should have heard when the nurse practitioners were talking about what it looks like on the ground is they consult with lots of physicians. It's the physician that patient is seeing the most. It doesn't make sense for consultation, referrals...it doesn't make sense for that to be one, single physician, the way we practice medicine now. There are specialists, and they should be getting consultation and referral to the appropriate specialist or the appropriate physician because of the patient's relationship with that physician. So as one of the doctors said, well, how...you know, do I stop my practice, what does that look like? That's the exact kinds of questions we could discuss with an interim study on this part of the statute we are leaving in, about the importance of collaborative care. And I think that's really...that's how we move forward. We have been at an impasse on IPAs for years. We get rid of the IPAs; that allows us to move forward in really talking about studying what these collaborative, consultative, and referral networks should look like. And that's where our attention, in terms of future study, should be. Just checking here to see what...and again, the nurse practitioners are not asking to go out and practice all by

themselves without consulting anyone else. They are passionate about collaboration. We have a tool in statute to encourage and require that. That was the position of one of the...Dr. Buntain said the NMA's position is the law should encourage collaboration. The current law does that. The IPA is not necessary for that to happen. And also, again, with some of the maps and where nurse practitioners are now, again I wanted to emphasize that it's difficult to get an IPA in some of those areas. So that is another explanation for why they may not be in some of those areas. Also, as we've pointed out before, it's difficult to recruit and retain nurse practitioners, especially those critical ones we need for mental health. And so we are training them and they're going other places. And so, again, it's...because they have an easier time practicing in rural areas in other states, we're having a difficult time of keeping them. Finally, I'll close with just a...and also I want to say again, remember that we are not talking about direct supervision; that is not at all what the IPA is even about. There have been some discussions also about differences in how much education people with different training have. And I want to remind you, everyone on this committee, I know, is committed to health outcomes and evidence. Head-to-head comparison of educational hours is not the appropriate measure of clinical success or patient safety. The appropriate measure is patient outcomes. Forty years of patient outcomes and clinical research demonstrates that nurse practitioners consistently provide high-quality and safe care. Two, there are over 40 years of research and over 100 published articles that attest to the quality and safety of nurse practitioner care. The National Governors report published in 2012 titled "The Role of Nurse Practitioners in Meeting the Increased Demand for Primary Care" found that existing research suggests that nurse practitioners have the potential to perform a subset of primary care services as well or better than physicians, and, further, extended utilization of nurse practitioners has the potential to increase access to healthcare, particularly in historically underserved areas. You have also heard concerns about diagnostics. If diagnostics were an issue, we would expect an uptick in malpractice in cases (sic) that provide full practice authority. Let me remind you of a point I mentioned earlier. There has been no increase in malpractice complaints or action taken against the licensure by the state boards of nursing in those 16 states with experience with full practice authority for nurse practitioners. So finally we're getting close to the dinner hour. (Laughter) All right? So you're probably all hungry. I'm going to close with two food analogies. All right? (Laughter) All right. Nurse practitioners are nurse practitioners. They do not want to pretend to be doctors; they are nurse practitioners. And they have different training; they have different hours; they have different scope. And, in fact, one of the nurses I was talking to today said, it's about apples and oranges. Right? Apples and oranges. Two different types of providers, and they're both important for, you know, our "fruit salad" of effective healthcare, moving forward. And, in fact, just yesterday, we in this committee just moved on a bill to make sure that oranges don't pretend to be apples. Right? We just passed that; we just moved that out of committee to make sure that there's clear credentialing so that the patient would know what the credentials are of the person they're going to see. If they prefer apples, they can go get apples; if they...but if they prefer oranges, they can go get oranges, and oranges are still

nutritious and delicious. Right? (Laughter) Finally, I think you heard, especially with a few of the last testifiers in support, they talked a bit about what we often refer to as "the sausage making." That happened when this got put in statute. And, you know, as a new member here, I have just seen that sometimes happens. When you're trying to move something through, and to make everybody happy, you add amendment. And so people say, you know, the two things you don't want to see; you don't want to see...are sausage being made and laws being made. I would venture to say that the IPA that's in this current statute is gristle in the sausage; it's time to remove it. Thank you. [LB916]

SENATOR CAMPBELL: And that concludes our hearing today on (laughter) LB916. Thank you, all. [LB916]

SENATOR WATERMEIER: Well, I was hungry till I heard that. [LB916]

SENATOR HOWARD: Yeah. (Laugh) [LB916]

SENATOR WATERMEIER: Now I'm not hungry anymore. [LB916]