[LB107]

The Committee on Health and Human Services met at 1:30 p.m. on Thursday, January 22, 2015, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB107. Senators present: Kathy Campbell, Chairperson; Sara Howard, Vice Chairperson; Roy Baker; Tanya Cook; Sue Crawford; Mark Kolterman; and Merv Riepe. Senators absent: None.

SENATOR CAMPBELL: (Recorder malfunction) I'm Kathy Campbell and I serve as Chair of the Health and Human Services Committee. And for some of you who have been here many, many, many, many times, a few of these directions are...might be a little different. I first of all want to start out and say that most of the senators here will have an iPad or computer with them, because what we are doing is, instead of the big black book with all the bills in it, we are doing a pilot to try to eliminate a lot of paper. And this whole system was set up for us by the clerk, Brennen Miller. So we're learning along with everyone else. So the rest of the procedures will sound pretty familiar. If you have a cell phone or a device that makes noise, would you please turn it off or silence it for sure? If you did bring handouts, and handouts are not required, but if you did, we would like 15 copies. If you will be testifying today, there are very bright orange sheets on both sides of the hearing room, and we need to have you complete those. Write very legibly. And each time that you testify, you need to provide an orange sheet. When you come up to testify, you give the orange sheet...a page will come forward usually and take it and give it to the clerk. We do use the light system, and today it will be very important. I'll probably talk a little bit more about how we're going to work with LB107 when we get to it. But each testifier is allowed five minutes before the committee. And you will see a green light and it will stay on for a long time, four minutes. And then it will go to yellow and you have one minute left before you hit red and I'm trying to get your attention. We want you to come forward and state your name for the record and spell it so that the people who transcribe can hear you speak and spell your name correctly. With that, we will start with introductions of the committee. And I'll start on my far right.

SENATOR KOLTERMAN: I'm Senator Kolterman from Seward, York, and Polk Counties.

SENATOR BAKER: I'm Senator Roy Baker, Gage County, part of Southern Lancaster County.

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

JOSELYN LUEDTKE: Joselyn Luedtke, legal counsel for the committee.

SENATOR COOK: I'm Senator Tanya Cook. I represent the 13th Legislative District in northeast Douglas County and Omaha.

SENATOR RIEPE: I'm Merv Riepe. I represent District 12, which is Millard and Ralston.

BRENNEN MILLER: I'm Brennen Miller. I'm committee clerk.

KATHY CAMPBELL: We have two pages with us today. Jay, who is helping Senator Kolterman there, is from Dalton, Nebraska. Jay is a student at UNL studying in ag economics. And Brook, who is over here to my left, is from Omaha. Brook is at UNL studying advertising, public relations, and poli-sci. So this is the right place to be with a poli-sci minor or major. Anyway, we really do welcome you and appreciate your time today. We're going to start out with some annual reports that come before the Health and Human Services Committee. And I have to say, I'm always delighted for this day to come because so much work goes into the efforts of the people that you will hear from today. They are only going to give you a teeny bit of all the work that they do. So we'll start with a briefing on the Nebraska Children's Commission by its chairperson, Karen Authier. And you all need to know that the Children's Commission spent all day yesterday in a retreat and had a business meeting this morning, so Karen is probably very relieved to get to this point and be able to go home. (Laughter) Welcome.

KAREN AUTHIER: Good afternoon.

KATHY CAMPBELL: And we'll go ahead and have you state your name and spell it for us.

KAREN AUTHIER: (Exhibit 1) My name is Karen Authier, and I'm here representing the Nebraska Children's Home and I serve...or, excuse me, I'm representing Nebraska Children's Commission. (Laugh) I serve as the chair of that commission. I am the CEO of Nebraska Children's Home Society. So I didn't have a switch in identities. It's just kind of a dual role. I am...on the commission, I represent the provider agencies. You have the written testimony and there's obviously no way I am going to make you listen to everything that's in the report. So I do want to hit the highlights. And especially since there are some new senators, just a reminder that the commission is relatively new...was a product of the Legislature in 2012. And our first meeting was in July of 2012. And we have been meeting on a regular basis monthly since then. And the last...each session of the Legislature seems to bring a few changes to the commission in terms of either additional work, which we have welcomed, or some changes. So just to report to you that the changes from LB269 in the last session of the Legislature have been very workable. And we are very grateful for some of those changes. The move to the Foster Care Review Office went very smoothly. You added two members to the commission which...that has been a very good addition for us. Both the executive director of the Foster Care Review Office and the state...the Inspector General for Child Welfare have provided new insights and great expertise. And then also, very importantly, the policy analyst provided for a staff position, and Bethany Connor is out

there today, that has allowed us, I think, to do our work. We've been able to go into some policy issues in much more depth. So that's been a great resource for the commission. The commission is organized...our work is done in various smaller groups in addition to the whole body. Some of those are committees that were created by statute. So any of the committees of the commission are actually committees that were created by statute and they are under the umbrella of the commission. So that means the commission approves their reports, but all of the committees have members that are appointed. Their appointment is confirmed by the commission, but they are not all members of the commission. This works very well, because it gives the commission a breadth of experience far broader than the actual members of the commission and allows us to, I think, have some of the best minds in the state addressing the very specialized work of each of the committees: Juvenile Services Committee; Foster Care Reimbursement Rate Committee; Bridge to Independence, which was formerly the Young Adult Voluntary Services and Support Committee and was renamed in statute last...well, one of the last sessions of the Legislature; and then the Psychotropic Medication Committee. The work groups also are very active and the work groups...there are four work groups that are related to the four goals of the commission's strategic plan: Community Ownership of Child Well-Being; System of Care; Technology and Data; and the Work Force Work Group. And then some task forces, which...the works groups, their work is ongoing. Some task forces that have addressed specific issues: Statutory Responsibilities, taking a look at what was left on our plate from the original LB821 legislation that we had not yet reported out on; a Governance on Organizational Structure Task Force; and a very new Legal Parties Task Force that's looking at some issues about...as it relates to attorneys representing various parties in juvenile court hearings. The Reimbursement Rate Committee has...is...had met very steadily. And there was...there have been two of those. There was one that was in the...in original legislation in LB820 in 2012. It came into being at the same time the commission did. They did their work and then subsequently there was another bill introduced, so this is sort of the second round with a different kind of appointment. That group was charged in monitoring what was going on with assessments that were determining the level of care for children in foster care. The legislation that recreated this committee, LB530, provided for pilots at various sites around the state. So that committee is monitoring that. And also there were some difficulties with the implementation of the foster care rates that were agreed upon in the first go-around. And so that committee was tasked with arriving at some resolution of that issue. They had a February 1, 2014, deadline...did not meet that, because there was significant difference of opinion, and finally submitted recommendations for approval by the commission in May of 2014. Some people think that was problematic that the time lag...I think the committee itself viewed it as time that was needed to come to some consensus on some issues that would have caused problems down the road. So all of the parties involved in the committee, which includes the Department of Health and Human Services, foster parents, private provider agencies and others were in agreement that the work of the committee was successful in that everybody came away

from the table satisfied. And the implementation has really been relatively smooth. And, in fact, before Director Pristow left the department, he had made a request that the committee take on group home rates, because he thought the process worked so well. So I think that it's a good sign that the Legislature had some sense that by creating a committee to do that, to make those recommendations, that it could save some grief down the road. And I believe it did. The Office of Juvenile Services Committee is another committee that regularly submits reports to the Judiciary Committee of the Legislature. They have been delving into many issues related to children in...that are the Juvenile Services population. I'm not even going to begin to summarize that. They have submitted reports. I didn't bring those with me today, but I can certainly...I'm sure you have access to those, but I can make sure we get those to you. But those recommendations have all been approved by the commission. So, again, there's a smaller body that has a lot of people involved in the recommendations and then approval by the commission. Bridge to Independence Committee has been very active in making sure that the legislation that was passed to assist youth that were aging out of the foster care system is working the way it's supposed to. And that oversight also has gone very well. They were very involved in working with the department on the rules and regulations that provided for that transition and provided for the services and supports. They also...there was a report that was just submitted in December to this committee that was their year-end report. That also was approved by the commission. They had some recommendations in that report regarding some specific issues about gaps in services, issues related to designees for the payment of the extended guardianship component, and some situations where tribal youth were falling through the cracks, lack of eligibility to Right Turn post adoption/guardianship services. And I believe that has been pretty well resolved by a change in the contract between the state and...my agency happens to be one of the agencies involved with Right Turn. So I think that has been addressed. Limitations in the evaluation plan were another concern. And a big issue for the commission has been the ineligibility of youth served by probation and Office of Juvenile Services. And the Bridge to Independence Committee is forming a smaller work group to look at what that would mean, what that would take to include juvenile justice youth in those services. Psychotropic Medication Committee is monitoring, has not been as active, is going to get active again. Community Ownership of Child Well-Being Work Group is an extremely active work group. This group...there was a strong commitment when...in the strategic plan of the commission that the well-being of children in Nebraska is the responsibility of all Nebraskans, not just the Legislature, not just the Department of Health and Human Services, not just the private agencies. And so out of that came a model for community ownership of child well-being and implementation of that model through community collaboratives that have been developed across the state. I've personally been involved in some of these. It's very exciting to see people come together that are across...not just across agencies, but it's public sector, private sector, faith community...working on what the community is defining as a problem. So in Grand Island, the one I've been involved with has been prevention of teen pregnancy. In other areas it's...Fremont it's general child well-being.

But they've been very successful in engaging the community and coming up with resources that are not necessarily taxpayer resources to provide for those services. Facilitated conferencing was a bill. There was a bill introduced in the Legislature last session that passed. We were involved in that in taking a look at how facilitated conferencing can benefit children in juvenile court. We're going to be continuing to take a look at how that is working. And then a new focus on collaborative funding...a lot of questions coming up about, are we using the funding that we have in a most...the most efficient, effective way? And could we...are we duplicating it sometimes with some kinds of funding? Are there huge gaps in other areas? Can we...collaborative funding is one term. You can also...there are...I won't begin to explain to you all the differences in these terms. But collaborative funding, braided funding, blended funding...what it really means is pulling together funding from various sources, not just governmental sources but some state money, some federal money, county money, as well as private funding. And so that's something that we'll continue to focus on. The System of Care Work Group has been very involved in working with the Division of Behavioral Health. They had...they spent most of last year working on a system of care plan to make sure that children had access to the right services wherever they lived. And the...they completed their work for the planning, and I just heard this morning that they're going to be resuming their work and looking at how to move toward implementation. And the commission has strong representation on that. Technology and Data Work Force: There has been great concern about whether the technology that we're using is the best and whether we're able to collect and analyze the kind of data we need to make decisions. This group...it's been a little over a year ago. It was in December that we did forward a report from their group with some options that were suggested as ways to improve the use of technology. With that particular task, that work group felt that they'd taken that as far as they could as an advisory group and really the report then needs to be acted upon by decision makers, not just advisors. And so we're...that group is looking at whole population measures. And much of yesterday and this morning was spent also in taking a look at how the commission can select the right sets of data to look at to better grasp what's going on with children being served particularly by child welfare, because that's where we have data. But it's such an overwhelming amount of data. We need a better way to make sense of it. We've also made some changes in terms of the organization. The original legislation left some gaps in terms of governance. And so there was a small task force that met to...so, for instance, I was elected chair. My intention was not to be chair for life. (Laugh) And so there were some decisions made by the commission about the governance of the commission itself. And that was very helpful. Finally, the most recent task force we put together is the Legal Parties Task Force chaired by Kim Hawekotte who will be testifying later but has done a great job of pulling together people to look at the role that's being played by attorneys in juvenile court, whether...what that role should look like, what it looks like now, what the recommendations are, and they have just submitted their report to the commission on the role of the guardian ad litem. The commission is endorsing that report and is looking forward to hearing where they're going, the next steps, which will be looking at the other attorney roles that are played

out in juvenile court. One last thing: We have been asked by a private funder, a foundation, if the Children's Commission would be involved in a project that they are undertaking to try to get a better handle on the sources of child welfare funding: where it comes from, where it goes. That may sound like a simple question. It is not. And so the Sherwood Foundation is funding a contract with Child Focus, which is a national research organization focusing specifically on children. And we have a couple people that we've been involved with who are putting together...they've been working with Liz Hruska, needless to say. But they're going to be putting together a report that should be released in March. And these...the people who are putting this together have had experience doing this in other states. They have a good understanding of the federal funding and how that...how the federal funding works. But they're learning about how that works in Nebraska. They had asked if the commission would appoint members to the advisory committee, which we did. And I am on that committee. And they will be releasing that report in March, and the commission will be involved in that release. It's a...it will not have recommendations. It's made...its intent is to simply be a reference document so people like you, people like me, can take a look at this, try to make sense of it for ourselves, and come up with some recommendations as to, are there places that we could combine some of that funding and get more bang for our buck? So that...it's been a busy year. And I thank this committee. I thank the Legislature for having the wisdom and the vision to establish a group that can pick up a number of pieces, look at them under a microscope if necessary, and get back to not just you all but to others with some recommendation. I think it provides a marvelous opportunity for involvement in a structured way for many of the citizens of Nebraska.

SENATOR CAMPBELL: I concur. Questions from the senators? What we may want to do, Karen, is perhaps come back in March after the finance report and do a briefing for the committee...

KAREN AUTHIER: Right.

SENATOR CAMPBELL: ...and kind of an update. For the senators, the statute allows ex officio nonvoting membership from the Legislature: the Chair of the Health and Human Services Committee, the Chair of Judiciary, and the Chair of Appropriations. Senator Coash and I have been the two people involved from the Legislature, and it's been a great way to listen to the experts in child welfare talk and debate some of these issues. It's been a great avenue. So we will have you back again.

KAREN AUTHIER: Okay.

SENATOR CAMPBELL: Thank you, Karen.

KAREN AUTHIER: Thank you.

SENATOR CAMPBELL: And thanks very much for everyone who serves on the commission.

KAREN AUTHIER: Thank you.

SENATOR CAMPBELL: Our next report and briefing to the committee is by the Inspector General of Child Welfare Annual Report. And as Julie Rogers is coming forward, I do want to remind the senators that we have the only Inspector General of Child Welfare in the United States that is a part of the legislative branch. And so we found that out when Julie went to a national conference. So welcome, Julie, and go right ahead.

JULIE ROGERS: (Exhibits 2, 3) Thank you. Good afternoon, Chairperson Campbell, members of the Health and Human Services Committee. My name is Julie Rogers, J-u-l-i-e R-o-g-e-r-s. I'm the Inspector General of Nebraska Child Welfare. The Office of the Inspector General of Nebraska Child Welfare was created to provide increased accountability and oversight of Nebraska's child welfare system including any public or private individual or agency serving children in the state's care. The way we think of the child welfare system, generally, is any child-serving government or government-supported entity in Nebraska. The OIG investigates death or serious injury of a child which occurs in foster homes, private agencies, child care facilities, and others under contract with or receiving services through the Department of Health and Human Services or Juvenile Probation and complaints of wrongdoing to children and families being served by or through the Department of Health and Human Services or private entities. We provide accountability and oversight of Nebraska's child welfare system by tracking issues and themes. System improvement recommendations are made both informally and formally to Legislature's Health and Human Services Committee and the Department of Health and Human Services Division of Children and Family Services. In being charged with investigating problems in Nebraska's child welfare system and the purpose of doing so is not only to uncover wrongdoing or serious oversight but in every instance to look for system-wide implications. We strive to provide a systemic perspective which can guide lawmakers, advocates, administrators, and other stakeholders in efforts to improve Nebraska's child welfare system. Over the first two years of operation, we received hundreds of complaints and notices of serious incidents involving children in the state's care which have been examined in detail, acquainting our office with the perspectives of all groups who interact with our Children and Family Services system, from parents, youth, and school officials to judges, family attorneys, and therapists. The office deals primarily in stories, the opinions and anecdotes of individuals cross the child welfare system as they relate them to us and record them in official records. We have a very unique perspective. We have been granted access to all relevant Department of Health and Human Services personnel and documentation and the documentation of all providers who work under any DHHS contract. Because the office is not responsible for any aspect of service provision, we are free from the

sorts of biases that affect almost all other players with access to confidential information. Every agency and service provider has a natural incentive to place their work in the best possible light. Due to the sensitive nature of our work, we take great care when investigating a case or systems issue to weigh the available evidence, solicit all relevant perspectives, and remain objective. Our annual report, which came out September 15, 2014...it's based on the fiscal year 2013 and '14, acknowledges positive development in the Department of Health and Human Services Children and Family Services Division's management structure and improvement in some key statistical measures as it goes from crisis to stability. The report points to areas of insufficient progress. Nebraska was still not meeting important goals in child welfare such as timeliness of permanency for state wards, rates of contact with both parents, and involving families in decision making. In addition, families have too many caseworkers over the length of their case and caseload targets set forth in statute are very difficult to meet. In our observation, there is a continued lack of zealous representation by attorneys and guardians at litem in juvenile courts. Nebraska has yet to adopt trauma-informed, evidence-based practices to help match children and families with effective behavioral health services. The report discusses what these system failures mean for many of the children and families involved in our child welfare system. It calls specifically for measures to improve the quality and retention of caseworkers within the Division of Children and Family Services and staff at the Youth Rehabilitation and Treatment Centers. Management structure changes can only accomplish so much. Ultimately, caseworker performance is key to a great child welfare system. In order to continue to improve, Children and Family Services will need to attract stronger candidates, retain them longer, train them better, and lower their caseloads, which I understand is being worked on intently. As Children and Family Services shifts its focus from major structural overhauls to the more nuanced, qualitative aspects of excellent social work and service provision, further improvements depend increasingly on performance and professionalism of our front line workers. In 2012 the Legislature passed LB961, which mandated maximum caseload sizes for Children and Family Services caseworkers. Every service area has a very difficult time meeting caseload targets in any given month. Other areas outlined in the report include the importance of Nebraska child welfare data analysis and the importance of extended family involvement in child welfare cases, expanding the family first...or Family Finding pilot, for example. Also included in the report is an overview of the Youth Rehabilitation and Treatment Centers, the placement of last resort for children in our juvenile justice system. They are thought of as the most restrictive placement for juveniles, meant to house and provide treatment to only those violent or dangerous youth who cannot be safely placed within their community or in any less restrictive setting. Many of the problems that remain within child welfare and juvenile justice require complicated and nuanced solutions and involve coordinated action among different agencies and branches of government. As we look forward to focusing on quality, the Office of the Inspector General...we remain cautiously optimistic that child-serving entities in Nebraska are continuing to progress to better and more appropriate services for

children and families. So, some numbers about contacts to our office: We investigate complaints of violations that arise from a variety of sources. In fiscal year 2013 and '14, we received approximately 120 specific complaints from the public. We reviewed 225 Children and Family Services critical incident reports, 15 of which rose to the level of further or full investigation. Around 80 inquiries came for information from various sources about situations occurring in or around state government relating to children. Whether investigating critical incident reports or individual complaints, we thoroughly review each. This includes gathering information from N-FOCUS as well as JUSTICE, the system that contains court documents, and talking with a variety...various parties about the case, usually with the caseworker and/or supervisor. Then we determine whether to exercise options of opening an investigation or formally referring the complaint to another entity such as the Ombudsman's Office to resolve. Sometimes after reviews are completed, it could be determined that no jurisdiction exists for case-specific action by our office, for example, custody issues in divorce cases, issues related specifically to juveniles on probation, or issues related to the courts. Again, systemic issues are always noted. Next, on page three of the testimony are numbers for intakes for this fiscal year from July to December 2014. We've had ten more intakes than July through December of 2013. And we have opened 18 full investigations in the first six months of this fiscal year. And if you note, last year...12-month period, we had to open 15. So we will expect much higher numbers towards the end of this fiscal year. So this calendar year for 2015, we're recognizing several areas relating to child welfare and juvenile justice that we will monitor for further understanding of progress. This is not an exhaustive list, but rather a recognition that development and advancement of these topics will be the focus over the coming year. These include: juvenile justice cases, as all have switched through the juvenile justice reform from Office of Juvenile Services--Health and Human Services--wards to probation supervision; the State Ward Permanency Pilot Project; Alternative Response; and then the Department of Health and Human Services formal grievance process. I wanted to update the committee on the grievance process. The September 2014 report that we submitted reported that the department did not yet have a grievance process. They now have one. And it is an internal formal grievance process, but this far, no report...we have not...no reports have been provided to our office. Also, to note, Nebraska Families Collaborative does...they do have a complaint process established per requirements within their contract for services with the department. But they are not required to forward their determinations but will voluntarily share those outcomes with us. Staffing of the office: In July of 2014, Sarah Amsberry was hired as our intake executive assistant. And in October of 2014, Sarah Forrest was hired as assistant inspector general, handling much of the investigative work. This has allowed the office to begin to reach its full potential. Being fully staffed has allowed us to identify subject matter areas that will be a focus during this calendar year. They include: Youth Rehabilitation and Treatment Center in Kearney that is with the Ombudsman's Office; the Child Abuse and Neglect Hotline; initial assessment; disrupted foster placements and/or adoptions based on sexual abuse; and finally, Youth Rehabilitation and Treatment Center in Geneva. Finally, I recognize that

there are fewer court-involved families in our system. And that is a very positive step, but we cannot become shortsighted in focusing only on these numbers. Each case represents a unique child who may be in need or in danger. Simply closing a case or failing to open one is not, in itself, a victory, not if that family needs further help. If caseworkers don't have the tools they need to do their jobs well, if we don't build a service system that effectively treats high-needs youth, if we don't see that families are consistently represented in court, then our child welfare system fails. When the state intervenes in the lives of families, we need to be confident that we're improving their chances at real success. Thank you.

SENATOR CAMPBELL: Thank you, Julie. Questions from the senators? Senator Riepe.

SENATOR RIEPE: Thank you, Senator Campbell. I'm new to this committee, and so I have some maybe foundation questions. The first one might be, do we refer to you as "General?" (Laughter) No? Okay.

JULIE ROGERS: Julie is fine.

SENATOR RIEPE: Okay. The first one that I have is, on the background, it sounded like your service delivery is nonrelated to the financial performance. It's strictly service performance.

JULIE ROGERS: That's right, though we could take financial performance complaints. Of those complaints that I have...I received in the first two years, I referred them to the Auditor's office...

SENATOR RIEPE: Okay.

JULIE ROGERS: ...because I did not have the capacity to deal with that.

SENATOR RIEPE: That was another question I had, whether you were considered an auditor or not.

JULIE ROGERS: No.

SENATOR RIEPE: And you have a role relationship with the Ombudsman.

JULIE ROGERS: Yes.

SENATOR RIEPE: Is that a complementary one, or is that a...

JULIE ROGERS: It is.

SENATOR RIEPE: ...check and balance one?

JULIE ROGERS: It is...the Office of the Inspector General is within the Ombudsman's Office. So we are part of the division of the Legislature. The Ombudsman appoints my position, so I was appointed by Marshall Lux in consultation with the Chair of the Health and Human Services Committee and the Chair of the Exec Board.

SENATOR RIEPE: Okay. Do you report independent from the chief executive officer of the Department of Health and Human Services?

JULIE ROGERS: Yes.

SENATOR RIEPE: Okay. I think that's good. Who all..so who initiates a review? Or do you just randomly select and...

JULIE ROGERS: So, there's two different tracks of reviewing cases. One is complaints. And we have a hotline. We have a toll-free number. We have an on-line complaint form. So anyone can complain about any aspect of the Child Welfare System. And we review every one of those. The other track is, we are required to investigate every death or serious injury that happens to a child in the state's custody.

SENATOR RIEPE: Um-hum.

JULIE ROGERS: Those...we get notice from detention centers, Juvenile Probation, and then the Department of Health and Human Services. The Department of Health and Human Services has a critical incident reporting...critical incident report that they send out every time there is some sort of critical incident. And we get every one of those. And so then we look at it to see if there is (1) any systems issues, but (2) if there's been a death or serious injury that then we must investigate...open a full investigation.

SENATOR RIEPE: So you...well, I guess my follow-up question is, is you're not able to be in a situation where you say, 80 percent of the people that we deal with are very satisfied or anything, because you're only dealing with the follow up with the difficult cases to give some objectivity to maybe what the caseworkers are doing. Is that fair to say?

JULIE ROGERS: Yeah. I think that would be fair to say. Yeah.

SENATOR RIEPE: Okay. Thank you very much. Thank you for testifying today as well.

JULIE ROGERS: Yeah. Yeah.

SENATOR RIEPE: Thank you.

SENATOR CAMPBELL: Part of the reason for the Inspector General, we should indicate, in Child Welfare was that we wanted a position that, when all the senators who were involved in any of that and all of us sitting here are gone, that there is someone who is watching over the system, and number two, identifying those trends or issues for which the Legislature should be aware of or potentially take action. And that has really been where Julie Rogers has been just excellent in being the eyes and ears of the Legislature, as well as the system, to say, these are the broader issues that are coming. So her job is really not so much the individual looking at cases as, what does she see in the broader context? What trends are they illuminating? And so that really becomes the important job as well as the investigation of incidents. Julie is required, within her job and by statute, to report on a very regular basis to the Chair of Health and Human Services and share with...the confidence, at least, of some of the incident reports. One of the issues on the floor of the Legislature when this position was passed was if an individual senator had some situation arise, how would they be able to access, knowing how that situation...and we explained that they would come to the Chair of the Health and Human Services Committee. And then, in consultation with Julie, we would discuss the incident. So Julie's job is really the very serious nature here of what happens in Child Welfare. Senator Riepe.

SENATOR RIEPE: Senator Campbell, it sounds like Julie can never leave. (Laughter)

SENATOR CAMPBELL: That would be my objective. And we were very fortunate to find and have Julie come forward with the position. We will provide, if Julie wouldn't mind sending electronically to the new senators, the...your bio and give some idea of your background.

JULIE ROGERS: Sure.

SENATOR CAMPBELL: Julie is an attorney and has done a lot of work in juvenile issues before coming to this position. Any other questions that you wanted to ask?

JULIE ROGERS: Could I just clarify one thing?

SENATOR CAMPBELL: Sure.

JULIE ROGERS: The way...so the Ombudsman's Office handles complaints as well. And there are, I think, at least three time...three full-time staff people dealing with complaints specifically about Health and Human Services. And the way we kind of give complaints out...if it's a complaint to be mediated immediately and there's a problem that needs to be solved, that's the Ombudsman's side. The Ombudsman's side is, they're problem solvers, case by case basis, very informally. Our side is looking at systemic issues based on complaints. We staff a lot with the Ombudsman's office. And

picking out systemic issues and problem solving that way and just sort of looking backward and being a very formal process of investigation, if that's helpful.

SENATOR RIEPE: Very good. Thanks for the clarification.

JULIE ROGERS: Sure.

SENATOR CAMPBELL: Julie, I have a number of issues which you and I can sit down and take a look at in terms of the report. But one thing that I wanted to mention was, in your report you bring up the information about the number of medications that our youth are on when they are in YRTCs.

JULIE ROGERS: Yes.

SENATOR CAMPBELL: And we'll let the committee read the full report and they can see that. But I would ask that perhaps that's a topic that you might deal with the Children's Commission and ask them to look at that, because that whole issue is troublesome.

JULIE ROGERS: Yes. And I know that the commission has a Psychotropic Meds committee. And so to look at the YRTCs specifically would be a good thing of that committee as well.

SENATOR CAMPBELL: Right. And as the committee reads the full report--this is very thorough--and we have some issues, we'll be glad to invite you back.

JULIE ROGERS: Please do.

SENATOR CAMPBELL: Okay. Thank you very much.

JULIE ROGERS: Thank you.

SENATOR CAMPBELL: Our next report is from the Nebraska Foster Care Review Office. Kim Hawekotte is coming forward. I contacted Kim and asked that she bring copies for everybody. Her annual report looks like this. And I apologize that mine is so beat up. And I really do have a good excuse. I mean, this is not just excuse. My dog actually decided to sit on it. (Laughter). And...

KIM HAWEKOTTE: We do call this one the bumblebee edition, because it's kind of yellow and black.

SENATOR CAMPBELL: Is that the...is that it?

KIM HAWEKOTTE: Yes.

SENATOR CAMPBELL: All right. I want to say before Kim starts here, I would highly encourage the committee on all the reports you're given, obviously, to read them. But in the six years I've been in the Legislature, I have not read a report from the Foster Care Review Office as thorough as this one. You really are to be commended. I mean, it is the most thorough of any we've had. So...

KIM HAWEKOTTE: (Exhibit 4) Thank you, Senator Campbell and members of the committee. I am Kim Hawekotte. It's K-i-m H-a-w-e-k-o-t-t-e, and I am the executive director of the Foster Care Review Office. Pursuant to Nebraska statutes, the Foster Care Review Office is to submit quarterly reports to the Legislature and to all stakeholders regarding all children in out-of-home care. And I've listed in my testimony during 2004 what those reports are. Usually our March, our June, and our September reports are very issue specific on something we are seeing within the system. And then our December 1 report, the one we call the bumblebee edition, is our annual report that contains data for the entire year in looking at that. Now, just as some education, the Foster Care Review Office is an independent state agency. And our role is to track children's outcome and facilitate case file reviews for all children in out-of-home care. And out-of-home care is defined very broadly. It's not just foster care, as some people think, being it's called the Foster Care Review Office. But it's really any type of out-of-home care. So they might be in a group home. They might be in a shelter. They might be in detention. They might be in any type of out-of-home care. Throughout the testimony that I did give you, I do make reference to specific pages within the annual report so that you can look up any more data that you might want or information. But I do...we do explain within the report what our case file review process is and what it all involves so you can see that. But what we have is, we have over 275 local board members from across the state that meet every month that look at children in out-of-home care specific cases and then make recommendations on those. For...so for many of you senators, you probably know people that live on our...that serve on our local boards. It's a volunteer basis. I mean, it is a true benefit to this state that these people with this type of background have dedicated their lives to helping with these children. And we do have a list of all of our board members in here, too, for you. But in fiscal year 2014-15, we reviewed over 4,451 case files. And that was on 3,179 state wards. And that's during the whole year time period. We then have an independent tracking system where we track everything that we find from the reviews and then also based upon the data that we receive from N-FOCUS, because we have full access to DHHS N-FOCUS to do these. Couple of changes that I just wanted to clarify on our annual report this year: In prior years our annual report was based upon a calendar year. And I always felt bad coming to talk to you guys because that meant our data was a year old. So what we did in this report...we changed it to a fiscal year report, so we are going from July 1 through June 30 of every year so that when you get this report, it will be four months old in data instead of a year and four months old. So we have

changed that to get you more current data. But what this means for this report is that we were only able to get data from January 1 through June 30 of 2014, because we...but starting in our next annual report next year, it will include an entire year. So I want to be very clear on that. Also, to be very clear on this report...that it only involves 3(a) abuse/neglect kids, so children that are state wards within the Department of Health and Human Services, not probation. We have been working with probation to develop a case review process on probation youth. Once we started working on that...there was some statutes that are in conflict. And I know sitting before you is LB265. And that would then change and clarify some of the statutory issues that have come up. But I want to be very clear to this committee that probation and the courts have been very willing to work with us and we are trying to work through the process. So I don't want that understanding out there. We are...we just need some statutory clarification. But for all of you...you know, for every child in out-of-home care or a state ward, we're really looking at three things. What is the safety of that child? What is the permanency of that child? And what is the well-being of that child? And one thing that we're really trying to do as an agency is start looking at well-being, because we feel as an agency we need to be able to answer two questions to assist each of us and all other stakeholders out there. Are children safe while they are in out-of-home care, because if they're not safe, we need to look into that? And second, are children and families receiving the services they need so that when they exit being a state ward they are better off than when they entered, because if they are not better off, we as a system need to ask, what are we doing wrong in that area? So throughout our annual report we...there's a lot of data in here. After each set of data, we do include recommendations that we feel would benefit the system as we go forward. So I'm always available for any further questions. And we also have data in here at the end by county, because I know for some senators they're very concerned with their individual counties or their areas. That data is broken up in the back by counties and we can do more of that, too. So first question: Are children safe when they're in out-of-home care? We know anytime a child is removed from the home it is a traumatic event for that child no matter what that home is like. So we first look at, what are the reasons that children were removed from their home here in Nebraska? And the data really hasn't changed over the last couple of years. We found that 74 percent of the cases that we reviewed, children were removed because of neglect issues, not because of abuse but because of neglect. 52 percent of the cases we reviewed, children were removed because of parental substance abuse. So if we know those are the two main issues children are being removed from home, we as a system have to look at, what services do we have available to deal with those issues? We also then look at when children are out of home, are they safe? We found, when we did our case file reviews, that nine of the children we found, we felt were unsafe in their current placement. And when that happens, we immediately contact the HHS hotline, we contact the case manager, because that is an immediate situation and we feel we are mandatory reporters. But even more concerning to us and something we feel we need to look into further...that 8 percent of the children that we reviewed that had moved placements within six months were being moved because of allegations of abuse or

neglect in that prior placement. So there was something going on in that placement that caused it to be...for those children to move. So that is an area we feel we need to look into further, because as a state, we have to ensure that those children are safe when they're in our care no matter where they're placed. So the next question we really then want to look at is, are they better off when they leave? So there is a lot of data that we have given you in this report. There's just a couple of areas I want to touch on that we feel are key areas in determining that. First is to look at case management. There's a lot of data and research out there with regards to the effect of case management on the lifetime of a case. We found that for one out of every four children that we reviewed, they spent 50 percent or more of their life in out-of-home care, which might be partially understandable because a lot of the children in out-of-home care are under the age of five. So you could get to 50 percent of their life. To me, what is even more important is that 23 percent or 682 of the children we track had been out of home two years or longer...continuously out of home two years or longer. And even more concerning is that 2 percent or 75 percent of the children that we track have been out of home five years or longer. And they're still a state ward. We as a system feel that that is not acceptable. We're not doing something right. We also then looked at case manager changes, because there's a lot of research out there that changing of case managers directly impacts the permanency for a child. Across the state, it varied anywhere from 32 to 46 percent of the children had more than four case managers during their case. Now, I have to put a caveat on this data. Because we only track children in out-of-home care, the number of case manager changes are only during that time period where that child was in out-of-home care. That does not include any case manager changes that might have occurred before they went out of home or after they went home. So we're just looking at that time period when that child was in out-of-home care and the number of case manager changes. I have to say, as a system, we have seen improvement in that area in the past year, which we feel is very positive. But we still feel there's a long way to go to stabilize that work force situation. The other data which does show...look like an improvement but we are questioning the improvement of it is 30 percent of the children in out-of-home care as of the date specific, which is June 30, 2014, had been in out-of-home care before. So they had been removed, been home, and then removed again. So that's one out of three. And we feel that that statistic is too high. What are we not doing to stabilize that home to keep them home? Now, this is an improvement, because in prior years, it was between 36 and 40 percent. We feel part of that improvement is probably because youth have moved from the Department of Health and Human Services to probation, and we know that a lot of your teenage youth do go in and out of the home more often just because of the situation. So we are still concerned with the 32 percent. Another area that we are working with HHS on with regards to case management is that one out of the three cases we reviewed, there was...we found that the HHS plan for that child was either incomplete or outdated. So we have been working with HHS administration to see, is that a documentation issue? Is that a case management issue? So we are working on that one with them. But on a positive note--I always like to give positive things, too--is that we really wanted to

commend Health and Human Services for improving the documentation with them seeing their children, because what we saw in that documentation now is that 97 percent of the children had seen their case manager within 60 days of our review, which is a great improvement. And we do want to commend that for...them for that improvement, because previously we were talking 50 to 60 percent. So that is an improvement that they have done. Next set of data that we did look at was the court and legal system, because we all know the impact that the court system can have including legal parties. One out of four children that we reviewed did not have their case adjudicated by the court within 90 days. So we need to look at a system...why are...what do we need to do to assist that? Next data, of course everybody is very interested in, is that we found 46 percent of the guardian ad litems statewide had not visited their child, or we couldn't find any documentation that they had visited their child. We don't know which one it is. It could be that they are doing it. But we couldn't find any type of documentation. And that did vary greatly from across the state, so I gave you some of that data. And I think that this data speaks highly as to LB15 and LB265 with regards to the requirements for guardian ad litems in this state. The other area of the court and legal system that I do want to bring up is we, as a state, we feel have done an excellent job of now establishing paternity within the juvenile court. So 85 percent of the cases reviewed, paternity was established on the biological fathers, which is great. But, I always have a but, I am an attorney, I have a but, but only 60 percent of the fathers were adjudicated within the court. So we're doing much better at identifying the father, but we're not doing as great a job within the system to bring them within the court case or to do the family finding or to provide the services for those biological fathers. So we are also working with stakeholders to see how we can improve that situation. Identification is great, but you need to go the next step. Placements is always a huge concern, number of placements that a child has. And what information does that placement have? One of the other areas that we brought up in the report we're concerned about is that in 63 percent of the cases we reviewed, we couldn't determine whether or not that child's out-of-home placement had received their health and medical information. So if I'm a foster parent and I don't have that information, it's very difficult to care for that child. Also, one factor we always look at is in the number of placements that a child has over their lifetime. One in three children had four or more placements. National research says four placements or more can be very damaging to a child and so that means about 33 to 35 percent of our children had four or more placements during the time period that they're in out-of-home care. Then we took a look at the data and we have more detail in here. Okay, what was the reasons for that placement move, because if we can't determine the reasons for the placement move, how do we correct a system? And of those children that did change placements, one in four of them, or about 25 percent of them, it was usually related to the child's behavior...is the reason that was given for the move. So we really need to think about, as a system, how has trauma helped enter into the life of that child and how have we either helped or did not help that child to avoid that placement move? Another good data increase that we feel a lot is, again, due to the move of the delinquent status population to probation is that now

40 percent...47 percent of the children in out-of-home care were either in relative or kinship homes. And that's a great increase. It was previously about 29 percent. We have now gone up to about 47 percent are with relative or kinship. So that is a good improvement. One of the areas that's near and dear to my heart is education. Fifty-one percent of the school-aged children that we reviewed were either not on target in school or we couldn't determine if they were on target. Education is key for all of ours, and if we are at 51 percent, we couldn't determine our on-target, we are not helping our children to be successful. Twenty-six percent of the cases we reviewed, the children were involved...enrolled in special education. And I know I have educators on this committee. You know that that is a fairly large percentage, larger than most school districts have, but out-of-state wards do. Also, pursuant to an Educational Board snapshot that was just completed by the Department of Education, state wards in this state graduated at a rate of 44 percent compared to a graduation rate of nonwards of 88 percent. So education has to be a key well-being indicator that we need to look at as a system. How do we ensure these youth are getting educated? You talked a little bit about physical/mental health. Twenty-six percent of the children we've reviewed were on psychotropic meds, so one in four. And 37 percent of the children we reviewed had a diagnosed mental health and/or trauma-related condition. So we know that they have the mental and behavioral health issues. One of the areas, the first areas, that we looked into for the first time this year, because it became so prevalent by our staff, is looking at adoption and guardianship disruptions, because we kept hearing it from our staff. And so we looked at the data. There were 44 youth or 6 percent of the children we've reviewed that reentered out-of-home care because of a disrupted adoption. And there were 68 or 10 percent of the children we've reviewed that came to out-of-home care again due to a disrupted guardianship. And part of the recommendations that we do make here is that we really feel in the next year, as a system, we need to work with stakeholders to look at those 100/110 youth to figure out why we did not achieve permanency as we thought we had through an adoption or guardianship. Next, I did want to talk some about, because we felt it was very important, this past year, in our opinion, we have seen a growth in the collaborative efforts going on out there among stakeholders. And that is so important for this system because no one of us can make any improvements. We have to all work together. So I really wanted to lay out for you some of the very important collaborative efforts that are going on. I divided it into joint data projects so that you would know datawise. One of them that we're excited about is the Barriers to Permanency Project, and that is a collaborative effort between Health and Human Services, the Court Improvement Project, Inspector General, and us, where we looked at, over the past year, every youth that had been in out-of-home care three years or longer. And what was their barriers to permanency? What part of our system was not working right to give them permanency? We have now completed that. Our goal is to have a written report out to everybody by March 1. So we will gladly make that available. The other report that was done is a trial home visit report where we looked specifically, collaboratively with groups, at children that had been out of home, and they were returned home to the parent, and then after six months that court case had not

closed but was continuing on in the court. We wanted to know why those cases were not closing. What were the systemic issues that were happening? Again, that project has been completed and it's my understanding a report, a joint report, will be issued by the end of this month on that one, so we'll have that data. There's also...I have included in here some systemic projects that have started over the past year that we feel have had a very positive impact on this system. One, there's monthly leadership meetings now between Health and Human Services, the Court Improvement Project, Inspector General, probation, and us, where the leaders are now sitting down and taking a look at data, trying to make some data-based decisions, seeing where we agree and disagree, so that we can move forward. We also have now monthly IV-E meetings, where we as a state are looking at, what is our IV-E penetration rate? Why did this case not qualify for IV-E? How can we do better? And we have seen over the past year a great improvement in our IV-E penetration rate because of this collaborative type meeting. The next one is a very personal one just for the Foster Care Review Office. We made a conscious decision this past year to put substantial resources to creating...to create a new SQL database. We call it FCTS, just because we thought that sounded nice. (Laughter) But we call it FCTS. But the whole object of doing that SQL database is to be able to take our 30 years' worth of data and data from Health and Human Services and from probation to be able to track the life of that child as they're going through the system and also to be able to do some predictive analytics and outcome-based look at the data so when we stand before you a year from now, we'll be able to better say, this worked, this didn't work, this caused a problem, this didn't cause a problem. So LB265 kind of creates and is built and based upon this database that we are currently creating. And we hope to have it created by July 1, working with CIO.

SENATOR CAMPBELL: We probably need to get to the recommendations.

KIM HAWEKOTTE: Right. So the recommendations are very clear. I've already talked about them. We want to be able to review probation cases. We want to be able to review for children during that six-month time period that they're returned home, to really work with the Nebraska Children's Commission on that well-being, especially that educational piece as to what we need to do as a system, and then the data...to create that data system so that we could do better.

SENATOR CAMPBELL: Thanks, Kim. We heard the report. And yesterday, I didn't open on my own bill, but we did have the bill about the Children's Commission adding the person from education.

KIM HAWEKOTTE: Right.

SENATOR CAMPBELL: So we had no proponents, no opponents, no neutral. (Laughter) I came back to my own bill and everybody was gone. So what we probably will do is, when you have some of the reports finished, we'll do maybe another briefing

for the committee to come back because that will enable them to have to look at the report and the new reports and come back. Any quick questions before we conclude with Kim? But I highly encourage you to take a look at it. Senator Kolterman.

SENATOR KOLTERMAN: Yes, Senator Campbell. I just have a comment. Being new to this committee, this is a little bit overwhelming. (Laughter) But I really appreciate the fact that you put all this information together and you referenced your report...or your synopsis to the report, will make it a lot easier for us to follow.

KIM HAWEKOTTE: Um-hum.

SENATOR KOLTERMAN: And it looks like it's a lot of interesting reading. Ultimately, you're putting children first.

KIM HAWEKOTTE: Ultimately putting children first. And I'm always available, or anybody from our office, to visit individually, to give to you more information. If you have other data that you might need specific to your area, that's what we're here for.

SENATOR KOLTERMAN: Thank you.

KIM HAWEKOTTE: So...

SENATOR CAMPBELL: Any others? Thank you, Kim, very much.

KIM HAWEKOTTE: Thanks.

SENATOR CAMPBELL: Our last report today is from the Maternal and Child Death Review Team. And representing that review team is Dr. Acierno. Welcome.

JOSEPH ACIERNO: Good afternoon. Good afternoon, Senator Campbell, members of the Health and Human Services, my name is Dr. Joseph Acierno. That's J-o-s-e-p-h A-c-i-e-r-n-o. I am the chief medical officer and the director of the Division of Public Health with the Nebraska Department of Health and Human Services. I'm also the chairperson of the Child and Maternal Death Review Team. And I'm here today to provide some information regarding the Child and Maternal Death Review Team. I will just tell you, even though I...my role as chief medical officer/director, the report from the team isn't necessarily the position of the department. The team is made up of very dedicated folks ranging from law enforcement to pathologists, pediatricians, advocates, people with expertise in various things. Most is set out by statute, what is required, and then the other possibilities. We'll be expanding the team now that we're doing maternal death reviews. We will have an obstetrician on board. And there's another member and it just escaped me, her specialty, but I've been with the team now for about six years...well, maybe a little bit more than that. And they are truly...some have been with

this team since it started up in the '90s. So they've watched all the trends and really, all they do is give up their time. And they might get some cookies and that's about it. And we meet four times a year as the team itself, and then we have subcommittees who look at specific things, let's say whether it's SIDS or whether it's homicide. And people work to their strengths. So you understand law enforcement is going to work on homicide. I'll be working on SIDS. And medical, we have a neonatologist on the group. And so you will be getting...the way it looks, how this has been set up, is annually you are getting...I call it the mini report. It's about two to three pages, which you have, that kind of shows the raw data for the year in how things are looking. And every two years we're coming out with a longer report. It takes two years to really look at a trend of what's going on, and so we'll have another larger report that will come out this year, and those will be for deaths during--now it will seem old, but there's reasons to it--2010 to 2011 for those deaths. And it's because it takes that much time not only to get everything from vital records, but then we are sending off for material, whether it's medical records, law enforcement, autopsy reports. Occasionally we need a school record. And there are times we just can't find anything. It's very odd sometimes, but all we have is a news clip. And we can't find what's going on. So our goal, really, with the team is, we don't really judge care. We don't judge individuals, so to speak. Our goal is to basically look at the information and determine what we believe may have been a cause of death, even though occasionally we may have a little difference of opinion with the death certificate. You know, sometimes we'll go, hmm, that's interesting. And we'll...we may even reclassify it on rare occasion in our report, what we think it is. But that's very rare that's done. And that just gets into another area. We could probably talk for half hour or an hour on death certificates and the education of physicians and those who do that. But we look at all of that information, and then we look...we put it all together. We meet as a team and we look at preventability. That's really what this is about. We're not trying to...we're trying to determine how many of these are preventable. And if they're preventable, how? What recommendations can we make to help things along? As you will see from the report that most of the deaths are...the highest percentage are medical related. In much of those, if you look at how it all breaks out in preventability, most, when you really look at them in a larger picture, you can't say are really preventable because we're not finding medical error normally in most of those. There's certain syndromes, conditions, where...that we can't just say as a team, that would have been prevented. Occasionally, you know, we look at issues of prenatal care and vaccinations, all those types of things. But to give you...so we...so every two years we give you that report. We look at the preventability. It's not real time. Most people...we get inquiries all the time: Well, there's been a death; we want to know what the Child Death Review said. Well, we may not see that case for a year or two, because then...and we have to look through it. Our goal is not to be real time information out. As a matter of fact, pursuant to the statute, it is...we can't disclose any of the information we have. So it's kind of odd. People call us up and want our information. We say, well, you're not allowed to get our information. So we're really almost looking at it in a retrospective. I find interesting, over time, as my view as the chairman of the Child

Death Review Team...I guess I haven't gotten used to putting "maternal" in there. It's always the Child Death Review Team to me. But it's...what we've...the themes are consistent every report. And what I get concerned about is, generally, how many people are even reading the report anymore? We've tried to actually change its format. I've tried to cut it down. When I first started, the first report was 82 pages. And I figured most of you don't want to read 82 pages of anything. (Laugh) So...and so we've tried to cut it down tremendously and still be able to give recommendations. Actually, we try to track on the Web site how many hits we're getting to the report. So we kind of see it. And it's...I will tell you, at times it's discouraging. Right when it comes out, we get a real upswing and the media might be interested, but then it kind of falls off. And then if a little issue comes up, you can kind of see the bump. But sometimes I wonder about the audience. Who is reading it? I hope all of you are, because it's really for your benefit as well. So, those are some of the observations I've had over time of putting together a report. And it really is the dedication of many people within the department as well as all the volunteers who try to put the report together to make it meaningful. Again, the themes are consistent. But what we have seen over time is a trend down. If you go back to '93 to today, the trendline is down. It's wonderful. Sometimes I don't know that we can explain it, though. You know, you keep beating the same drums and you...hopefully people are listening. And to kind of give you a few statistics, as I said we're finalizing a report for two years of '10 and '11. We're finalizing that report. At least one-third in the...our prior larger report found that at least one-third of all child deaths were preventable. You may say, well, shouldn't it be more than that? Well, so many are medical driven. If you take out the medical, I would say most of them we're looking...that are preventable. They've declined for most of the past decade, flat from 2011 to 2013. And from 2010 to 2014 to date, the leading categories of death were: medical causes over 72 percent; unintentional injury 14.8 percent; undetermined 3.6. We do get undetermined causes. We have cases that even after we look at it, it's not well-explained. And that's disheartening at times because we'd like to be able to categorize them. Homicide is 3.4 percent, and other 1.5. At least 10 percent of all natural deaths were attributed to SIDS. The single largest category of unintentional injury deaths were related to motor vehicle crashes. It's probably not surprising. SIDS has been interesting because I think numbers have come down for a couple reasons. We've learned more about sleep positions, all those types of things. So we've been able to recategorize some of these. Well what's true of SIDS, we're starting to realize there may be more behind it. It may be co-sleeping, suffocation, as we look at the autopsies. And we've kind of put it together. And our goal here is not to cast blame on any individual. We don't look at it that way. Many people have...feel enough guilt sometimes if there is an issue that they may have contributed to a death of a child, so that isn't our goal. We're just trying to take a look at it. But I think Back to Sleep has been a great campaign throughout the country. I think that has helped tremendously in bringing it down. As far as motor vehicles, it amazes me. It's usually because of lack of wearing a seat belt even though we keep talking about it. State patrol...everyone keeps talking about it. When you look at other accidents whether it's fire, anything...smoke detectors

that just don't exist or don't work, because we look at law enforcement reports. We see what fire marshal has to say. We look at all of it...drownings where there is improper fencing or proper supervision, those types of things. So the themes continue. We're just seeing them coming down over time. As far as abuse goes and as somebody who...neglect, these are very difficult areas to analyze generally, especially neglect. We all have neglectful behavior at times, but when does it rise to just sheer neglect? If you turn your head and a kid runs off and falls into a pool, is that neglect? We have these conversations all the time. Where does that begin and end? So I think we try to be fair with those types of things. I will tell you, with maternal deaths, even though we are talking about an annual report, there really aren't all that many maternal deaths every year. It's going to take time to understand trending of what we're seeing. Since...and just to give you some background, to date, just looking back, we're aware of 102 maternal deaths since 1997. And so that's based on the recent pregnancy check box on a death certificate. So if you kind of look at that over time, you're only getting a handful of those over time. So it's going to take us some years to really find trend. Probably the initial reports you're going to see are, okay, these were cause of death in these handful. But to understand why it's happening or a trend, is probably going to take about four or five years of reports to determine that. So what we do is we're matching vital...the vital statistics records on all deaths to women ages 10 to 49 and...with birth, fetal death records for potential maternal death. So we're trying to match up things, and we've been working through the system of how to do that. And we're also going to be working with the Nebraska Medical Association for some of their expertise looking at some of the deaths that are medically related as far as some of the mothers go. I think with the goal with the maternal death review is to really understand maybe some of the medical issues more than anything else. To me, a car accident is just a sheer accident and they happen to have been pregnant. They just fall into another category. So, personally, I'm not so interested in those. Yes, I am from a human standpoint, but for a statistical analysis, I think we're more interested probably in the medical-related areas. So, I mean, generally, some of the trends I...we still are seeing, you know, we still see homicide. We're seeing suicides. Those have kind of crept up a little bit. We get these little blips, but suicide has always been concerning that we're seeing in some of the younger folks. It's ATV accidents. You know, people don't protect themselves. We see all kinds of things in some of the accidents. And all we could really do is, we try to educate. We work with other...we work with groups, whether it's, let's say, the NMA. If it's a medical issue, we'll work with them in an educational format to get word out there. But it is hard to carry message at times. How many times can you tell people to wear a seat belt, have their kids in proper restraint? There's...and so I...that's why I get a little concerned about how the report comes across at times, that's it...there's a lot of people working hard on it but sometimes it comes across as same old, same old. But I don't think that means we shouldn't do it. But I think we just have to keep beating the drum. It's sinking in. Statistically, it's showing. It's sinking in. But sometimes it gets a little frustrating when every year you're reviewing it and it's like you're watching the same movie over and over again. So, yeah.

SENATOR CAMPBELL: Doctor Acierno, we probably ought to get to the questions.

JOSEPH ACIERNO: Yes.

SENATOR CAMPBELL: Any questions? Senator Howard.

JOSEPH ACIERNO: Yeah.

SENATOR HOWARD: Thank you, Senator Campbell. But I've taken an interest in the Maternal and Child Death Review Board...

JOSEPH ACIERNO: Yeah.

SENATOR HOWARD: ...mostly because I was responsible for adding the word maternal to it.

JOSEPH ACIERNO: Right.

SENATOR HOWARD: But I wanted to ask you, when we passed my bill, we added the Inspector General to your team.

JOSEPH ACIERNO: Um-hum.

SENATOR HOWARD: How is that going?

JOSEPH ACIERNO: Well, adding the folks to the team hasn't been an issue. It's just that there's nothing really to review on that and...yet. But as far as...any member is welcome, because they all bring expertise. So, it's taking us a little time to get the members up to speed. And we only meet four times a year, so...

SENATOR HOWARD: Right.

JOSEPH ACIERNO: ...it's kind of getting everyone integrated and brought up to speed, but there's really no issues. I welcome anyone on the team because they're just...they realize there's more work in it than maybe they anticipated. And then when you mandate they be there, that just makes it more fun. (Laughter)

SENATOR HOWARD: Right, and I agree. If I may, a follow-up.

JOSEPH ACIERNO: Yeah.

SENATOR HOWARD: One of the reasons behind adding the Inspector General was

because I have a particular interest in child deaths of state wards.

JOSEPH ACIERNO: Um-hum.

SENATOR HOWARD: And as you consider child deaths, do you consider whether or not they are wards of the state or not?

JOSEPH ACIERNO: Yes. As a matter of fact, what the team has been trying to do, and I don't think it's unique to here, and I don't think...the analysis isn't ready yet, so to speak. But we're trying to look at how many of these individuals, regardless of cause of death, have touched the system somewhere, have come in contact with some service of the state, and see if there's a disproportionate number. But then we're trying to figure out, okay, so we're trying to match up, but what does it mean sometimes? And that's where this gets difficult. Let's say somebody touches the system but they die of a medical cause where you say, hmm, that's kind of interesting. Why did they? So we're taking a look at that. We're not the only state who has looked at it, but I think we're starting to take a closer look at that whole issue. And it's going to take some time to really put together the cause and effect if there really is one.

SENATOR HOWARD: Thank you.

JOSEPH ACIERNO: Sure.

SENATOR HOWARD: Thank you, Senator.

SENATOR CAMPBELL: Do you need more resources to do that, because at some point, the report...I understand the reports, you know, you have to gather all this and look at the trends.

JOSEPH ACIERNO: Yeah.

SENATOR CAMPBELL: But at some point, given the interest of specific data, do we need to put more resources in to at least...maybe not speed up, but at least have a more comprehensive picture, some of the specifics?

JOSEPH ACIERNO: Hmm. I'd have to think about what resources would be helpful, because the greatest resource are the minds that are working it. It would...yeah, would I like to speed it up? Yes. I went back historically and looked at when this all started in the early '90s and how it just fell off. Nobody was doing reports. And so it has always been behind the curve in time. And we've tried to speed it up. And the minute you try to speed it up then we get held up because we can't get everything. More people, that's not going to help it. I'd have to think about that, Senator.

SENATOR CAMPBELL: I wish you would.

JOSEPH ACIERNO: We can have that conversation about what could help. I'm actually very pleased to hear interest, because I feel like I've been doing this for years, and I'm not sure who's been listening.

SENATOR CAMPBELL: Oh, we are.

JOSEPH ACIERNO: I know you have, but, you know, we haven't had this kind of conversation since I've been the chair.

SENATOR CAMPBELL: Right.

JOSEPH ACIERNO: So...

SENATOR CAMPBELL: And we decided that at this point we needed to step that view up.

JOSEPH ACIERNO: Appreciate that.

SENATOR CAMPBELL: Senator, go right ahead.

SENATOR RIEPE: Senator Campbell, thank you. Two days ago I introduced a bill for handsfree for cellular phones and texting while driving. And do we have any statistics on fatalities or anything related to cell phone use and...

JOSEPH ACIERNO: I don't have that.

SENATOR RIEPE: Okay.

JOSEPH ACIERNO: I can't think of a case that I looked at that had that specifically with it.

SENATOR RIEPE: I was thinking...

JOSEPH ACIERNO: It doesn't mean it won't. It is interesting. As society changes, you do see some interesting trends, but...

SENATOR RIEPE: I was hoping to call you back. (Laughter)

JOSEPH ACIERNO: I'll text you after. (Laughter)

SENATOR RIEPE: Okay.

SENATOR CAMPBELL: Having sat on Transportation, the Department of Motor Vehicles will most likely provide a lot of your data, Senator. They'll testify, I'm sure, on that bill. Before you go, Dr. Acierno...

JOSEPH ACIERNO: Sure.

SENATOR CAMPBELL: ...I just wanted to mention, when I was at the National Council of State Legislators annual meeting, NCSL's meeting in Minneapolis, I had the opportunity to listen to a presentation from the state of Florida. And they have really started putting more resources into analyzation of the data. And then what they are doing is doing a very intensive campaign and they are earmarking some particular area that they are beginning to see needs attention. And I understand that we, you know, preach about all kinds of things. But I was particularly impressed with their effort and what they put together. And that's why the question of more resources. And perhaps we can put together an interim study that might take a look at what you would need.

JOSEPH ACIERNO: Yeah. Possibly. And it's good to know that and we could pull on that. We do look at how other states have done things from reports to...I mean, we can pull it all together and say, what are they doing that seems to work or doesn't seem to work? So that's good to know. And we'll actually pull up some of Florida's work so we know what's going on.

SENATOR CAMPBELL: Yeah. Um-hum. And we will be back in touch with you for sure...

JOSEPH ACIERNO: Please.

SENATOR CAMPBELL: ...on this one. Thank you very much for coming today.

JOSEPH ACIERNO: Thank you.

SENATOR CAMPBELL: Okay. That concludes the briefings before the committee. If you are leaving after hearing the presentations, please leave quietly. We will proceed to LB107, which is Senator Crawford's bill to eliminate integrated practice agreements and provide for transition-to-practice agreements for nurse practitioners. I have to say that we have made a concerted effort on this bill to talk to both the proponents and the opponents to this bill. And I want to thank the clerk, Brennen Miller, for doing so. What we are going to try to do this afternoon is, we're going to start somewhat of a pilot here to see how this works. But we're going to do an hour's presentation of the proponents. And I'll watch the clock. And then in an hour we'll go to the opponents. We have also asked for a list. So if you do not hear your name called but you want to testify, that doesn't mean that you will not have an opportunity. It's just, we're going to start with the

lists that were provided by both opponents and proponents. Okay. With that understanding, Senator Crawford, please go ahead and open on your bill.

SENATOR CRAWFORD: Thank you. Good afternoon, Chairwoman Campbell and fellow members of the Health and Human Services Committee. My name is Sue Crawford, S-u-e C-r-a-w-f-o-r-d, and I represent the 45th Legislative District of Bellevue, Offutt, and eastern Sarpy County. Today I'm presenting to the committee LB107, a bill identical to LB916 as amended, which the Legislature passed on a 43 to 0 vote last session before then-Governor Dave Heineman pocket vetoed the legislation. Colleagues, today you will hear from physicians that LB107 is about a nurse practitioner's scope of practice, three words that often strike fear or at least trepidation in Health Committee members' hearts. Please allow me to set the record straight. LB107 is not about a nurse practitioner's scope of practice or who has more clinical hours or nurse practitioners pretending to be physicians. LB107, to borrow words from Senator Watermeier, who prioritized LB916 last year, is about a scope of business. The bill is about a restriction of trade and a governmental regulation that currently does not improve patient safety or health outcomes. The Integrated Practice Agreement limits competition and access to our healthcare system. In a report issued last March, the Federal Trade Commission has cautioned states against restrictions like the Integrated Practice Agreement, because these restrictions give one group of healthcare providers, in this case physicians, gatekeeping authority over another group of providers, nurse practitioners, and their access to the marketplace. There are nurse practitioners and small business owners here today who will speak about the challenges they face, particularly in rural areas, in gaining access to the marketplace. These small business owners are often unable to find a physician willing to sign an Integrated Practice Agreement or face paying a physician thousands of dollars for their signature. If a nurse practitioner is able to secure a physician's signature, the piece of paper is filed in Lincoln. Despite the word "integrated" in its name, the Integrated Practice Agreement is not integrated care. We learned at the hearing last year that nurse practitioners collaborate, consult, and refer with the providers who make the most sense for the patient that is in front of them at any time in order to provide the best care to patients. An Integrated Practice Agreement with a single physician simply does not make sense given the kind of collaboration, consultation, and referral that leads to high-quality, coordinated care in practice settings today. Nurse practitioners are still required to collaborate, refer, and consult with physicians as part of team-based, patient-centered care. LB107 does not change that. You can look at the bill language and see that language on the practice act about consulting, referring, and collaborating remains in the practice act. Under LB107, nurse practitioners will continue to collaborate and refer with the physician or physicians who make the most sense for the patient just as they are now. Moreover, let me remind you that the existing Integrated Practice Agreement does not require any second check on a nurse practitioner's diagnosis. Removing the IPA from statute, the question before us today with LB107, does not remove any existing second check on diagnostics. It does allow more patients in our state to have

access to diagnostics and more quickly. A report from UNMC last year found that the highest percentage of growth in nurse practitioner placement is in rural primary care. So removing the integrated practice restriction, as this bill does, addresses our urgent need to improve access to primary care and access in our rural communities. The Integrated Practice Agreement now in statute also limits work force development in Nebraska. Psychiatric nurse practitioners that we train in our state leave Nebraska to practice in other states and cite practice restrictions as a key reason that they leave Nebraska. Who knows how many others are stuck in Nebraska and unable to practice? Colleagues, we have neighboring states that do not place these restrictions on their nurse practitioners, and we are losing this valuable work force to those other states. In front of you are letters of support from Rhonda Hawks on behalf of Advocates for Behavioral Health, the Center for Rural Affairs, OneWorld Health Center, the American Association of Nurse Practitioners, the Nebraska Board of Nursing, and several nurse practitioners who have been unable to practice in rural areas because they have been unable to find a physician willing to sign an IPA with them. In addition, you will hear testimony from advocates from several organizations today, including 12 that let us know ahead of time, and there may be others who wish to testify: the Nebraska Nurse Practitioners, Platte Valley Women's Healthcare, Nebraska Association of Nurse Anesthetists, a former Board of Health chairwoman, Nebraska Hospital Association, the AARP Nebraska Chapter, the Center for Rural Affairs, Friends of Public Health, the Nebraska Nurses Association, Americans for Prosperity, and the Nebraska Association of School Boards. As you can see, there are a broad range of organizations across the state that recognize the importance of this bill to remove the Integrated Practice Agreement and ensure that we have quality access to healthcare across our state. I am welcome to answer any questions now, but I will also be here to answer questions at closing. [LB107]

SENATOR CAMPBELL: Okay. Any questions from the senators before we begin? Thank you, Senator Crawford. Our first proponent. This is Kelley... [LB107]

KELLEY HASENAUER: Hasenauer. [LB107]

SENATOR CAMPBELL: ...Hasenauer. Would you go ahead and state your name and spell it? [LB107]

KELLEY HASENAUER: (Exhibit 1) Yes, 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 licensed in the state of Nebraska, and I support removing the Integrated Practice Agreement, or IPA, from the licensure requirements of nurse practitioners in Nebraska. On behalf of the Nebraska Nurse Practitioners, I'd like to thank you, Senator Campbell, and the Health and Human Services Committee for your support of this bill. And through this testimony, I'd like to share the struggle that I personally had with applying for a waiver of the Integrated Practice Agreement or IPA. I've been a nurse practitioner for almost 14 years and I have

close to 30,000 hours of direct patient care experience as a licensed, board certified nurse practitioner. I have practiced for 12 of those years in the southwestern Nebraska community of North Platte. Besides many years of direct patient care experience, I hold a doctorate in nursing practice and have served as an associate professor of nursing at the University of Nebraska Medical Center, training nurse practitioners. I'm also the APRN representative on the State Board of Nursing. I have provided a copy of what the Integrated Practice Agreement is for your reference during my testimony today. In 2012, I opened 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 November 2013, my physician business partner announced that he was leaving the practice to move to a different community to become a hospital employee. We have a wonderful working relationship, and he is willing to maintain my practice agreement. However, should something happen to him tomorrow, such as a tragic car accident, I would instantly be an unlicensed nurse practitioner and unable to see my patients. The only way a nurse practitioner in Nebraska can be licensed without an Integrated Practice Agreement is by obtaining a waiver from the state APRN Board. Last year, Dr. Acierno in his 407 review report alluded that the IPA was a viable option for nurse practitioners, particularly those who are experienced, if they are unable to obtain an IPA. Due to the incredible risk I was taking on as the sole owner of a clinic, I felt it was imperative that I obtain a waiver of the IPA to ensure that my ability to care for patients would not be interrupted. My application, which is included in full with a copy of my testimony, discussed the practical difficulties of locating another physician to sign an IPA, including the reluctance of physicians in my community to help a competing business. After a month of waiting, I was advised that I had been granted an IPA waiver, but only for three months. As an experienced, highly educated, qualified provider and the new owner of a busy clinic with employees and patients relying on me, a three-month waiver did not provide the sustainable option that was needed. At this time, I continue to own and operate a busy healthcare clinic. I work diligently to be an active and productive member of my medical community. I volunteer monthly at a local Title X agency. I help train the next generation of nurse practitioners and medical students by providing clinical site opportunities during their training. And I volunteer over 20 hours a month on the State Board of Nursing. I am passionate about the profession of nursing. I feel strongly that nurse practitioners are not just junior physicians that many would make us out to be. Nurse practitioners are skilled and expert clinicians with our own unique training, education, and body of knowledge. We approach patient care with a distinctly unique style. Our outcomes and cost effectiveness are well proven in study after study. And most importantly, we are not asking to expand the services that we already provide. LB107 does nothing to increase scope of practice or decrease our ability to collaborate and consult with other health professionals. We already do this on a daily basis regardless of our IPA. I want to leave you with a quote as I leave today. One famous man once said: Be the change you want to see in the world. All of us know that our current healthcare system is not working. Healthcare costs are too high and there are too many people who do not have access to services. If we continue with the

traditional medical model and don't begin to change outdated regulations that limit other healthcare professionals such as NPs from doing the work they are trained to do, we will have a hard time creating change. Let's work together to remove the regulatory barriers that keep NPs from practicing to their full ability. Let's help be the change that we want to see in healthcare today. Your support for LB107 will allow entrepreneurial nurse practitioners like myself to invest in their Nebraska communities by creating innovative practices that can help to meet the basic healthcare needs of our citizens. I thank you for your time and attention and welcome any questions. [LB107]

SENATOR CAMPBELL: Thank you very much, Ms. Hasenauer. [LB107]

KELLEY HASENAUER: Um-hum. [LB107]

SENATOR CAMPBELL: Questions from the senators? Senator Riepe. [LB107]

SENATOR RIEPE: Thank you, Senator Campbell. I have a question. Do you have hospital privileges? [LB107]

KELLEY HASENAUER: I do. [LB107]

SENATOR RIEPE: In your particular discipline and...was that easy to obtain those privileges, or... [LB107]

KELLEY HASENAUER: It was not. And it...which was interesting. I already held privileges at the hospital for ten years. But when my physician colleague moved out of the community, I had to really renegotiate those because I had to show that I could continue to handle those privileges with him being out of our community. [LB107]

SENATOR RIEPE: Thank you. [LB107]

KELLEY HASENAUER: Um-hum. [LB107]

SENATOR RIEPE: Thank you for appearing. [LB107]

SENATOR CAMPBELL: Any other questions? Thank you very much. [LB107]

KELLEY HASENAUER: Yes, thank you. [LB107]

SENATOR CAMPBELL: Our next proponent? Our next proponent is Cathy Phillips. Is that correct? [LB107]

CATHY PHILLIPS: (Exhibits 2, 3, 4) Senator Campbell and committee members, my name is Cathy Phillips, C-a-t-h-y P-h-i-l-l-i-p-s. I am a rural psychiatric nurse

practitioner, NP, in Hastings. I thank you for allowing me to testify in support of LB107 on behalf of the 500-plus members of Nebraska Nurse Practitioners. Nebraska NPs are required to maintain an Integrated Practice Agreement, IPA, with a collaborating physician in the same specialty area and in the same geographic location. This IPA is a practice barrier for NPs and an access to care barrier for Nebraskans. I work in a hospital-owned clinic. My IPA is with a hospital-employed psychiatrist at no cost to me. Others are less fortunate. They or their employers pay $600 to $2,000 monthly for an IPA, receiving little to no service. The physician is often not on the premises but will collect the fee. One NP works for an urgent care clinic. The owners pay for the IPA with a nonclinic physician. This NP and physician have never met. Another NP left Nebraska, finding it more feasible to practice with full authority in remote, rural Alaska. Her Nebraska collaborating physician was often out of the country and required international calls to maintain the IPA. As Kelley illustrated, practice owners are extremely vulnerable. They pay IPA fees to remain in business and when the collaborating physician moves or retires, patients are at risk as practices must close if an IPA cannot be secured. Hospital-employed physicians cannot provide IPAs to nonhospital-employed NPs due to conflict of interest. Qualified NPs who want to open practices have no collaborating physicians available. This is particularly pertinent in rural Nebraska. To illustrate, you were provided letters of support from two rural psychiatric NPs. One from Scottsbluff pays Nebraska licensure for a Colorado psychiatrist to provide an IPA. Another provided testimony last year for LB916 and is still unable to practice in underserved Cherry County due to the IPA barrier. Eighty-eight Nebraska counties are psychiatric provider shortage areas; 37 have no psychiatric provider. Many Nebraska counties, possibly in your own districts, rely on NPs to fill voids in worsening provider shortages. There are 1,300 NPs in Nebraska who may be the sole healthcare provider in some counties. Approximately 75 are psychiatric NPs. As Senator Crawford indicated, we lose qualified NPs yearly, many to full practice authority states. Additionally, Nebraska has 65 primary care shortage counties. In states with full practice authority, research shows that NPs gravitate to rural areas. There is extensive national support for IPA removal, also called full practice authority, to solve these shortages including the Institute of Medicine, the National Governors report, the Rural Health Research Center, and the Federal Trade Commission. The NP 407 review provides an extensive list of references with the supporting research. Nineteen states and the District of Columbia now have full practice authority and no full practice authority state has ever repealed that legislation. NPs are part of the Nebraska solution by consistently providing high-quality, cost-effective, and accessible healthcare. No evidence supports IPAs provide greater public safety. No evidence suggests increased liability claims in full practice authority states. No evidence correlates educational differences with quality of care differences. Forty years of research does support NP clinical outcomes and patient satisfaction measures meeting or exceeding physician comparators. The issue is no longer finding evidence. It is removing barriers. Healthcare is evidence based. Healthcare legislation should be evidence based. The evidence supports removal of the IPA requirement for NPs in Nebraska. We respectfully ask for

your support of LB107, and I thank you for your service to our state. I will take any questions that you might have. [LB107]

SENATOR CAMPBELL: Senator Riepe. [LB107]

SENATOR RIEPE: I do have a question. And that is: Those of you who hold doctorates, do you...are you referred to by the public as doctor, and is that confusing to the general public who aren't knowledgeable about credentials? [LB107]

CATHY PHILLIPS: To clarify, Senator Riepe, I do not hold a doctoral degree at this point. I have a master's degree. There is consensus nationally: By the end of 2015, all nurse practitioners entering into nurse practitioner programs will be...excuse me, for licensure, will be required to have a doctoral degree. And in the interest of full disclosure, yes, we would be required to clarify our credentials and our title, although I would remind the committee that the title doctor is not necessarily specific to physicians. It would apply to dentists, veterinarians, and English professors in the academic setting as well. But, yes, thank you for your question. [LB107]

SENATOR RIEPE: It's difficult to go into a hospital and not find...or to find someone who is not a doctor. [LB107]

CATHY PHILLIPS: That...yes. [LB107]

SENATOR RIEPE: You're either a doctor of pharmacy or a doctor of occupational therapy or physical therapy or on down the line. I was just concerned about the confusion that that might... [LB107]

CATHY PHILLIPS: I would understand that, Senator Riepe. And generally, the nurse practitioners would introduce themselves. I would imagine that Dr. Hasenauer would introduce herself as Dr. Hasenauer, your nurse practitioner, and clarify if there were any questions that he or she has a doctorate level of education in nursing practice. [LB107]

SENATOR RIEPE: Thank you. [LB107]

SENATOR CAMPBELL: Any other questions? Okay. Thank you very much, Ms. Phillips. [LB107]

CATHY PHILLIPS: Thank you. [LB107]

SENATOR CAMPBELL: Our next proponent on my list is Sean Scribner. Scribner? Good afternoon. [LB107]

SEAN SCRIBNER: (Exhibit 5) Hi. Senator Campbell, committee members, my name is

Sean Scribner, spelled S-e-a-n S-c-r-i-b-n-e-r. I'm here representing the Nebraska Association of Nurse Anesthetists, a statewide organization of more than 350 members. Our membership provides anesthesia in 99 percent of the hospitals in Nebraska. We also provide anesthesia in 83 of the counties, service...83 of the counties in Nebraska are solely serviced by CRNAs. And we feel that we contribute a critical component to the healthcare delivery system. In this very room 20 years ago, our senior colleagues were at a public hearing of Health and Human Services on a bill which removed the requirement for CRNAs to be supervised by a physician. And at that hearing we heard testimony very much like I suspect you will hear today. They literally said, prepare for coffins to line the streets. However, you know, we were told that it would be dangerous for our patients. If the Legislature was passed, harm and death would be a certain result, and I can tell you that that certainly has not been the case since we've been practicing independently since 1992. What has happened is that Nebraska has become an attractive venue for nurse anesthetists to locate their careers and their lives, strengthening and improving the...and extending healthcare in Nebraska. All one has to do is look at the future population projections in our state and the accessibility and affordability of healthcare to understand the critically important role of advanced practice nurses. None of the members of this committee were serving during the '91-92 legislative sessions when our practice was changed to allow independent CRNA practice. But the senators involved in that decision at that time deserve our consideration today. They considered and examined a controversial healthcare issue and decided to make a change, a change that not everyone was pleased with, but one which has improved healthcare for Nebraskans and thus the very quality of life in our state. The Nebraska Association of Nurse Anesthetists urges this committee to undertake the same course of action. Thank you for the opportunity to being heard, and I'd be happy to answer any questions. [LB107]

SENATOR CAMPBELL: Thank you, Mr. Scribner. Questions from the senators? Senator Riepe. [LB107]

SENATOR RIEPE: I again have a two-part question. Do you have peer review...a peer review process that you... [LB107]

SEAN SCRIBNER: We do. [LB107]

SENATOR RIEPE: Okay. [LB107]

SEAN SCRIBNER: It's...at this point it's...yes, we do. [LB107]

SENATOR RIEPE: Okay. My second question was, are you required to report to the national data bank for any misbehaviors or anything that would fall in that? Physicians are. [LB107]

SEAN SCRIBNER: Right. [LB107]

SENATOR RIEPE: Okay. [LB107]

SEAN SCRIBNER: I mean, I assume that...I can get you...back to that...get you information on that. I would assume that would fall under the same as when you hold a nursing licensure as far as incidences being reviewed. And then if you were found to be at fault then that would be reviewed separately. [LB107]

SENATOR RIEPE: I think it's a matter of looking for a level playing field... [LB107]

SEAN SCRIBNER: Right. [LB107]

SENATOR RIEPE: ...and accountability. [LB107]

SEAN SCRIBNER: Yes. [LB107]

SENATOR RIEPE: Thank you. [LB107]

SENATOR CAMPBELL: Could you follow up on that, Mr. Scribner, and get back to us, please? [LB107]

SEAN SCRIBNER: I will. Absolutely. [LB107]

SENATOR CAMPBELL: All right. Thank you. Our next testifier is Linda Lazure. Good afternoon. [LB107]

LINDA LAZURE: (Exhibit 6) Hi there. I'm Dr. Linda Lazure. I'm a Ph.D., RN. Linda Lazure, L-i-n-d-a L-a-z-u-r-e. I'm former president of the Nebraska Nurses Association when the 1996 LB414 was passed and former chair of the Nebraska Board of Health. In 1996 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 respective groups were at the signing. Then-Governor Ben Nelson described the development into law as, quote, one of the most collegial and collaborative he had ever experienced. As a new member of the Nebraska Board of Health, one of my first committee tasks was to approve the rules and regulations which emanated from that statute. Today I'm speaking to urge your support of LB107. I can assure you that the 1996 insertion of the Integrated Practice Agreement, the IPA, into LB414 was not predicated on evidence-based practice, nor was it a validated mechanism to assure safe care to Nebraska citizens. The IPA was an expedient political compromise and I was part of it. The nursing profession did not have a large amount of evidence that now exists validating the safety and quality of care delivered by NPs. The technological advances that now routinely assist healthcare professionals to

have "ready availability" for consultation did not exist at that time. Collaborative consultation is much more accessible today. The many Institute of Medicine, or IOM, reports, particularly the 1990 (sic) report "To Err is Human: Building a Safer Healthcare (sic) System" and the 2001 report "Crossing the Quality Chasm: A New Health System for the 21st Century" were not available. The "Quality Chasm" report, for example, provided ten rules for redesign of the 21st century healthcare delivery system that really resonate clearly for all of us today. You have the list in front of you. I'm going to just emphasize two: The patient is the source of control; and cooperation among clinicians is a priority. Now best practices and evidence are incorporated into all the national credentialing standards. Now there is a whole new generation of nurses and healthcare providers that by the nature of their more contemporary education and practice, recognize and use best practices that are based on solid evidence. In 1996, I did think that the IPA would open the long-closed door to collaborative practice by providing a mere affidavit that the nurse practitioner, the NP, would identify at least one physician colleague for "consultation, collaboration, and referral." The IPA has long undergone misinterpretation from the inception of the rules and regulations emanating from LB414. I can tell you that the IPA was never intended to be an impediment to access to the quality, cost-effective care the NPs can provide, yet somehow it has become just that: a barrier to full practice authority. In closing, the very professional Nebraska Nurse Practitioners have made a strong case for passage of LB107 and I hope your careful scrutiny of the facts once again will support your efforts. I respectfully ask you to support improved access to much needed healthcare for Nebraskans and support LB107. [LB107]

SENATOR CAMPBELL: Thank you very much. Questions? Senator Cook. [LB107]

SENATOR COOK: Thank you, Madam Chair. And thank you, Dr. Lazure, for coming today. [LB107]

LINDA LAZURE: Hi. Thank you. [LB107]

SENATOR COOK: Thank you for sharing that you were part of that initial process. Could you share with the committee maybe one more recollection from that process... [LB107]

LINDA LAZURE: Yes. [LB107]

SENATOR COOK: ...that might help us in our deliberations? [LB107]

LINDA LAZURE: It was interesting, because at the time, Senator Withem was the Speaker of the house. And I particularly remember this because it was the night before we all had to meet, and we had to exchange each other's homework to try to improve the bill and perfect it. (Laugh) And so we stayed here overnight and perfected that. And

that's when the...both the APRN Board and the Integrated Practice Agreement had come to fruition. But I feared that the APRN Board would be a bill buster, so to speak, and I was terrified going into this negotiation, I'll tell you. [LB107]

SENATOR COOK: Thank you. [LB107]

LINDA LAZURE: Any other questions? [LB107]

SENATOR CAMPBELL: So, you indicated that it...in your eyes it was a political compromise. [LB107]

LINDA LAZURE: Yes. [LB107]

SENATOR CAMPBELL: And so the original bill did not have the Integrated Practice Agreement or was... [LB107]

LINDA LAZURE: From the beginning, the nurse practitioners did not want an Integrated Practice Agreement. But that...the Integrated Practice Agreement came in early on. And, Senator Cook, I should clarify that the APRN Board came later, okay? So the Integrated Practice Agreement was always kind of thought...but the way it was framed was that it would be an affidavit only; that it would be available just to have on file; and that the nurse practitioners would be consulting, referring, and collaborating. [LB107]

SENATOR CAMPBELL: Okay. Thank you, Dr. Lazure. Any other questions? Thank you. [LB107]

LINDA LAZURE: Thanks. [LB107]

SENATOR CAMPBELL: Our next testifier is Bruce Rieker. Good afternoon. [LB107]

BRUCE RIEKER: (Exhibit 7) Good afternoon. This is going to be very short. (Laughter; witness has laryngitis) [LB107]

SENATOR COOK: Oh, boy. [LB107]

SENATOR CAMPBELL: I've been there. [LB107]

BRUCE RIEKER: Yeah. I'm Bruce Rieker with the Nebraska Hospital Association, B-r-u-c-e R-i-e-k-e-r. For the reasons in our testimony, we support this bill. (Laughter) [LB107]

SENATOR CAMPBELL: Okay. Thank you, Mr. Rieker. We all have your written testimony in front of us. [LB107]

BRUCE RIEKER: Yeah. [LB107]

SENATOR CAMPBELL: And we will spare you the questions. But for the record, that is the shortest testimony you have ever given. (Laughter) [LB107]

BRUCE RIEKER: It's still green. (Laughter) [LB107]

SENATOR CAMPBELL: I know that. I know that. It's usually not. Okay. Goodness. We don't want all the testifiers to do that. All right. Our next testifier is Mark Intermill. Good afternoon. [LB107]

MARK INTERMILL: (Exhibit 8) Good afternoon, Senator Campbell. And excuse me. I'm dealing with the same thing, too. (Laughter) [LB107]

SENATOR CAMPBELL: Catching. It's catching. [LB107]

MARK INTERMILL: Mine will...I will be a little bit longer, though. My name is Mark Intermill, M-a-r-k I-n-t-e-r-m-i-l-l and I'm here today on behalf of AARP Nebraska. I...you have a written statement. I'm just going to summarize it. I am usually reluctant to, as a representative of a consumer organization, to engage in disputes between healthcare professionals. But we decided that we needed to weigh in on this based on evidence that we were able to review and also just the context of healthcare in the state of Nebraska. The third, fourth, and fifth paragraphs of my statement refer to three reports that we've reviewed, the first being a 2012 report from the National Governors Association that recommends that states consider removing barriers to practice for nurse practitioners and emphasizing the role because of the growing demand for primary care. The second report was the Institute of Medicine's 2011 report that looked at the access to care issue and the importance of allowing nurse practitioners to participate in access to care. And finally, the first one referenced in the testimony is the Federal Trade Commission report. That's a fairly recent 2014 report that looks at the issue of access...providing opportunities for nurse practitioners to practice from the trade perspective. And that provides...really indicated to me that we do need to look at the opportunities that we provide to nurse practitioners primarily because we have 60 of our 93 counties that are medically underserved for primary care. Many of those are in rural parts of the state that contain a high percentage of people over the age of 65. I looked at my home county of Nuckolls County which is not medically underserved, but the two counties on either side of it are. We're looking at a five-county area with 25,000 people and about 26 percent of the entire population over the age of 65. We need to be assured that we can provide primary care for the individuals in that area. So for those reasons we support LB107. And I'd be happy to try to respond to questions. [LB107]

SENATOR CAMPBELL: Thank you, Mr. Intermill. Questions from any of the senators?

We appreciate your testimony. Thank you. [LB107]

MARK INTERMILL: Thank you. [LB107]

SENATOR CAMPBELL: Our next testifier is Rich Lombardi. [LB107]

RICH LOMBARDI: Good afternoon, Chairman. [LB107]

SENATOR CAMPBELL: Good afternoon. [LB107]

RICH LOMBARDI: (Exhibits 9, 10) Members of the committee, my name is Rich Lombardi. I'm appearing today on behalf of two organizations that I'd like to submit testimony for. The first organization is with... [LB107]

SENATOR CAMPBELL: Mr. Lombardi, could you... [LB107]

RICH LOMBARDI: Speak... [LB107]

SENATOR CAMPBELL: ...spell your name. [LB107]

RICH LOMBARDI: Excuse me. Lombardi, L-o-m-b-a-r-d-i. [LB107]

SENATOR CAMPBELL: Thank you. [LB107]

RICH LOMBARDI: And I serve as the registered lobbyist for Friends of Public Health in Nebraska, which is an...which is the advocacy organization for the public health directors...the local public health directors. And then I'm also testifying in favor of LB107 with the Center for Rural Affairs. I believe both organizations have sent you via e-mail their testimony. The Center for Rural Affairs is an organization that's been around since 1973 and in the last...and their purpose is to work on rural public policy issues. And for the last five years they've been very much engaged in the healthcare challenges that are faced in rural areas. I would commend to you their testimony from the standpoint that it's a very erudite and very articulate discussion of the shortages and the problems in...for access and some of the very good reasons to support the expansion of this scope. Friends of Public Health are on the ground on a daily basis and are very conscious of the healthcare work force challenges in rural communities and have language here to support this. So I'd like to share that with the committee. Thank you very much. [LB107]

SENATOR CAMPBELL: Thank you, Mr. Lombardi. Do we already have copies of that from the clerk? [LB107]

RICH LOMBARDI: Let me make sure you do. [LB107]

SENATOR CAMPBELL: We do? Brennen, do we have copies? [LB107]

BRENNEN MILLER: I'll need those. [LB107]

SENATOR CAMPBELL: Okay. [LB107]

BRENNEN MILLER: Thanks, Rich. [LB107]

SENATOR CAMPBELL: Thank you, Mr. Lombardi. [LB107]

RICH LOMBARDI: Thank you. Thank you very much. [LB107]

SENATOR CAMPBELL: Our next testifier is--I'm sorry--Melissa Florell. Good afternoon. [LB107]

MELISSA FLORELL: (Exhibit 11) Good afternoon. My name is Melissa Florell, spelled M-e-l-i-s-s-a F-l-o-r-e-l-l, and I'm speaking on behalf of the Nebraska Nurses Association. The Nebraska Nurses Association is the voice of registered nurses in the state of Nebraska. And we're asking for your support of LB107. Elimination of the Integrated Practice Agreement removes an unnecessary barrier to care for many Nebraskans. Full practice authority for nurse practitioners is an essential component of the care continuum and can provide a point of entry for many consumers. And full practice authority for nurse practitioners will increase access and help address the shortage of primary care providers. In addition to my career as a registered nurse, my family and I also farm in Kearney County. I've witnessed the effect of limited primary care providers firsthand among my friends, family, and patients. An unrestricted practice for nurse practitioners can have a positive impact of the health and prosperity of rural Nebraskans. As you've heard before today, residents of rural areas tend to be older, face more chronic illnesses than their urban counterparts on a per capita basis, and research shows that the majority of nurse practitioners are ready to address those issues by practicing in rural areas as primary care providers. Full practice authority provides an opportunity for integrated and effective primary care for rural Nebraskans. And as healthcare continues to evolve, it's essential that every member of the healthcare team practice to the top of their license and education. We're not going to address the problems facing our country unless we're able to do that. And removal of the IPA for nurse practitioners makes that best practice a reality. And there's volumes of evidence that support the efficacy of full practice authority, and it's borne out in the real life experience of patients and providers in states like New Mexico, Colorado, and Iowa. Nebraska's IPA destabilizes our nursing work force as new nurse practitioners and experienced nurse practitioners leave the state for...to practice in those without an IPA. Integrated...removing our IPA will provide stability for our current work force and align Nebraska with the 19 states that already support full practice authority for nurse

practitioners. The Nebraska Nurses Association strongly supports LB107 and we encourage you respectfully to advance LB107. [LB107]

SENATOR CAMPBELL: Okay. Questions? Senator Riepe. [LB107]

SENATOR RIEPE: Thank you, Senator Campbell. I have a question I wish I would have asked earlier. And that is, if you're particularly in a women's healthcare practice, sometimes in the process of a delivery it turns into a C-section. Do you have surgical privileges to be able to do that or do you have to call in an ob-gyn to be able to do that surgery? [LB107]

MELISSA FLORELL: My master's degree is not a practice masters. I am not a nurse practitioner. However, in my experience, nurse practitioners are always practicing in collaboration with their providers and would...and are actually more likely to pass that patient up the care continuum when it's necessary. [LB107]

SENATOR RIEPE: My concern is that C-sections sometimes happen very quickly...the need for one. [LB107]

MELISSA FLORELL: And I... [LB107]

SENATOR RIEPE: And so the question gets to be is, while you might find them in the doctors' lounge, you may not always find them in the OB section. Now that's...that would be a concern that I have. [LB107]

MELISSA FLORELL: And I certainly will pass your concern along and allow my nurse practitioner colleagues to address that. [LB107]

SENATOR RIEPE: I'm sure there's a good answer. I just don't know it. Thank you. [LB107]

MELISSA FLORELL: There is. [LB107]

SENATOR RIEPE: Thank you, Senator Campbell. [LB107]

SENATOR CAMPBELL: Thank you, Senator. Other questions? Thank you very much for your testimony. [LB107]

MELISSA FLORELL: Yes. [LB107]

SENATOR CAMPBELL: Our next testifier is Matt Litt. Good afternoon. [LB107]

MATT LITT: (Exhibit 12) Good afternoon. Good afternoon, Chairman Campbell and

members of the Health and Human Services Committee. And thank you for the opportunity to speak to today. And my name is Matt Litt, M-a-t-t L-i-t-t, and I'm the Nebraska director of Americans for Prosperity, and I'm here today to lend our support to LB107. Our organization has long been committed to improving healthcare for Nebraskans. Our efforts in healthcare policy can be summed up by the Mercatus Center at George Mason University in that we have a goal of producing better health for more people at lower cost on a continuous basis. In some instances, that means removing burdensome and unnecessary government regulations including regulations that inhibit the ability of healthcare professionals to provide quality care directly to patients. One of the greatest challenges facing American healthcare industry today is the imbalance between the demand for healthcare services and the shortage of professionals. With Nebraska's demographic shift, healthcare professionals will be under even greater pressure to provide the kind of timely and high-quality care that we have come to expect while this crisis will be most pronounced in rural parts of our state. Meeting these needs means reexamining and revising antiquated and outdated laws that limit the choices available to patients. Our current laws, for example, prevent nurse practitioners from operating outside the IPAs that we've been hearing about. And while these laws were originally conceived as a way to protect patients, they've created a protectionist barrier that limits patient access and drives up our healthcare costs. And I think it's also important to highlight that these competitive changes to allow for greater access to healthcare do not have to come at the cost of decreased patient safety, which we've heard a lot about so far already. The aims are not necessarily inversely related and both goals can be achieved. And has been noted by previous testifiers, there is a body of evidence about the benefits of the proposed agreement. We may not always agree on particular policies, but I do know from this committee's record that solving the problem of access to affordable care is a shared concern and is an issue that Senator Campbell, as Chairman, deserves a great deal of credit and recognition for making a priority of the Legislature. It is in that spirit for providing safe, effective, and affordable care to Nebraskans that I respectfully request your support of LB107. Thank you for your time and I will attempt to answer any questions you have. [LB107]

SENATOR CAMPBELL: Thank you, Mr. Litt. Questions from the senators, anyone? Thank you for coming today. [LB107]

MATT LITT: Thank you. [LB107]

SENATOR CAMPBELL: Our next testifier is Jennifer Jorgensen. Good afternoon. [LB107]

JENNIFER JORGENSEN: Hello. Good afternoon. Senator Campbell, members of the committee, my name is Jennifer Jorgensen, J-e-n-n-i-f-e-r J-o-r-g-e-n-s-e-n, and I'm here on behalf of the Nebraska Association of School Boards today. We are here in support of LB107. And our interest in LB107 comes from our recent efforts with the

Nebraska Whole Child Project. The Nebraska Whole Child Project is actually an interlocal agency that was formed by NESB. And we've had the pleasure of meeting with some of the senators--Senator Campbell, Senator Howard--about our efforts with the Whole Child Project. And the Whole Child Project addresses student health and student wellness and it also studies the effects of student health and wellness on the actual academic success of our students in our schools. It currently has 64 member school districts throughout Nebraska. Our short-term vision with the Whole Child Project incorporates students' physical health and wellness. It also includes student obesity and physical activity. However, our long-term vision for the project also includes student behavioral and mental health as well. LB107, if it's successful, will lead to more practitioners available to our schools and our Educational Service Units to help deal with our students' mental wellness and also their physical wellness. And it also provides another way for the Whole Child Project to network with healthcare professionals throughout our state and collaborate regarding our efforts in student mental health initiatives and student wellness. For those reasons, the NESB offers our support of LB107. And I'll answer any questions if any of the senators have any. [LB107]

SENATOR CAMPBELL: Any questions, Senators? Senator Riepe. [LB107]

JENNIFER JORGENSEN: Yes. [LB107]

SENATOR RIEPE: I do have a question. Are you advocating for in-school clinics? [LB107]

JENNIFER JORGENSEN: At this time, the Whole Child Project does not have anything to discuss about in-school clinics. We are just starting with the Whole Child Project, so we're not exactly sure where our vision is going to go with that. We're here testifying today for the ability to collaborate with some of these practitioners in rural and urban areas for our schools. [LB107]

SENATOR RIEPE: My experience is that the younger students may need the immunizations. By the time they get to high school, they need counseling for mental health services. [LB107]

JENNIFER JORGENSEN: Exactly. [LB107]

SENATOR RIEPE: Not mental illness, just mental health services for those emotional problems more than...they've had their vaccines by then so they're good to go. [LB107]

JENNIFER JORGENSEN: Yes. Absolutely. [LB107]

SENATOR RIEPE: I was just curious what your driving force was. [LB107]

JENNIFER JORGENSEN: Right now, the Whole Child Project is looking to put programs--best practices--in place so schools have resources that we could provide to them to help them collaborate, again, with some of the health practitioners that are in their communities, not necessarily at this point in the schools. [LB107]

SENATOR RIEPE: Yes. May I ask another question? [LB107]

SENATOR CAMPBELL: Sure. Absolutely. [LB107]

SENATOR RIEPE: My concern gets to be, in some communities where healthcare resources are scarce to begin with, is, in a nine-month school, if you're, in essence, competing with the local practitioners who should be taking care of those children, if you will... [LB107]

JENNIFER JORGENSEN: Right. [LB107]

SENATOR RIEPE: ...so it seems to me like it might be a needless duplication, which is a hot button of mine, but... [LB107]

JENNIFER JORGENSEN: And I think the only answer I can provide at this time for that is, we don't see it as a duplication or as a competition. It's more of a collaboration, is what our hopes are, in the Whole Child Project helping to link those resources with the schools and the local practitioners. [LB107]

SENATOR RIEPE: Okay. Thank you. [LB107]

JENNIFER JORGENSEN: Thank you. [LB107]

SENATOR CAMPBELL: Any other questions, Senators? Thank you for coming today. [LB107]

JENNIFER JORGENSEN: Thank you very much. [LB107]

SENATOR CAMPBELL: That has reached the end of the prepared list for me. Other proponents in the room who wish to testify? Thank you. As you're making your way forward, is there anyone else in the hearing room as a proponent that wishes to testify? Please raise your hand, I guess. Okay. Good afternoon. [LB107]

LAZARO SPINDOLA: (Exhibit 13) Good afternoon, Chairwoman Campbell and other members of the Health and Human Services Committee. For the record, my name is Lazaro Spindola. That would be L-a-z-a-r-o S-p-i-n-d-o-l-a. I am the executive director of the Latino American Commission. I stand in support of LB107 and I wish to thank Senator Crawford for its introduction. LB107 will facilitate the transition to practice by

nurse practitioners without deterring the quality of care offered. In fact, care will improve thanks to the emphasis on collaborative models of medical practice and multidisciplinary approaches. The University of Nebraska Health Professions Tracking Service determined that there are 63 primary care physicians per 100,000 people in Nebraska and the largest gap is affecting the rural areas. Another alarming finding is that the number of primary care physicians older than 65 has grown by 78 percent in the past five years. And this was a 2012 study. In 2008, the American Medical Association reported that one-third of Nebraska's primary care practitioners were over 50 years of age. You know, when I graduated from medical school, I thought I could practice medicine until I died. And maybe that long-gone era, it was possible, but nowadays the technical, psychological, and legal demands placed on the medical profession make this highly improbable. Medicine is a human-burning profession. The second page of your handout has a map of the federally designated primary care medically underserved areas in Nebraska. Please notice that most of the areas with high percentages of Latino populations fall within the medically underserved areas of poor populations. One of those areas is Polk County. Another one is north Omaha and south Omaha. The largest and fastest growing minority in the state lives in the areas where primary care medicine is at a quantitative deficit. So am I being selfish? Absolutely. I represent Latinos. I am Latino and I live in a medically underserved area. So, you know, after 20 years as a trauma surgeon and 10 years as a public health officer, one thing that I learned is that the lack or scarcity of primary care practitioners only leads to cluttering of the emergency rooms in the hospitals with an increased cost in the treatment of conditions that could have been easily preventable or treatable early. I will address a couple of your questions. One of them was the confusion. One of the things that I am is that I am a medical interpreter training. The figure of nurse practitioner does not exist in South America. So we had to spend a considerable amount of time training our interpreters to explain to the patients, what was the figure of a nurse practitioner. And, yes, at the beginning there was confusion. But once that thing that we call primary care provider/patient relationship was established, the patients were perfectly happy and perfectly satisfied with the care being offered to them. Your second question referred to what happens with a C-section. When I began practicing here in the states, I was highly doubtful about the training or the capability of the nurse practitioners that work with me. With time, I realized that this was pretty much a relationship like that that exists between a first-year resident and a third-year resident or a specialist. In other words, the first-year resident will go as far as he feels he can go, and then he will call his higher-ranking resident or specialist. And I never saw any of them err on the wrong side. In fact, they usually err more in consulting you for things that they are perfectly capable to diagnose and treat. So that's my experience in that sense. I urge you to support this bill because I believe that it will be something to increase our primary care providers in Nebraska. Thank you for having me, and I will try to answer any questions that you may have. [LB107]

SENATOR CAMPBELL: Senator Riepe. [LB107]

SENATOR RIEPE: Thank you, Senator Campbell. I do have a follow-up question, because...and I respect very much your being here and testifying. My point would be, is calling up the next level, probably in the teaching situation, you're going to have senior residents. [LB107]

LAZARO SPINDOLA: Yes. [LB107]

SENATOR RIEPE: If we go out to a critical access hospital in Nebraska, there is no next step up that's next door. [LB107]

LAZARO SPINDOLA: Well, in the particular case for delivery is usually....oh, I'm sorry. [LB107]

SENATOR CAMPBELL: Doctor, just make sure you're speaking into the mike. [LB107]

LAZARO SPINDOLA: I'm sorry. [LB107]

SENATOR CAMPBELL: Thank you. [LB107]

LAZARO SPINDOLA: In the particular case of delivery, it's probably taking place in a hospital, and the hospital should have an obstetrician available for consultation at any moment. And if it doesn't, the nurse practitioner...I doubt that she will be, you know, taking care of a delivery in a hospital that doesn't have an obstetrician nearby. At least what I saw was that they would take their patients ready to deliver to a hospital where they had the available resources in case of need. [LB107]

SENATOR RIEPE: Um-hum. With all due respect, I don't think that's the way it plays out in the western part of the state of Nebraska. [LB107]

LAZARO SPINDOLA: You do not think so? Then I encourage you to solve that issue. (Laughter) [LB107]

SENATOR RIEPE: If you're out at a critical access hospital, it's 25 beds. And the next hospital might be Scottsbluff, which is maybe an hour and a half. There's not time to transfer a patient an hour and a half during a C-Section...going into a C-Section. I'm not being argumentative, I just don't... [LB107]

LAZARO SPINDOLA: How would that change if the primary care provider was a primary care physician? [LB107]

SENATOR RIEPE: Well, that's a good...that's a very good point. That's a very good point. I concede that. I'm not trying to be difficult on it. [LB107]

LAZARO SPINDOLA: Oh, no, no, no. [LB107]

SENATOR RIEPE: I'm just trying to get my head wrapped around it and how to...what privileges, because I'm... [LB107]

SENATOR CAMPBELL: Gentlemen. [LB107]

SENATOR RIEPE: Oh, I'm sorry. [LB107]

SENATOR CAMPBELL: No, you're fine. The senator...the practice here is that the senator can ask the questions. The testifier cannot, (laughter), even though you did it very politely, I might add. [LB107]

LAZARO SPINDOLA: Thank you. [LB107]

SENATOR CAMPBELL: Senator, proceed with your question. [LB107]

SENATOR RIEPE: Thank you. That really gives me an advantage, doesn't it? (Laughter) [LB107]

LAZARO SPINDOLA: That's why you're the senator. That's why you're the lawmaker. [LB107]

SENATOR RIEPE: It's just a question. You know, the devil is in the detail. I'm trying to figure out how the details...how this works. And I, too, am very supportive of reduced cost and... [LB107]

LAZARO SPINDOLA: And I would love to sit down with you and try to figure out a solution, Senator. [LB107]

SENATOR RIEPE: May I have another question, Senator? [LB107]

SENATOR CAMPBELL: Certainly. [LB107]

SENATOR RIEPE: Thank you. My question gets to...on this question, different one--and I wish you could ask some back--but this one deals with language in terms of Spanish as a primary language. [LB107]

LAZARO SPINDOLA: Um-hum. [LB107]

SENATOR RIEPE: Very difficult using interpreters, as you know, and I'm not sure the...within clinical nurse practitioners the percentage that are bilingual or Spanish

speaking or...I, you know, that's a little naughty detail that plays out at some point along the way. [LB107]

LAZARO SPINDOLA: There are very few. The percentage of bilingual nurse practitioners is very few, yes, like the percentage of...any type of healthcare provider is very low. But we try to compensate by training professionally medical interpreters not only on the nuances of his language, but also medical terminology, clinical situations, that kind of thing. [LB107]

SENATOR RIEPE: Thank you very much. [LB107]

LAZARO SPINDOLA: You're welcome. [LB107]

SENATOR CAMPBELL: Senator Howard. [LB107]

SENATOR HOWARD: Thank you, Senator Campbell. Thank you for coming, Lazaro. [LB107]

LAZARO SPINDOLA: Thank you. [LB107]

SENATOR HOWARD: It's always wonderful to see you. Just for a clarification--and you may now know this--but my understanding was that nurse practitioners are different from nurse midwives, and so it's fairly rare that a nurse practitioner would be attending to a birth. Is that something that...is that your understanding? [LB107]

LAZARO SPINDOLA: That is correct. That is my understanding. In fact, a nurse midwife always works in collaboration with an ob-gyn specialist. [LB107]

SENATOR HOWARD: Perfect. Thank you for clarifying that. [LB107]

LAZARO SPINDOLA: You're welcome. [LB107]

SENATOR CAMPBELL: I think we'll hear more about this as we go on. Thank you very much. [LB107]

LAZARO SPINDOLA: You're welcome. Okay. [LB107]

SENATOR CAMPBELL: Thank you, Doctor. One last call for any proponent. Okay. We will move to those who are opponents of the bill. And I will get out my list here. And I much appreciate both sides providing this for us. Dr. Richard Blatny. Is Dr. Blatny here? Okay. Good afternoon. Go right ahead. [LB107]

RICHARD BLATNY: (Exhibit 14) Good afternoon, Senators. My name is Dr. Richard

Blatny. I am a board certified family physician practicing in Fairbury, Nebraska, along with three other family physicians and three midlevel providers. [LB107]

SENATOR CAMPBELL: Doctor. [LB107]

RICHARD BLATNY: I'm sorry. [LB107]

SENATOR CAMPBELL: I'm going to stop you right there. You have to spell your name for us. [LB107]

RICHARD BLATNY: Oh, I'm sorry. Richard, R-i-c-h-a-r-d, Blatny, B-l-a-t-n-y. [LB107]

SENATOR CAMPBELL: Thanks. [LB107]

RICHARD BLATNY: We have had mid-level providers working with us in our clinic for over...in excess of 30 years. And, therefore, I am very familiar with their capabilities. I would first off like to point out that our opposition...oh, and I also want to say that I am currently the president of the Nebraska Medical Association and I am, therefore, speaking for the Nebraska Medical Association. I would like to first off point out our opposition to LB107 is not a turf battle. There are plenty of patients for everyone to see and we are extremely busy. Passing LB107 won't really affect any of us. But it will affect the citizens of Nebraska in a very negative way. It will put them in harm's way if nurse practitioners are allowed to practice unsupervised. Advance nurse...advanced practice registered nurses are a valuable resource, as are physician assistants, working as part of a medical team with physician supervision. They are trained as mid-levels, and you can see from the wheels that I passed out, it compares their hours of training with those of other individuals and physicians. I believe there's going to be some discussion of that by some of the other testifiers, but what I'll skip to is the fact that they have roughly 2.5 years of training--formal training--in their graduate school. And where they really lack education is in their clinical supervision. They...according to testimony last year have an average of 500 clinical hours of supervision at the time of graduation. If you compare that with physicians, at the time of their graduation, they have between 12,000 and 16,000 hours of clinical supervision. In other words, nurse practitioners have 4 percent of the clinical experience of a physician when they start out practicing. Although they would like to deem themselves physician equivalents, it is obvious they do not have the in-depth training necessary to make the correct diagnosis when treating more complex problems. And this really leads to discussing what I think is the second misconception here today, and that is that nurse practitioners will only care for straightforward, uncomplicated cases. I'm here to tell you, there's no way to limit who walks in your door. If you set up practice, in an average day we do see some simple things. We see sore throats. We see ear infections, etcetera. But we also every single day have very complex patients that come in. The patients themselves may not realize how complex they are. If the nurse practitioner doesn't recognize that, mistakes are going to be made

and individuals are going be injured. There is an insurance carrier, CNA, which is a very large insurance carrier, who compiles statistics of closed malpractice cases over the entire United States. They insure over 27,000 nurse practitioners. A startling fact is that for a supervised nurse practitioner, the average malpractice claim paid is $4,750-some. If you're an unsupervised, independent nurse practitioner, the average malpractice claim is $293,000. Now that is pretty much extreme to me. It's a staggering difference. It points out the inherent risk to our patients of allowing independent nurse practice. The citizens of Nebraska, your constituents, expect you to pass bills that protect them, not put them in harm's way. Passing LB107 will indeed put them in harm's way. One of the portions of this study--and it's a very in-depth study--but in the study, unexpected death--that's death related to the...unrelated to the normal course of illness--was the most common patient injury associated with nurse practitioner negligence claims, followed by cerebrovascular accident/stroke, cancer that was either undiagnosed or delayed in diagnosis, and infection, abscess, and sepsis. All these are very serious problems. [LB107]

SENATOR CAMPBELL: Dr. Blatny, we're kind of at that red light there. So, I know, it comes up awfully fast. [LB107]

RICHARD BLATNY: All right. Well, when... [LB107]

SENATOR CAMPBELL: But we want to make sure we get all your colleagues, because I have a long list here. [LB107]

RICHARD BLATNY: I guess what I want to say is that these are very serious complications which take place frequently in the United States, and that's what indeed this study shows. It is not a simple thing that patients are treated and just simply putting somebody out in a rural area doesn't mean that they're going to be adequately taken care of. The final thing I had is that the distribution of nurse practitioners in Nebraska is not going to change if this bill is passed. In the 17 or 18 other states, there's been no change in distribution. They still are mainly in the large areas. They do not go outstate. We have a waiver that is available. Their board grants the waivers and they've only granted two or three in the entire time that this bill has been there. I would like to discuss more, but obviously my time is gone. [LB107]

SENATOR CAMPBELL: It is, sir. [LB107]

RICHARD BLATNY: I thank you for your attention, and I'd be willing to take any questions. [LB107]

SENATOR CAMPBELL: Questions? Senator Riepe. [LB107]

SENATOR RIEPE: Thank you, Senator Campbell. I have two different questions. One

was, it seems to me that, like in the last legislative session that was noted by Senator Campbell...or I'm sorry, Senator Crawford, as we began, it was 43 to nothing of support. And I believe that that came down to the clinical hours of experience. Is that still the primary issue or concern of the American...or Nebraska Medical Association? [LB107]

RICHARD BLATNY: Well, the current future of medicine in Nebraska and in the United States appears to be everyone working together. And that is primary, the patient centered medical home--I think others are going to address that--and where we all work together. The concerns are that...and that is the most cost-effective way to provide care. The concerns are that...the hours are a big thing, yes. It's also, who are they supervised by? We offered to discuss this with the nurse practitioners this past year, but no one really wanted to discuss it. They want to supervise all their own people. We have physicians who would do a very good job and would help ensure that perhaps their clinical experience is more worthwhile to them, but that didn't come about. I think the lack of clinical hours, which is huge, is part of it, but the other thing is the in-depth training. They're only...they're at 2.5 years compared to physicians that are there, what, at least seven. They aren't really trained to take care of these very complex patients. And even taking care of them for short periods of time can upset the delicate balance of medicines that perhaps we have to keep those individuals alive. So I still think that what we really would like to see is all of us working together. We don't feel this is going to change the distribution at all. If there's some individual that really wants to go out there, let them get a waiver and do it. [LB107]

SENATOR RIEPE: My concern would be, it's not with someone that has 10, 12, 14 years of experience. My concern would be a fresh graduate... [LB107]

RICHARD BLATNY: Exactly. [LB107]

SENATOR RIEPE: ...who...so, we may have to have some stipulations there. [LB107]

RICHARD BLATNY: Yes. [LB107]

SENATOR RIEPE: May I have a follow-up question, Senator Campbell? [LB107]

SENATOR CAMPBELL: Sure. [LB107]

SENATOR RIEPE: Thank you very much. The second question I would have is, in your opinion, is some care better than...or no care better than some care, or... [LB107]

RICHARD BLATNY: No. [LB107]

SENATOR RIEPE: Okay. [LB107]

RICHARD BLATNY: That is not my...I think that is the absolute wrong way to go, because many times, when a patient walks in your door, whether it be a nurse practitioner or a physician, they expect you to have the answers. They expect quality care. If they misdiagnose a skin lesion and it later ends up being a malignant melanoma that takes their life...if they think the shortness of breath was because of their emphysema but, by golly, they have a pulmonary embolism, they're going to walk out of the door and within the next day be dead. You see there was a delay in treatment there. And so trying...seeing somebody and perhaps not getting the right care delays the diagnosis and then can end up causing major, major complications down the road. And, in fact, in this study, which was in excess of 70 pages, where they were discussing the pitfalls and how nurse practitioners were being sued for malpractice, they discussed that. And I think I mentioned delayed in diagnosis. Delay in diagnosis is the worry you have by somebody else trying for a week or two and then the patient suffering. [LB107]

SENATOR CAMPBELL: Senator Kolterman. [LB107]

SENATOR KOLTERMAN: Yeah. Thank you for testifying. My questions deals with what you just stated about diagnosis. Couldn't that happen with an M.D.? [LB107]

RICHARD BLATNY: It could happen with an M.D. [LB107]

SENATOR KOLTERMAN: The lesion and the...I mean, that's just as apt to happen with an M.D. as it is with... [LB107]

RICHARD BLATNY: No, I don't think it is, because if you spend 16,000 hours of clinical experience being shown this and this and this and this, versus 500 hours...Senator, 500 hours of clinical experience is equivalent to somebody working a 40 hour a week for 13 weeks. That's 3 months of training. How many of these really unusual situations is that person going to be able to see and see the proper way to treat? Not very many. That's why the physicians, at a minimum, spend 7 years. So I think, yes, a physician could make a mistake. Would I say that they never do? No. I mean, sure, they may. But I think...again this statistic is huge, what happens between supervised and unsupervised. Did I answer your question? [LB107]

SENATOR KOLTERMAN: Yeah. [LB107]

SENATOR CAMPBELL: Senator Howard. [LB107]

SENATOR HOWARD: Thank you, Senator Campbell. Thank you for your testimony today, Doctor. You mentioned that you work with three mid-levels in your clinic in Fairbury. [LB107]

RICHARD BLATNY: Yes. [LB107]

SENATOR HOWARD: Do you have an Integrated Practice Agreement with any of them? [LB107]

RICHARD BLATNY: Well, they're all...yes. I mean, they're all...what we have...currently, we have physician's assistants. [LB107]

SENATOR HOWARD: Okay. [LB107]

RICHARD BLATNY: But we are also...we have discussed this fully. If we need another midlevel provider--I know they don't like to hear that word--but if we do...and we all work very well together. I mean, we've worked over 30 years this way. We will have a...we will hire a nurse practitioner. I mean, there would be no problem with that. We started out with the PAs, and that's where we're at now. But we have no qualms about hiring a nurse practitioner. I just think...I think...and we have also had nurse practitioners with us for training. I've been on the teaching staff at the University of Nebraska Medical Center for 40 years, a long time. And so we have trained medical students. We have trained PAs. And we have nurse practitioners that have all come through for training. And so we're very aware of what they can do. And that's where we're at right now. [LB107]

SENATOR HOWARD: I think more my question relates...I'm curious about the function of IPAs. And so maybe a testifier who follows you may be able to speak to that... [LB107]

RICHARD BLATNY: Okay. [LB107]

SENATOR HOWARD: ...in the future. [LB107]

RICHARD BLATNY: Yes. [LB107]

SENATOR CAMPBELL: Thank you, Dr. Blatny. [LB107]

SENATOR RIEPE: Senator Campbell, can I have a quick question? [LB107]

SENATOR CAMPBELL: Oh, I'm sorry. Senator Riepe. [LB107]

SENATOR RIEPE: Thank you. Doctor, you're serving your community, and God bless you for it. Do you have a succession plan that...because I think with the baby boomers coming along, the demand of, you know, we're going to have to have a succession plan for gentlemen. [LB107]

RICHARD BLATNY: Um-hum. In other words, what hair I have left looks pretty grey. (Laugh) And I...yes, we do. We...well, for one, my son is a family physician practicing

with us also. And we...I think that we will not have a problem recruiting family physicians to our area. We provide excellent care. We very much need nurse practitioners or PAs to help us with the practice. We have no emergency room physicians. We are the emergency room physicians. So we're there day and night, basically. And so we all work together. And I think it's inviting, likewise, to the nurse practitioners and PAs to work in a place like ours, because we're large enough...we take care of a large area, but we're large enough to be able to have enough time off and cover the calls that it's at least livable. And that's the other thing. If you look at some of these areas like Cherry County and those, there...I'm sorry, but there probably aren't enough people out there to really economically keep a practice afloat. I mean, you have to have a certain number of people. Your...the cost of your overhead, if you have equipment, etcetera, is going to be probably between 65 and 75 percent overhead. So you have to see a lot of people. And... [LB107]

SENATOR RIEPE: Do you have about 2,000 in your practice to make it a full practice? [LB107]

RICHARD BLATNY: For...2,000 patients? [LB107]

SENATOR RIEPE: Yes. [LB107]

RICHARD BLATNY: Our drawing area is about 18,000, they tell us. [LB107]

SENATOR RIEPE: How many do you have in your practice? [LB107]

RICHARD BLATNY: We have way in excess of that. We probably...I...you know, that's a good question that I'll have the answer. But I don't honestly know. Now, our drawing area is 40 miles to the west, 30 miles to the east. We split between Beatrice, so...and we're...we have quite a few patients from Kansas. So they drive 30 to 40 miles to see us. [LB107]

SENATOR RIEPE: You must be good. Thank you. [LB107]

RICHARD BLATNY: Well,... [LB107]

SENATOR CAMPBELL: Thank you very much. I'm sorry. I'm just going to go on, here... [LB107]

RICHARD BLATNY: Sure. [LB107]

SENATOR CAMPBELL: ...because we have a great number of people that want to visit. [LB107]

RICHARD BLATNY: Thank you. [LB107]

SENATOR CAMPBELL: And I want to remind senators that you have a long list here, and I want to get to everybody that wants to say something. Before you start, sir, Senator...or, Dr. Bleicher, are we going to make it for you? Okay. She has a commitment, and so I was trying to watch the time for her. Go right ahead, sir. [LB107]

KEVIN NOHNER: (Exhibits 15, 16, 17, 18, 19) Good afternoon. My name is Dr. Kevin Nohner, K-e-v-i-n N-o-h-n-e-r. Senator Campbell and committee, thank you for letting me testify. I'm going to bring it up to a much higher level of discussion. I oppose LB107 because I think it's not the right solution. I don't think we're asking the right questions. And I think that the solution that's offered...the train has left the station. This is not the way to resolve and reform healthcare for Nebraskans. In my job, I'm a family medicine physician. I have practiced in Omaha for 30 years. Currently, I'm half time clinic and I'm half time ACO medical director for UniNet. I am a big proponent for transforming healthcare in Nebraska to a value-based care system. That's where I think that LB107 falls short. I've had the privilege of working with nurse practitioners, and I hope to continue to do so through my lifetime. I think they bring a wonderful skill set to the office. And I don't think I need to be sitting next to them to do it. And with advances in telehealth and technology that should be available in the coming years, I just foresee that collaboration is just going to become much easier. But we throw some terms out that are really easy to misuse: collaboration, integration. What do they really mean? Well, as an ACO medical director, when I say integration, I mean that my computer can talk to somebody across town. I can get a response quickly. It goes into my work queue. I have a coordinated list of medications. I know what the treatment plan is. If, at 3:00 in the morning, I get a call, I can look it up on the computer and I know what my partner did at, you know, 4:00 in the afternoon. Not only that, that electronic medical records system can collect data. It can sift it into patient registries. My care coordinating part of the team can do outreach and use that data for population health, getting people in for preventative health measures. And we can do management of chronic diseases. This goes far beyond what most people think when they say, we're going to integrate or collaborate. I can tell you, as somebody who has had 2 brothers-in-law who died from cancer, that sometimes that collaboration of care, even in a metro area, is very poor. And I feel like they would have been lost if I hadn't been a medical professional. So I think that, really, we have to look at, what are we trying to achieve? One of the missions for the Nebraska Medical Association is to advocate for the public health of Nebraska. I do think that there's some safety issues. And there's some doctors that are going to miss stuff. And there's going to be nurse practitioners and PAs that miss stuff. But the concern I had last year is the same concern I have this year. I don't think LB107 really addresses the whole issue of, what does it mean to be a collaborating physician? What are the regulations? What about the board of licensure and the qualifications that are needed? In my 30 years, I passed three parts of the national boards. I took board certification. And, besides the extensive continuing education, I've recertified. I've taken

the boards four times more. Now, I don't see where we're looking at that. Last year, as president of the NMA, I asked the nurses, what are the grievances? I don't understand the problem. It heartened me to think that at one point people sat around the table. I think legislating a resolution or going to a court system to get a resolution is the last resort. And I don't think LB107 does it. The patient centered home and truly integrated care will decrease the cost of medicine. Patients are much more satisfied with the results. And we can improve the quality of outcomes. And I think that you cannot do that as a free spirit in an independent position who won't be able to afford the electronic record, who won't have the ability to collaborate the way we wish they could. And so I oppose it. And the material I handed out as you...that's a generic letter. It didn't go along with my testimony. But there's two articles by Atul Gawande, who I think will show you that doctors are a big part of the problem. When I testified in Senator Howard's health policy class, and one of her students said, do all the doctors think like you do? And I said...I kind of chuckled. I said, no, I don't think they do, but we're going to work on it. And I think that these will give you insight into some of the changes that we have to do. You know, one of our prior speakers quoted Gandhi. Well, I think if we keep doing the same things over and over and expect different outcomes, that's the definition of insanity. And so I think we have to think these things through. And I don't think LB107 gets us where we need to go. So I appreciate your time. [LB107]

SENATOR CAMPBELL: Thank you, Doctor. I'm going to stop you right there in case there are any questions from the senators. And these are all your materials, right? [LB107]

KEVIN NOHNER: Yeah. Those are just for your reference. [LB107]

SENATOR CAMPBELL: Okay. Great. And your testimony, correct? [LB107]

KEVIN NOHNER: No, that's my letter. That will be going to the senators individually. I didn't make a copy of my testimony. [LB107]

SENATOR CAMPBELL: Oh, all right. No, no, no, that's fine. But, I mean, I wanted to make sure that you knew that we have the letter. [LB107]

KEVIN NOHNER: Yes. Yeah. Thank you. [LB107]

SENATOR CAMPBELL: Thank you, Doctor. Our next testifier is Dr. Stacie Bleicher. Good afternoon. [LB107]

STACIE BLEICHER: (Exhibit 20) Good afternoon. Senator Campbell and committee members, my name is Stacie Bleicher. It's S-t-a-c-i-e. Last name is B-l-e-i-c-h-e-r. I am a general pediatrician practicing here in Lincoln but have been very involved in some statewide government committees and most recently on the future of medicine work

group that was convened by this committee and the insurance committee. And I'm talking on behalf of the Nebraska chapter of the American Academy of Pediatrics today. And that is a group that contains over 300 pediatric physicians, both general and specialists, that practice in this state. And we do have concerns and oppose LB107. I will not rehash the issues about number of hours in clinical training. I will say my personal experience, after having three years of medical school, three years of residency in pediatrics, and then an additional year as staff at University of Iowa Hospitals, that when I got out into pediatric practice, there was still a very significant learning curve. It was very good to have a practitioner I was in practice with to use as a mentor and colleagues that I knew in town that could answer questions. And I think that those sorts of interrelationships are very important for new practitioners and certainly even more so for people that would have a shorter practice and clinical experience history. My primary job in my public policy issues is to be an advocate for children. And I don't want to take shortcuts if I can help it in terms of their medical help. We know that impacts their growth development, their success in education. And missing little things in kids like a child that's vomiting and having terrible problems...well, it turns out she has a tumor in her kidney. That was something I experienced in residency, and the child went on to do well because she was...her diagnosis was made promptly and she could be treated at early stages of her cancer. But those sorts of experiences in my detailed training really informed me in my practice in the future. And those sorts of experiences may not be available in the nurse practitioner training. I...to me, personally, my biggest concern after working on the future of medicine work force group is that integration is terribly important and more teamwork approach to things...I agree. I know we have a healthcare provider shortage in this state that's going to progressively get worse. And yet we want to create a sustainable method of improving services that are available in underserved areas. My thought would be, you know, maybe our training programs need to put more emphasis on actually, at training level, integrating PAs, nurse practitioners, physicians...incentivizing them as a group, potentially, to go out to underserved areas or, you know, to go to the inner city to underserved areas. But they're already having an introduction to, how do we function as a team? But I think that teamwork is important. You know, if we have nurses that want to practice in Cherry County but they have no physicians nearby that are available for consultation, that puts them at some risk in terms of not being able to make referrals when they feel they need to. And it puts them at a great disadvantage of practicing good medicine also. So I think we need to look at team building and supporting healthcare in those sorts of settings rather than necessarily saying, well, we'll get one person to go out there and take care of everybody because it's going to be a very difficult task. My letter does not exactly follow that, but I'd be happy to answer any questions you might have. [LB107]

SENATOR CAMPBELL: Senator Howard. [LB107]

SENATOR HOWARD: I'll be very quick, I promise. Thank you, Senator Campbell. [LB107]

SENATOR CAMPBELL: You don't have to be quick. (Laugh) We just want to make sure we get everybody in. [LB107]

SENATOR HOWARD: I'll speak very quickly. You talked a lot about team-based approach. And as we look at healthcare as it's evolving, we are looking at patient centered medical home and integrated care and that sort of thing. My question is sort of, in this bill in particular, is there anything that would prevent a nurse practitioner from continuing in an integrated care setting? [LB107]

STACIE BLEICHER: I don't think it would be preventive. I'm a little concerned about...I'm not sure that the number of hours of a supervisory nurse practitioner would necessarily give them the level of backup and supervision that a physician might. And I know that's optional that they could have one or the other. And I don't have any qualms with our practitioners, practitioners who have been in practice in their specialty area for prolonged years. You know, they know more than a new resident going out and practice, very likely. But I feel, especially those early training years, that I think that it's important to try to build that collaboration with the next step up, as they discussed before. So... [LB107]

SENATOR HOWARD: Thank you. [LB107]

STACIE BLEICHER: You're welcome. [LB107]

SENATOR CAMPBELL: Other questions? Thank you, Dr. Bleicher. [LB107]

STACIE BLEICHER: Thank you. [LB107]

SENATOR CAMPBELL: You should know, Dr. Bleicher is a frequent testifier here. Our next testifier on my list is Joey Beauvais. I'm probably not saying that right. Good afternoon. [LB107]

JOSEF BEAUVAIS: Good afternoon. My name is Josef Beauvais. It's J-o-s-e-f B-e-a-u-v-a-i-s. [LB107]

SENATOR CAMPBELL: Oh, I didn't have the A. [LB107]

JOSEF BEAUVAIS: (Laugh) And I am a third-year medical student at the Creighton University School of Medicine and a former registered nurse and a holder of a Bachelor of Science in nursing from Creighton University. I'm here today to talk to you a little bit about the curriculum and diagnostic differences which exist between undergraduate nursing and medical school. To give you a bit of perspective, I grew up in Columbus, Nebraska. My father is a physician and my mother is a retired nurse. I enrolled in the

Creighton Bachelor of Science in nursing program in 2006, graduated in 2010. I was encouraged to pursue graduate school by numerous people, and I wanted to make an informed decision, so I decided to evaluate both the nurse practitioner role or the physician role. I shadowed nurse practitioners and physicians in various specialties. And in Columbus, you know, the nurse practitioners work really well with the local physicians. But in the practices that I shadowed, it was encouraged and expected that the NP consult with the physicians on complex medical matters. And after seeing the limitations of the nurse practitioners from an educational and a practical standpoint, I elected to go into medicine because I was enticed by the more robust curriculum and training that it was going to offer me. Next year I'm going to be applying for residencies in emergency medicine. And I know that it took a greater investment in terms of time and tuition, but I chose this path because I wanted to provide the highest level of care that I could for patients. And on the surface, undergraduate nursing education and medical school appear similar. Your first two years are filled with basic science classes. You'll take anatomy, physiology, and pharmacology, while your last two years are going to emphasize more on clinical practice and leadership. What you have to understand, however, though, is that the classes are taught at different levels. The nursing-level courses are mostly introductory-level courses. And they're meant to mirror the expectations and the role that nurses are going to have in the clinical practice setting. For sake of reference, when I went to go to apply to medical school, only one of my undergraduate courses actually transferred and counted as credit for going into medical school. So your last two years are focused more on the practical matters of nursing: your clinical judgment, learning how to take care of multiple patients at once. So, you know, the education is different because the way we approach diagnosis is different. And even after doing well in a four-year nursing program such as Creighton, medical school has proven to be a demanding academic experience. Something that's very difficult to appreciate but, I think, essential to understand here is just how much subtlety there can be in making a diagnosis for a patient. Modern medicine is a rapidly expanding field. And it takes years of supervised clinical practice, I feel, in order to gain the level of clinical competency. And that's something that I don't think 2000 hours is going to be sufficient in order for someone to obtain. What this bill is proposing is giving nurse practitioners with too little clinical training too much independence. I'll be the first to admit that when I was a nurse, I didn't know what I didn't know. And when you aren't aware of what your limitations are, you don't seek the aid and the counsel of others until it's, unfortunately it's too late. And that's something that I'm okay with admitting with now because I'm still a student. I've still got some more years of training ahead of me. But that's hoping that when I'm an emergency room physician, I don't ever have to tell my patients, and I don't have to experience...I don't want to be hearing from somebody, I didn't know that I didn't know that. This is healthcare. And the stakes are always high, even with what can be, you know, a simple condition. That's why, for the health and safety of all Nebraskans, I urge you to be careful with who you decide is able to practice independently. All right, and I'll take any questions now. [LB107]

SENATOR CAMPBELL: Thank you very much, Mr. Beauvais. Questions from the senators? Seeing none, good luck with your studies, and I hope you practice in Nebraska. [LB107]

JOSEF BEAUVAIS: Thank you. [LB107]

SENATOR CAMPBELL: We're always recruiting, you know. (Laughter) Our next testifier is Alicia Smith. Good afternoon. [LB107]

ALICIA SMITH: Thank you. Good afternoon. Thank you for having me here today. My name is Alicia Smith, A-l-i-c-i-a S-m-i-t-h, and I am a first-year medical student at the University of Nebraska College of Medicine. So I've been in school less than six months. I actually drove here today right after a test that I studied for probably ten hours every day for the last two weeks. I'm currently taking physiology. And as Joey was explaining to you, our physiology, our core classes, the first two years of school are a little bit different than that of nursing students, PAs, NPs. Just as an example, when I was in anatomy, we had ten weeks to complete anatomy of the human body. We had gross dissection. We had lecture. And then we had a class called living anatomy, which was just kind of more like clinical. And while we were taking it, we were in lab with PA students who, just as an example, were roughly two units behind us at the same time and took a couple weeks longer than we did to complete the course, just kind of as a reference for the educational differences from that standpoint. Many of my points have been talked about. I don't want to bore you with the hours. You all know the difference. The 500 to 600 hours versus what we estimate is more like 8,000 hours before we graduate from medical school, so 8,000 of clinical experience in those first four years of school, followed by possibly up to even 20,000 hours during residency. And then that compares to the 2,000 hours that the nurse practitioners gain in their supervised training. So as a student, this training is my life. As you know, I do this every day. I don't work. I just go to school and I just study. So it's very important to me to understand why I'm doing this. And for me, if there was an alternate route where, if I could, you know, drop out of school this year, start nurse practitioner school next year, and be done in less time and be practicing independently, it makes me question why I'm doing what I'm doing. So are we devaluating primary care with this bill? Are we saying that this shortage of primary care can be addressed in this way? But then where will the physicians come from, because to me the shortage of primary care in what people say is upwards of 60 counties in Nebraska looks like an opportunity for me in six years to take advantage of? But if I could accomplish that in three years with up to $100,000 less debt, a lot less time that I dedicated to education, and a lot less stress, that's very enticing. However, for me, as we're taught every day in school, the patient is our priority. And the patient's healthcare is what is most important to us. And so it's hard for me to compare the hours of clinical experience and, without questioning, why am I receiving so many more hours? There must be a reason. It must be important. So I have to look at it as an opportunity. I am taking advantage of every possible level of training that I

can in order to be the best possible physician that I can. And how can I be confident that I am offering the best hospital care without the most training possible? And for me, being here every day of my life, it just seems...it seems like the choice. And if I could do it all over again, I would still choose medical school, because I want to be the best doctor that I can be. I want to know everything. Obviously I know that I won't. And I'll make mistakes. We all do. But I want to be able to be comfortable and confident when a patient walks through my door knowing that I can care for them and that I won't miss something. And if I do, then being able to say, hey, let me ask someone for help, because that's a big part of care, is asking for help. So just in conclusion, I think this training is highly necessary because we want to provide the best possible care to our patients, to your constituents. And should we risk the health of someone on less training? And I'll take any questions. [LB107]

SENATOR CAMPBELL: Questions, Senators? Senator Riepe. [LB107]

SENATOR RIEPE: Senator Campbell, thank you. My experience is that some of the older general practitioners, family practitioners, were very much engaged in a lot of procedures. The next generation became more...primary care doctors became triage doctors to all of the subspecialists that were there. My sense is, with a different level of active independent clinical nurse practitioners, family medicine physicians might go back to a role of being more like "specialists" in the practice of medicine. It's not that it takes away...can you respond to that? Do you see...I don't know what your intent for a specialty would be or if you have one, but do you see a greater role for family medicine that would go back to doing some of the things that they used to do? [LB107]

ALICIA SMITH: I have not decided on anything. Thanks for inquiring. But in my experience, right now we're being taught a wide variety of care so that we can provide preventative care as well as basic procedural care. I actually shadowed a doctor in Utica during undergrad. And she was a single physician with a PA that worked there part time. And she ran her own practice every day of the week, probably 7:00 a.m. till 4:00 or 5:00 at night. So she worked very long hours. And while I was there, she did do her preventative...her easy cases. She also did her own deliveries, her own colonoscopies, her own x-rays, all of these things. And what she always told me was that, if I can do this and I don't have to refer you out, it saves you money. I feel more comfortable because I am doing the care as opposed to sending you to a higher level physician and triaging, as you would say. Is that what you meant triaging? [LB107]

SENATOR RIEPE: Yes. Yes, exactly. [LB107]

ALICIA SMITH: So I guess I don't know if I'm answering your question, but...and it's only my first year. But I feel like, from what I've seen laid out in front of me, we are receiving care to make us both preventative doctors and treatment doctors so that we can take care of as much as possible on our own. So, yes, I would say that there is definitely a

shift towards more primary care. [LB107]

SENATOR RIEPE: My sense is, in the last 20 years we've probably underutilized the talent of family medicine or general...what used to be general practitioners. [LB107]

ALICIA SMITH: I agree. [LB107]

SENATOR RIEPE: So if we step them up, then we have a little bit void up to that point, is where I'm... [LB107]

ALICIA SMITH: Right. And I'm saying, if we don't have...if we don't feel like it's good...a good opportunity for physicians to go into primary care, then we might be missing out on that. [LB107]

SENATOR RIEPE: Some of that comes back to reimbursement. [LB107]

ALICIA SMITH: Are you going to ask me a question about that? [LB107]

SENATOR CAMPBELL: No. No. I apologize about that. Thank you. [LB107]

ALICIA SMITH: Okay, because I don't know how to answer that, so. (Laughter) [LB107]

SENATOR CAMPBELL: You're going to take the fifth on that one, huh, Ms. Smith? [LB107]

ALICIA SMITH: Yeah. I don't...I haven't reached that training yet. [LB107]

SENATOR CAMPBELL: I don't blame you. Any other questions, Senator? Ms. Smith, thank you for coming today and good luck on what the test tells you. [LB107]

ALICIA SMITH: Thank you. Oh, yeah. [LB107]

SENATOR CAMPBELL: Our next testifier is Kaitlyn Brittan. Good afternoon. [LB107]

KAITLYN BRITTAN: Good afternoon. I'm Kaitlyn Brittan, K-a-i-t-l-y-n B-r-i-t-t-a-n. I'm currently a fourth-year medical student at University of Nebraska Medical Center College of Medicine. And I will be getting my M.D. in May. I have chosen to pursue a career in internal medicine, which is considered a primary care field, and I will spend the next three years getting residency training. I think we all can agree that what matters most in this debate is the health and the safety of all of our loved ones, our patients, and your constituents. Our perspectives of what is safe is what really is differing on the sides of this argument. For years, physicians have undergone changes in their training requirements, increasing what training and what testing they have to undergo before

being certified and recertified. The reason for that is, it's so important to ensure our patients' safety. A primary care doctor will have over 20,000 hours before they get to practice independently. I think that's a number that everyone should keep in mind. By passing LB107, you would be taking a major step backwards in allowing NPs with substantially less training to practice independently. And that's in no one's best interest. This bill has been framed as nurse practitioners competing against the primary care physicians. This isn't a competition. Our training is not equivalent. And the health of Nebraska is not some prize to be had. I sit before you currently with 8,000 hours of clinical experience. That's four times the amount that is being proposed to be required in LB107 for adequate training of an independent nurse practitioner. I am confident in my abilities and my training. However, I can't say with 100 percent certainty that if you put me in a clinic working on my own that I could take care of, appropriately diagnose, and appropriately treat any person that walked in the door. As it's been said, you don't know what you don't know. Part of the reason that you need 20,000 hours of experience is, you may think someone walking in with a cough or shortness in breath is asthma or something straightforward, and it ends up being a pulmonary embolism that's life threatening. All of those hours are critical in making the right diagnosis and preventing major catastrophe. I will spend three more years, over 13,000 more hours, being supervised from where I sit right now. They will slowly give me increased autonomy in what I'm able to do on my own while still having the support of supervision if I need it and as I need it. Every single one of our patients, every single one of your constituents, deserves the best possible care. And if I, at 8,000 hours, can tell you that I am not prepared to take care of patients on my own, I can surely say that 2,000 hours is not enough. I also would like to point out that LB107 requires supervision for those 2,000 hours. Supervision can be a physician, but it also can be a nurse practitioner with 10,000 hours of clinical practice. Ten thousand hours isn't much more than where I'm at right now. And if I don't think I can practice independently, I surely can't supervise someone else and give them the appropriate guidance. Again, after eight years of undergraduate and medical education, 8,000 clinical hours, and $173,000 of debt that I have accrued solely in medical school, I'm going into primary care. But the message I'm seeing from LB107 is that if it's passed, why would I spend my time, my energy, my commitment, and the sacrifices of going through medical school if I could spend significantly less time, money, and energy to be an independent practitioner by going through an NP program? I think that this devalues the commitment that I have put it in, and I think that it also will disincentivize medical students to pursue primary care fields, which is the opposite of what we need right now. With the physician shortage, I think the last thing we want to do is disincentivize medical professionals from going into primary care fields. With that, I will end and answer any questions. [LB107]

SENATOR CAMPBELL: Questions? Senator Riepe. [LB107]

SENATOR RIEPE: Senator Campbell. Are patients informed enough to select an internist over a clinical nurse specialist? [LB107]

KAITLYN BRITTAN: I think that varies from patient to patient. I think that some people are more informed than others, so I don't think I can adequately... [LB107]

SENATOR RIEPE: I'm just thinking, in an urban market, as an internist you would have an incredible advantage over someone if the perception was of the 8,000 hours and someone else did not have that 8,000 that you would be...the sense of where they would go to. Now, that plays out differently when you get into other parts of the state. So I'm a real believer in market-based, market-driven type... [LB107]

KAITLYN BRITTAN: Absolutely. [LB107]

SENATOR RIEPE: ...and medical homes and that kind of stuff. So I... [LB107]

KAITLYN BRITTAN: Um-hum. [LB107]

SENATOR RIEPE: I was just curious about your opinion, if you didn't think that they would pick you as opposed to, you know, maybe a clinical nurse practitioner. [LB107]

KAITLYN BRITTAN: I think there is a lot of confusion as far as...I have relatives in western Nebraska. My family grew up in Alliance. I personally grew up in Omaha. And I know a lot of my relatives are not in the medical profession that are unaware of the differences between...the difference between a physician, an internist, a nurse practitioner, and they may not understand the amount of hours and training that are...differentiate the persons they would choose to go to. And I think that is a part of the problem. [LB107]

SENATOR RIEPE: Okay. Thank you. [LB107]

KAITLYN BRITTAN: Um-hum. [LB107]

SENATOR CAMPBELL: Any other questions, Senators? Thank you very much. [LB107]

KAITLYN BRITTAN: Thank you very much. [LB107]

SENATOR CAMPBELL: Our next testifier is Dr. Gregorius. Good afternoon. [LB107]

CHARLES GREGORIUS: Good afternoon, Senator Campbell. I appreciate the opportunity to be here. My name is Charles D. Gregorius. That's G-r-e-g-o-r-i-u-s. I have my printed notes but I did not have the whole thing printed out. And I'm really planning on responding to some of the things I've already heard today instead. First of all, I'd like to address what Mr. Scribner said, the CRNA. First of all, the Legislature had nothing to do with the relief that the CRNAs had when they were relieved of the need for

supervision. That was done by executive order of then-Governor Johanns. In part of that campaign to get rid of that supervisory requirement, a lot of things were misunderstood both by surgeons and by legislators. What was misunderstood was that what...the requirement for supervision of CRNAs was for supervision of the medical care of the patient. Now, in rural areas, that was done by the surgeon, because he was the doctor in the room. What was sold to the surgeons out there and to the legislators was that they were also supposed to be supervising the anesthetic care by the CRNA. And that is not true. As many people were told, most surgeons can't even spell anesthesia, much less know what they do. That may be a stretch, but they were not responsible for it. But people, including surgeons, were told that. And they went to their senators that sit in the Unicameral and said, relieve me of this. So that was one of the things that happened back then. The other thing they were told--the surgeons were told--is you're paying a higher premium for your malpractice insurance because you have to supervise me. St. Paul was the insurer at the time, and St. Paul told me in written letter, no, they do not pay extra for supervising any more than in the current situation with the NPs. Physicians do not pay a higher premium if they are collaborating with or integrated with a nurse practitioner. The analogy with nurse practitioners thus falls down pretty quickly. The other difference is that when a CRNA practices, there is a physician in the room whether they have an agreement or not. The surgeon is not going to work without an anesthetic, and the nurse anesthetist isn't going to put somebody to sleep if they're not going to have surgery. So the medical supervision is there all the time. Even in a dental office, the medical supervision is there because the dentists--I'm giving them credit--years ago, when I was president of the Nebraska Society of Anesthesiologists, came to me and said, help us write regulations to put into statute to increase the requirements of our dentists in terms of their knowledge of anesthesia, and they did that. And it's stiff, to the point where there are now dental anesthesiologists and a dental anesthesiologist society. Now I want to respond...oh, where did...I was going to respond to Senator Riepe. [LB107]

SENATOR CAMPBELL: You could go ahead, Dr. Gregorius, for the record. Absolutely. [LB107]

CHARLES GREGORIUS: Okay. Okay. With regard to specialists and family practice and what we are doing today, 40 years ago when I graduated...41, even then it was very difficult and most states did not allow you to go out of...come out of medical school and hang up your shingle. They required some postgraduate work. Some states still allowed it but not very many. It was recognized that things like family practice was indeed a specialty. When I was in medical school, first day of medical school, I was told by the head of...dean of students that the half-life if medicine was 3.25 years, which meant that by the time we graduated, half of what we had learned was going to be either outdated or replaced. In the year 2015, that half-life is probably closer to 2.5 years. And that's why every physician is going to be in some type of specialty or limited practice, whether it's family practice or OB or pediatrics or whatever. The days when a

family practitioner took out gall bladders and did inguinal hernia repairs, that's gone. It's just too complicated anymore. I would like to shut up and answer any questions that any of you might have. [LB107]

SENATOR CAMPBELL: A wise man watching the lights. (Laughter) Questions from the senators? Dr. Gregorius, if you want to share at a later time your comments, you can always send them to me and we'll get them to the committee. [LB107]

CHARLES GREGORIUS: All right. I thank you very much. I thank you all for your service to the state. [LB107]

SENATOR CAMPBELL: Thank you, Dr. Gregorius. Our next testifier is Dr. Michelle Sell. Good afternoon. [LB107]

MICHELLE SELL: (Exhibit 21) Good afternoon. Senator Campbell and members of the committee, my name is Michelle Sell, M-i-c-h-e-l-l-e S-e-l-l. I'm a board certified family practice physician and I practice in Merrick and Nance Counties, both listed as medically underserved in our state. Our team includes four physicians, three nurse practitioners, four physician assistants, and a whole host of people who make our system work. We deliver healthcare via three rural health clinics, two critical access hospitals that have inpatient units and emergency rooms, and four nursing homes. We serve about 12,000 people. There's no way that we could accomplish the things that we do without the team that we have. I'm here today to boast our system and to tell you how excited I am about it. The letter that I've submitted is actually written by one of our nurse practitioners, and they do have Integrated Practice Agreements with my partner. They do not pay a fee for that because they are part of the healthcare team. And what we do is deliver healthcare. I want...I'm excited to talk about this because this is what I signed up for. This is why I went to medical school for seven years. This is why I became a teacher of medicine, so that I could be a part of a group such as this that does a great job taking care of people. And we practice in an underserved area and so we like to think that they need it just as much as anybody else. So in response to the comment earlier, I don't think, necessarily, that some care is better than no care. I think our goal needs to be to deliver great care to everybody who needs it. One of the things that I love about this, and I said I signed up for this...the structure of medical education produces students who are teachers of medicine. So you transition from a junior medical student to a senior medical student, an intern, a resident, a supervisory resident, and into practice. And Dr. Bleicher alluded, once you get into practice, the learning curve is steep. This yields people who practice the art of medicine eventually, not necessarily the science of medicine. So please know that there's a difference. The science of medicine can be taught. It can be learned. It can be tested. It can be regurgitated. The art of medicine cannot. Developing the art of medicine is a process. It takes a long time. I've been in practice for five years and I'm getting there. I feel like I'm finally getting there. I have great help. In addition to being a teacher of medicine, I'm a

learner of medicine. I have a referral network that reaches from Denver to Des Moines. And there are some...and I get great help through that. But there are some expectations that go along with that. The physicians in my referral network expect that I've done an adequate workup of the patient and that I have the appropriate information to provide to them. Most importantly, my patients expect that I will access that network when I need them and we will get the help that we need. And my patients expect that I won't spend their money if we don't need to. These are the ways that I work alongside our physician assistants and alongside of our nurse practitioners to deliver great healthcare. Our nurse practitioners are as autonomous as they want to be. We have patients who prefer to see them in the clinic. And that is fine. We don't get them...we don't get in their way. They have different practice styles. Their schedules are structured differently. Oftentimes they're less busy than we are and they can spend more time with the patient and that's great. That's why we have them on the team. The difference, however, is that when those patients get sick and they need us the most we're also there. So when they're admitted to the hospital and they're acutely ill, we're right there beside them to help manage the patient. We don't take them...we don't take the patient away. We don't assume their care. We work right alongside them, but we're readily available whenever we need to be consulted. I do believe that the future of healthcare lies in this integrated team approach. I'm with Dr. Nohner. I have to say that I don't think this necessarily is solving the problem that we have. I think we need an integrated team approach, and I think we need to make sure that all members are accountable to one another. I will tell you that it makes me sad to hear about Integrated Practice Agreements if the physician and the nurse practitioner have never met, because neither of those people are holding each other accountable to each other. And that's not the way that we need to practice. Together we can deliver quality healthcare to remote, rural, and underserved areas. We need to establish the framework to do that and then support those systems that work. We cannot accomplish this by further fragmenting the healthcare system and by driving stakes between the disciplines. I would like to close, actually, by quoting our nurse practitioner. At the end of her letter, she said, "The fact that nurse practitioners add high value and absolute quality to physician care is well established." And I do agree. We ask that they augment, not replace, quality care offered by well-educated and trained physicians. That's all the comments I have and I'm happy to take any questions. [LB107]

SENATOR CAMPBELL: Thank you, Dr. Sell. Questions from the senators? Dr. Sell, thank you for doing and serving in an underserved area of the state. [LB107]

MICHELLE SELL: Yes. [LB107]

SENATOR CAMPBELL: Our next testifier is Dr. Richard Wurtz. Good afternoon. [LB107]

RICHARD WURTZ: (Exhibit 22) Good afternoon. Thank you, Senators. My name is

Richard Wurtz, R-i-c-h-a-r-d W-u-r-t-z, always misspelled, warts or something like that. I'm a medical doctor and a board certified family medicine physician. I'm going to summarize what I would like you to read in that and make it short. Medical licensure is earned through education, not legislation. The system of medical education for physicians is designed to ensure that we have the most comprehensive clinical training for, among other skills, health prevention...or health promotion, disease prevention, and treatment, as well as patient safety. This education is different than what nurse practitioners receive in kind, not merely in degree, as people have alluded to. And so I will try not to go into depth. But we are taught to diagnose and treat. We are also educated in tertiary care medical centers by expert scientists and clinical physicians. And then we go into residency where we have dedicated clinical staff who are dedicated to teaching. In fact, our first year in residency, they come into every patient visit in every room. These are physicians who publish data, who do research, and that's all they do. Five hundred hours of supervision is that teaching, is that right there showing didactic like that. And the 2,000 hours, I don't think that's it at all. That's where you're starting with nursing students. I have high esteem for nurses. My mother is still a nurse, certified oncology, still working full time, just so you know. I have taken nursing students in my office, RN students for the last 14...maybe 10 years, maybe a little over 10 years, because I've always insisted on having an RN as my nurse. And so we think it's very important to help nurses get education. These are nurses at the end of their Bachelor's of Science in nursing. And their excellent at...nurses. A lot of them are very good. And I think it's so important that I subject...some of my patients don't really like it, but I talk them up and say, here, they're going to learn, because they're very good, and I want to make sure of that. But they're not medical students. In fact, I'm going to start teaching medical students who will work also through my clinic, because there is a difference. I mean, there's a crucial role for both, but it is very important that there is a distinction made. I mean, it does a disservice to our relationship that I have to even call this to mind, okay? So keep in mind, also, that law is a teacher. One of the unfortunate ramifications of this bill, and those like it, is that since a nurse practitioner has been given permission to practice medicine without physician oversight, the patient will assume that this healthcare provider had been trained as a physician. This even happened this morning to a patient who said, oh, I saw Dr. so-and-so. I said, no, that's a PA. That's a PA. That's not a doctor. It happens all the time. How would they know, right? How would they know the difference unless it was explained every time? Well, extensive training is invaluable when you consider that a simple misdiagnosis or prescribing error can lead to significant morbidity or death. I saw the pulmonary embolism come into my office...new patient, 32-year-old guy, cough, shortness of breath, EKG normal. If you looked at the EKG, it was not normal...right heart strain, sent him to the CAT scan...pulmonary embolism. That happens all the time. Acute leukemia...Friday afternoon, the internist called me who admitted him. How did you get this on Friday afternoon? Well, I've been taught stuff. I'm not a genius. I'm not some, like, oh, look at, he's a genius. No. I've been educated. It's not a difference in intelligence. It's a difference in training. I mean, that's a critical distinction. So laws

governing medical licensure and supervision are meant to protect the public, not confuse them and certainly not to endanger them. Either a selective admissions process, a high standard of excellence in medical education to--among other things--diagnose and treat, extensive training supervised by experts, exhaustive objective testing, and rigorous certification followed by mandatory continuing medical education and recertification means something or it doesn't. You're opening a Pandora's box with this bill. It has ramifications for all professions, right? I mean, physical therapy assistants...nope, we're physical therapists. Oh, okay. Physicians assistants could practice on their own, right? So this is a very serious bill. And no emotional appeals or exceptions to rules or calls to catch up the profession to modern times will change the fact that this bill can destroy our profession and does a tremendous disservice to those physicians in training and patients soon waiting. I thank you for your time. I will take any questions you may have. [LB107]

SENATOR CAMPBELL: Thank you, Dr. Wurtz. Questions? No one? Thank you. Appreciate your testimony. Our next testifier is Dr. Phil McNeely. Good afternoon. [LB107]

PHILIP McNEELY: Good afternoon. Thank you very much. Actually, my first name is Joseph, but I go by Philip. [LB107]

SENATOR CAMPBELL: Oh, I'm sorry. [LB107]

PHILIP McNEELY: But that's okay. No, I go by Philip. I am board certified family doctor. I trained in Canada. [LB107]

SENATOR CAMPBELL: You need...we're going to stop right here. You just need to state your name and spell it. [LB107]

PHILIP McNEELY: Oh, I'm sorry. [LB107]

SENATOR CAMPBELL: That's quite all right. [LB107]

PHILIP McNEELY: Joseph, J-o-s-e-p-h, McNeely, M-c-N-e-e-l-y. [LB107]

SENATOR CAMPBELL: Go right ahead, sir. [LB107]

PHILIP McNEELY: Okay. So I'm a board certified family doctor. I trained in Canada, lived in Canada, worked in a rural area for nine years and then came to Nebraska. I do, I like to think, cradle to grave family medicine. I deliver babies. I look after babies. I look after old people. I also train nurse practitioners in my clinic and have for about the past ten years, usually a four-month stint, two or three times...one to two times a year. So I'm familiar with their basic knowledge, with their experience, with their training. And though

I, you know, enjoy doing it, I like them, I have them as friends, some of them are like my patients, they're not...they don't have nearly the depth of knowledge that a family practice resident or family practice doctor would have. They...you know, the bill is hoping to, I think, facilitate nurse practitioners to go out into the periphery and to practice in a rural area. And I think that's a disaster. They are not trained like Dr. Wurtz and some of the other...to handle those emergencies, those, you know, those complicated patients that live there. Case in point: When I was in Canada, I worked in a small area. There were 12 of us in the hospital. We lived about two hours from a large center, and we took residents--family practice residents--from McGill University, which is probably the best hospital in Canada and one of the best teaching hospitals in Canada. And we took their family practice residents for a month. And when they came to our hospital, we noticed that the vast majority of them were not prepared to handle the problems that we saw in the emergency because we didn't have any backup. They trained in a large hospital with a lot of specialists. So we developed, actually, the Rural Physicians of Canada. And we started to offer programs, CME, conferences, so these young doctors would feel real comfortable dealing with the emergencies without having resident backup, without having specialist backup. And so that's well-known in Canada. I just think, you know, the training that family practice residents get is far superior to nurse practitioners. And my concern is patient safety. The nurse practitioners work really well in collaboration with doctors. And...but to be independent on their own especially in the rural areas...I think that's dangerous. [LB107]

SENATOR CAMPBELL: Questions for Dr. McNeely? [LB107]

PHILIP McNEELY: Questions, Senators? [LB107]

SENATOR CAMPBELL: Thank you very much. [LB107]

PHILIP McNEELY: Thank you very much. [LB107]

SENATOR CAMPBELL: Our next testifier is Dr. George Voigtlander. While the doctor is proceeding to come forward, I have one other person on the list to testify, Ann Frohman. Is there anyone else in the hearing room who wishes to testify in opposition? Okay. Is there anyone in the room who wishes to testify in a neutral position? Okay. Thank you. I'm sorry. Go right ahead, Doctor. [LB107]

GEORGE VOIGTLANDER: (Exhibit 23) I'm George Voigtlander, speaking in opposition. Name is G-e-o-r-g-e V-o-i-g-t-l-a-n-d-e-r. As way of introduction, I'm a family physician from Pawnee City, a town of about 950 in the southeast corner of Nebraska. I've been in practice there for 34 years. I've also served on the Board of Advanced Nurse Practice for eight years and participated in the formulation of the regulations concerning that profession. Although I am from a very rural area in a corner of the state, I am familiar with many of the cities and towns of Nebraska. I was a medical director of the Medicare

Quality Improvement Organization and directed the beneficiary protection task. In the course of that work, I reviewed the care provided to Medicare beneficiaries by physicians, physician assistants, nurse practitioners, hospitals, nursing homes, physician offices, and ambulance services. This provided me with an understanding of the needs of both rural and urban patients as well as the medical personnel who try to meet their needs. I have collaborated with a number of advanced nurse practice...advanced practice nurses. I have never been compensated for any of these collaborations. For me, it's not a matter of money. It's a matter of safety. For me, the collaboration was a way to be sure that an APRN could have access to a physician advice and assistance to provide the optimal care to our patients and your constituents. Level of help needed varies. Some would call and discuss cases with me daily, others less often. The advanced practice nurses that have worked with me have all been dedicated to their patients, committed to providing the highest quality of care to them. Because of this commitment to their patients, they sought me out to collaborate with them to provide assistance in meeting this obligation. In one setting, a rural health clinic, by regulation I must not only collaborate but supervise the advanced practice nurses. In another setting, which receives federal entitlement funds, I must collaborate and evaluate the performance of the advanced practice nurses. Advanced nurse practice is a valuable service to rural patients. However, because of the differences in curriculum, intensity, and duration of training, they are not quite the same as a residency-trained family physician. Their communication skills, effective teaching skills, and different attitudes are complementary with the skills of a family physician in a rural practice. Rural practice has unique challenges: need for greater breadth and depth of education to recognize uncommon manifestation of common diseases and the uncommon more lethal diseases masquerading as an uncomplicated illness. The ability to discern these is only learned from long hours, in my case about 15,000 hours of residency, and exposures to many thousands of patients with all manners of need for diagnosis, treatment, and disease management. Challenges arise in rural practice. During a blizzard, our town was cut off from the rest of Nebraska and Kansas for three days. All highways were closed and weather prevented helicopters from flying. A young man managed to make it to our hospital after he had nearly amputated his finger. After a laborious repair and the grace of God, he has a perfectly functioning hand. I point this out because in rural Nebraska, you have to expect challenges unexpectedly. And when you are the only one there, you have to be able to salvage a disastrous situation. The argument has been raised that other states have eliminated collaboration. However, I find this argument invalid. Other states allow physician-assisted suicide, late term abortions, expanded Medicaid coverage, and have allowed for over-the-counter sale of Schedule I narcotics. Our Unicameral is unique not only in its constitution but in the independent thought that it has shown. The people of rural Nebraska need to be confident that their healthcare provider is equipped to deal with complex problems. We have set the bar high for our healthcare providers in Nebraska and the citizens deserve nothing less. I implore you not to lower it with LB107. Thank you very much for allowing me to express my opinions. [LB107]

SENATOR CAMPBELL: Thank you, Dr. Voigtlander. Questions? Senator Riepe. [LB107]

SENATOR RIEPE: Senator Campbell, thank you. Now, Doctor, are you in solo practice? [LB107]

GEORGE VOIGTLANDER: No. I am with two other physicians... [LB107]

SENATOR RIEPE: Okay. [LB107]

GEORGE VOIGTLANDER: ...one of which lives four miles out of town. The other commutes from Omaha. So in case of a blizzard, I'm the only one in town. [LB107]

SENATOR RIEPE: Okay. Thank you. [LB107]

SENATOR CAMPBELL: Senator Baker. [LB107]

SENATOR BAKER: Now, Dr. Voigtlander, do you currently have a signed supervision agreement with a nurse practitioner? [LB107]

GEORGE VOIGTLANDER: Yes, I do, with several. [LB107]

SENATOR BAKER: I'm just curious: Are those people salaried in your business or is it based on billing? [LB107]

GEORGE VOIGTLANDER: One is fee for service. The other two are salaried. [LB107]

SENATOR BAKER: Okay. My other question would be, when you bill insurance companies for services, is there any difference in which...in what the insurance companies will pay whether it's you or a nurse practitioner? [LB107]

GEORGE VOIGTLANDER: I'm not a very good businessman and my administrator really doesn't want me to know how that works. (Laughter) He just wants me to practice medicine. [LB107]

SENATOR BAKER: I understand. Thank you. [LB107]

SENATOR CAMPBELL: We all have those people who watch over us, don't we? [LB107]

GEORGE VOIGTLANDER: Yes, sir. [LB107]

SENATOR CAMPBELL: Any other questions from the senators today? Thank you for coming today, Dr. Voigtlander. [LB107]

GEORGE VOIGTLANDER: Thank you. [LB107]

SENATOR CAMPBELL: According to my take, we are at the last testifier for this hearing, Ann Frohman. Just let me make sure one more time, anyone else either side that might have come in? Excellent. Thank you. Good afternoon. [LB107]

ANN FROHMAN: Good afternoon. Last but not least...I appreciate the opportunity to be here. My name is Ann Frohman. For the record, that's spelled A-n-n F-r-o-h-m-a-n. I'm an attorney, although I don't go by doctor, so I'm not...I don't have any of the medical credentials that came before me. But I do represent as a registered lobbyist the Nebraska Medical Association. And I'm here just to kind of clarify a few points in terms of stressing what you heard today and how the Medical Association can help you continue to kind of find a path forward here. And in the testimony, I know there's been a discussion on the concern about safety, that it isn't a turf issue, that economics aren't there. We need care providers, and we need them desperately. We know that. The issue on safety, as we heard it, is one that's pretty sensitive because as the theme has been, well, if you don't know what you don't know on the provider side, that can be a challenge in delay of care. That can be a critical issue. But what we haven't talked about and what we want to help the committee with, is the issue of managing the expectations of the public, because what does the public know when they make a phone call to go see a nurse practitioner versus a physician? Are they in a position to know that, well, if it's chest pain, should I really be seeing a medical doctor versus a nurse practitioner? What do they know? I mean, what is the burden we are now putting on them? You know, do they drive by the NP to go to the M.D. that might be thirty miles away or wait a week? You know, these are the issues that I think this bill isn't going to resolve. Or when they call and make their request, who is doing the screening that, you really shouldn't see me, you've got to go on. Those are issues that I don't see resolved here that raise a concern. But what we think can help is...in this context is another bill that's being introduced this session, LB452, Senator Hilkemann's bill on trying to assist the public with some of the expectations. And that's on advertising and using your credentials. And we think that is a very good bill for consideration and ask that you weigh that as you weigh this because, in fact, what it does is it essentially gives the public as well as, you know, everybody a sense of, okay, what are these credentials? Let's start using them. We've worked hard for them. What do they mean? And I think that can go a long way. It won't solve all the problems, but it definitely is a starting point on the confusion side. We also talked about rural. This bill doesn't put any incentives in there for anybody to move into the rural. Now, I've heard, well, it removes a disincentive to leave the state. I don't know. My two daughters are in Iowa going to nurse practitioner...nursing school. And it had nothing to do with anything. They didn't know anything. That's...it's just...they want to run away from mom and dad. So we have other issues that you just can't legislate.

But with that said, the two issues that we're looking at and we're trying to help with in the rural area that we do think will make a difference is, look at student loans. You guys can make a difference here. And LB196, yes, is one of them, that we want you to take a look at and think about this problem in that context. There is more discussion we can have. The NMA stands ready to have those discussions. We have a great physician, Dr. Zetterman, who is all over this issue and he just has the knowledge base. So I think we can do this. We just haven't. They have in Kansas. They've done some great things in some other states, and we're falling behind, but we need the Legislature on those. Another rural issue, Senator Nordquist's bill, LB257, tackles telemedicine, or also known as telehealth. And while Medicaid picked this up last year, we believe that there's more than can be done. And this will be a difference maker, because when you're talking about psychiatric issues and dealing with the psychiatrists and the struggling there, what you have in this bill is setting the standards for what the insurance companies will look to when they want to pay on telehealth issues. And put that information out so providers know so that they can build their telehealth programs around something and know that it will be reimbursed. So we would ask that you consider those bills as you look at this in the context of trying to solve some of the bigger problems that we don't think this bill solves. If you want to solve some of these issues, we say tweak it. Don't tank the program. Work on the waivers. You can tie the costs with the costs of medical malpractice liability insurance. That is a true cost of providing the IPAs. So there's things that can be done. And with that, we just stand ready to help. [LB107]

SENATOR CAMPBELL: Questions? Senator Cook. [LB107]

SENATOR COOK: Thank you, Madam Chair. And thank you, not-Dr. Frohman. (Laughter) I guess, Mrs. Frohman/Ms. Frohman. Did you work with the committee...I'm sorry, with the sponsoring senator and her staff or did NMA work together on any of those ideas? There were three or four that sounded like interesting ideas: the tuition... [LB107]

ANN FROHMAN: I think... [LB107]

SENATOR COOK: ...the waiver. Did you talk about that during the interim? [LB107]

ANN FROHMAN: What...no, not this time. We hit an impasse. We did early on, thinking that, you know, the waiver process hasn't been used enough to be tossed. We just don't think there's a problem there. You know, we see the makeup of the committee that reviews those waivers as...you know, nurse practitioners are the majority. I mean, I believe...I've worked in the executive branch. I believe in it and know that you have this phrase called, exhaust administrative remedies before you, you know, pursue tossing stuff. And I don't know that that's been done. Sure, there's been a case. I acknowledge the challenges in North Platte. But I don't know that the Legislature is the answer for this sort of situation. I think we could do things outside of this. But in terms of the hours and

that sort of thing, no. But in terms of the process, yes, it could be tweaked. [LB107]

SENATOR COOK: Okay. Follow-up question. [LB107]

SENATOR CAMPBELL: Absolutely. [LB107]

SENATOR COOK: So what was the impasse, as you recall, that you met between when we adjourned last year, which was 2014, and now? [LB107]

ANN FROHMAN: Between last year and this year, nothing. [LB107]

SENATOR COOK: Okay, so there wasn't any conversation? [LB107]

ANN FROHMAN: I mean, we weren't in a position of bargaining power when we saw where we were with the votes last session. We still think the information is on our side. [LB107]

SENATOR COOK: Oh, I see. Thank you. [LB107]

SENATOR CAMPBELL: Other questions for Ann? And I...you know, we've had this discussion in the past. And part of the past...for the new senators, the reason this issue has come before the committee was the day that a nurse practitioner from the north central part of the state talked about having an Integrated Practice Agreement, never saw the doctor, he never reviewed any of her files, and just expected each year for her to send a $10,000 check. And I bring that up only because that was part of the genesis that drove the interest of the Health Committee in this issue and continues to drive our interests in all the issues you've articulated, Ann. [LB107]

ANN FROHMAN: And I think that's valid. I don't think this is the answer. The answer is, we should solve that problem and make sure that we have somebody available, make sure that the costs are reasonable. You know, I think you're throwing the baby out with the bathwater here. We just need to clean it up, but... [LB107]

SENATOR CAMPBELL: Thank you. Any additional questions or comments from the senators? Thank you, Ann, for your testimony. [LB107]

ANN FROHMAN: Thank you for your time. [LB107]

SENATOR CAMPBELL: That concludes our hearing for this afternoon. I...oh, I'm sorry. Senator...don't leave. Don't pack up. Senator Crawford has the right to close on her bill, and I apologize. (Laughter) [LB107]

SENATOR CRAWFORD: Thank you very much, Senator Campbell and colleagues. I

appreciate your thoughtful questions, and I appreciate the attention that everyone has paid to this. I just heard from a broad array of supporters including a physician, and you've just heard from over ten physicians and a lobbyist for the physicians in opposition. I'd just like to clear up a couple things for the record to make sure we have an accurate record. First, it was stated that the NMA invited nurse practitioners to discussion. And when I asked this morning, that was not the answer that I got. I do not believe there was an invitation. If an invitation was offered, I wasn't on the invitation list. So I just wanted to correct the record on that. I do want to say that for those who are concerned about patient confusion, LB452, which ensures that providers make their credentials clear, is a very important effort. And I have expressed to NMA my support of that bill. And actually, the nurse practitioners have also expressed support to the NMA on that bill. So the nurse practitioners are not wanting to confuse patients or pretend to be physicians. The nurse practitioners want to be nurse practitioners. And they want to be able to practice...nurse practitioners practice their practice to the full scope of their training and licensure. And we have seen again that in...we have 19 states and the District of Columbia where nurse practitioners practice without an Integrated Practice Agreement. And again, I want to emphasize that this is not nurse practitioners going out and being cowboys or cowgirls out there practicing by themselves and not talking to anyone else. Their practice act requires that they collaborate, consult, and refer. And as we've just heard, that's so much easier now with technology. So it's so much easier to establish those collaborations and make sure there are shared medical records and that there's good, clear communication between providers. The nurse practitioners are not wanting to practice without other...without physicians. They're not wanting to practice on their own without communication. They're wanting to provide what they provide best, which is good, quality patient care in consultation and referral networks. That's what they do. So they have a different kind of training as well as different hours of training, because they do something different. So it is true that we have complex cases that come into any primary care clinic. Now...but I assure you that there are complex cases in Iowa and in North Dakota and in Wyoming that come into those clinics. And we have over 40 years of evidence that nurse practitioners are able to provide safe and quality care, that there's no evidence that Integrated Practice Agreement is required in any way to protect patient safety. So it may be that a nurse practitioner makes a phone call or makes a referral. They do that. And it's important that you recognize that this is not a higher risk in our state because we are a rural state. If you look at other states that allow full practice authority, it includes many rural states such as our neighboring state of Iowa, such as Montana and Wyoming. Those are pretty rural states. And so we...none of those states have experienced patient safety failures that have caused any of them to think we should not allow nurse practitioners to practice with full practice authority. So it's very important to recognize that. And again, it's not...it is 40 years of study. And different institutes that have reviewed these studies and done meta-analyses of these studies include the Institute of Medicine in 2011, the National Governors Association in 2012, the Federal Trade Association in 2014. Medicine is changing, and the ability of providers to work in teams is changing. And all of these reviews of studies from a

variety of actors are all saying that it's important to allow nurse practitioners to practice with full practice authority to have safe and effective medicine. The Federal Trade Commission argues that it's important to not have these market restrictions in order to improve patient safety. And they argue that actually, when you put marketplace barriers in place, you restrict competition. And when you restrict competition, that can actually weaken patient safety. So that's an important argument that the Federal Trade Commission makes in terms of that. I do want to remind you again that there's no evidence of an increased number of liability claims in full authority states. So we have not seen more claims made in those full authority states. I also want to talk about some conflicting stats that were offered. It's all...I think often confusing when you hear one side give these stats and the other side give that stat. And sometimes it may be hard to figure out how they could both be true. Okay? So here's some different numbers from both sides and an explanation of how they could both be true. The nurse practitioners say that full...when you have full practice authority, you have a greater number of providers in rural areas. Okay? The NMA argues that the distribution of nurse practitioners in rural...doesn't change in rural areas. Okay? So how could those both be true? So let's just say right now for argument's sake...okay, right now we have over 50 percent of our people are in urban areas. So let's just say right now we have...imagine that we had a little over 50 percent of the nurse practitioners practicing in urban areas, and then the other half out across the state. So let's say that you doubled the number of nurse practitioners. Okay? So you might still have 50 percent of that doubled number practicing in those urban areas where half of your population is. So the distribution might not have changed, but, my goodness, the situation for people in those rural areas has changed greatly. You have twice as many nurse practitioners out there. Right? So the distribution may not change, but that doesn't mean that the number of nurse practitioners out there that are available to help serve those patients has not changed. So I also want to emphasize that there are many things that we need to do to improve healthcare...the future of healthcare in our state. And I've been so excited to work with Senator Campbell and Senator Gloor on those efforts about the future of healthcare. We need physicians and we need primary care physicians. We need to work on issues like loans, loan forgiveness, and those other issues. That's true. But that's not what this bill is about. This bill is about removing the Integrated Practice Agreement. We have many other bills on our plate to try to tackle those other problems that we also need to address. Removing the Integrated Practice Agreement doesn't...in no way prevents us from addressing all of those other important issues. And I also want to emphasize, I am a big fan of patient centered medical homes. And I've worked very closely with Senator Gloor on his effort on that front. And again, removing the Integrated Practice Agreement in no way reduces incentives for nurse practitioners to work in patient centered medical homes. All it does is it takes away an agreement with one physician. That's not integrated medicine. That's not team-based care. That's an agreement with one physician. The nurse practitioners want--and do already--collaborate, consult, and refer with whatever providers are appropriate for the patient that's in front of them. That's patient centered, team-based care, not a piece of paper with one doctor's signature on

it. So again, there are many things that we are going to discuss as a committee about how to improve patient care, many other things in addition to LB107 to do, but LB107 is a very important step in improving patient care for our patients in Nebraska. Thank you. [LB107]

SENATOR CAMPBELL: Thank you, Senator Crawford. We need to have for the record, the letters that we've received. So Brennen, I'm going to let you go through that. [LB107]

BRENNEN MILLER: (Exhibits 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) Letters of support: OneWorld Community Health Center, Nebraska Board of Nursing, American Association of Nurse Practitioners, Behavioral Health Support Foundation, Ginger Brasuell, and Cassie Banks. In opposition: Dr. Deepak Gangahar, Nebraska Academy of Family Physicians, Dr. Michael Eppel, American Psychiatric Association, Dr. Leslie Spry, Complete Family Medicine LLC, American Medical Association, Dr. Steve Lazoritz, American Society for Dermatologic--thought I was going to mess that one up--Surgery Association, Dr. Richard French. In the neutral position: the Nebraska Department of Health and Human Services. [LB107]

SENATOR CAMPBELL: Okay. I think that's all that I have on my desk, unless the senators saw anything different. So with that, we will conclude the hearing today for LB107, and I really want to thank both sides, because there was a concerted effort to move the hearing along. Thank you. [LB107]