[LB1011 LB1061 CONFIRMATION]

The Committee on Health and Human Services met at 1:30 p.m. on Thursday, February 25, 2016, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB1011, LB1061, and a gubernatorial appointment. Senators present: Kathy Campbell, Chairperson; Sara Howard, Vice Chairperson; Roy Baker; Sue Crawford; Nicole Fox; Mark Kolterman; and Merv Riepe. Senators absent: None.

SENATOR CAMPBELL: (Recorder malfunction)...of the Health and Human Services Committee. I'm Kathy Campbell and I serve as Chair for the committee and represent District 25 in east Lincoln. So we will start this afternoon with introductions. And Senator on my far right, would you like to start us out?

SENATOR KOLTERMAN: My name is Mark Kolterman, senator from District 24: Seward, York, and Polk Counties.

SENATOR BAKER: Senator Roy Baker, District 30: Gage County, part of Lancaster County.

JOSELYN LUEDTKE: Joselyn Luedtke, committee counsel.

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

ELICE HUBBERT: I'm Elice Hubbert; I'm the committee clerk.

SENATOR CAMPBELL: And our page?

CAITLIN WELTY: I'm Caitlin Welty; I'm a political science major at Nebraska Wesleyan from Omaha, Nebraska.

SENATOR CAMPBELL: Just a reminder to everyone that if you have a cell phone make sure it's on silent or turned off, because it's very disheartening when you're testifying and there's something ringing in the background. Our first hearing this afternoon is a confirmation hearing for Dr. Laeth Nasir. Dr. Nasir, would you come forward please and have a chair? And the confirmation is to serve on the Rural Health Advisory Committee. Doctor, am I pronouncing your name correctly? [CONFIRMATION]

LAETH NASIR: Exactly correct. Thank you. [CONFIRMATION]

SENATOR CAMPBELL: This is not a grueling testimony, let me tell you. What we're trying to do is really kind of have a dialogue between the committee and yourself. And we always start with, tell us a little bit about yourself. [CONFIRMATION]

LAETH NASIR: Okay. So I'm currently the chairman and a professor at Creighton University School of Family Medicine. I've been in my job currently since 2011. I've been in the state since 1989. I came and I worked at the University of Nebraska Medical Center for almost 20 years before I left the state for a couple of years and then came back to my current position. [CONFIRMATION]

SENATOR CAMPBELL: Okay. I want you to know that I was leafing through...you have an extended vitae and a lot of published articles. But I would like you to tell us a little bit about the interim years that you were gone. And you were in the--I'm going to make sure I say it right--United Emirates. [CONFIRMATION]

LAETH NASIR: Correct. I was in the United Arab Emirates. I was the chairman of their family medicine department at the main university there. [CONFIRMATION]

SENATOR CAMPBELL: And what prompted you to take the position there? [CONFIRMATION]

LAETH NASIR: Well, one of my research interests, one of my main research interests, is primary care mental health in Arab countries. And so that was a very attractive position for me to take and to do some research while I was there. [CONFIRMATION]

SENATOR CAMPBELL: Interesting. And you were there for a period of what, two years? [CONFIRMATION]

LAETH NASIR: Yes. About two, two and a half years, yes. [CONFIRMATION]

SENATOR CAMPBELL: And then came back. I am always pleased to see someone from family medicine be willing to devote time to one of the advisory boards or commissions that we have because that's such an important gateway in medicine and the health of Nebraskans in family medicine. So are we recruiting enough students to family medicine, Doctor? [CONFIRMATION]

LAETH NASIR: Well, it's never enough. You know, I'm really, really pleased to be back in this state. And I think what we have in Nebraska--because I've worked in a lot of different places--I think what we have in Nebraska is really unique. And I think we've started the work of training enough family physicians, particularly to work in rural areas, but we really...it's an ongoing struggle and we face some new challenges now with the way that healthcare is going. Healthcare is becoming increasingly corporatized. And with that, there are lots of economies of scale and so on and so forth that are going on. And I think that's a challenge for us, particularly in Nebraska, because training somebody who has a broad training that they need for family medicine in rural areas is an expensive and difficult process. And it's really not necessarily the most efficient way to...or some people would say it is not the most efficient way to train a medical professional. However, it's critical for our rural areas. For example, even if you look at ancillary medical staff--nurses, NPs, and so on and so forth--if they can't train and understand, for example, pediatric patients and geriatric patients, if they can't do all of that then we really are disadvantaging some of our population. And so I see it as one of my focuses in this commission to make sure that we keep our eye on the ball of doing this for our state. [CONFIRMATION]

SENATOR CAMPBELL: Well, we've been spending time this session learning about primary direct care, Senator Riepe's bill, which is a different way of approaching primary care. But it has been fascinating to watch the dialogue about it. Are you very well versed in that, Doctor? [CONFIRMATION]

LAETH NASIR: I'm familiar with it, yes. [CONFIRMATION]

SENATOR CAMPBELL: I'm sure Senator Riepe would spend a lot of time bringing you up to speed about it. [CONFIRMATION]

SENATOR RIEPE: More than you'd want. [CONFIRMATION]

LAETH NASIR: Yes. [CONFIRMATION]

SENATOR CAMPBELL: He can give you a lot of information. But it has sparked, I think, a good discussion. I'm hopeful, as the bill comes to the floor, that it will spark more discussion about the importance of primary care and what that can mean for the health of Nebraskans. So your service in family medicine on the Rural Advisory would be critical, I would think, to giving a different perspective. [CONFIRMATION]

LAETH NASIR: I hope so. [CONFIRMATION]

SENATOR CAMPBELL: Questions? Senator Kolterman. [CONFIRMATION]

SENATOR KOLTERMAN: Yeah, I just have one question. Do you have a daughter that's an MD as well? [CONFIRMATION]

LAETH NASIR: No. [CONFIRMATION]

SENATOR KOLTERMAN: Okay. I thought she did a family practice rotation...similar name. [CONFIRMATION]

LAETH NASIR: Oh, okay. Is this Rima (phonetic)? [CONFIRMATION]

SENATOR KOLTERMAN: Pardon me? [CONFIRMATION]

LAETH NASIR: Rima, perhaps? Was this a number of years ago? [CONFIRMATION]

SENATOR KOLTERMAN: About five years ago. [CONFIRMATION]

LAETH NASIR: You know, I know her. She's not related to me though. [CONFIRMATION]

SENATOR KOLTERMAN: Okay. Thank you. [CONFIRMATION]

SENATOR CAMPBELL: Senator Riepe. [CONFIRMATION]

SENATOR RIEPE: Thank you, Senator Campbell. A question I have: Out of Creighton, what percentage of residents, if you will, end up going...or staying in Nebraska, I guess, and then going out to maybe the more rural parts? I spent a number of years at Bergan and we always referred to you as, Creighton is the University of California at Creighton. [CONFIRMATION]

LAETH NASIR: Yes, yes, that's very true. So, you know, there's a little bit of a silver lining there, because if you look at the map, if you take the map of the United States...I've seen some data from one of our family practice organizations and you are able actually to see where all of your graduates are practicing in the United States. And Creighton has this huge--I mean, it's almost every state in the Union, Puerto Rico, Hawaii, everyplace. And there's not very much in Nebraska. So there's a little bit of a silver lining there in that we get some awfully good publicity for Nebraska and people really...all of our medical students really look fondly upon their state. Unfortunately, in the last generation...if you look a generation ago it was, indeed, Creighton that

was populating all of these towns in Iowa and Nebraska or many of them. However, with the way that tuition has changed and the way that things have gone, essentially there have been more and more people from California, from other states coming to Creighton. And it's just like anybody else, it's difficult to ask somebody to stay someplace that's not home for them. So it's just natural for them to go back home. And I think this is one of the things that I have noted a number of times to the administration in our university is that we do need to try and develop a pipeline of Nebraska kids to come through Creighton and really to help repopulate... [CONFIRMATION]

SENATOR RIEPE: Sort of an academic walk-on program? [CONFIRMATION]

LAETH NASIR: Yeah. Yeah. [CONFIRMATION]

SENATOR RIEPE: Well, we're very fortunate to have two schools of medicine in the state of Nebraska. [CONFIRMATION]

SENATOR CAMPBELL: Exactly. [CONFIRMATION]

SENATOR RIEPE: Thank you, Chairman. Thank you, sir. [CONFIRMATION]

LAETH NASIR: Thank you. [CONFIRMATION]

SENATOR CAMPBELL: Well, and I also think whenever we've had discussions with regard to issues or bills and Creighton people have testified, I also know that Creighton does a good job of recruiting from all across the nation. And most likely that's why you're seeing the diversity of states represented at Creighton. Probably does more recruitment across the country than UNMC does I think. [CONFIRMATION]

LAETH NASIR: Yes, that is true. [CONFIRMATION]

SENATOR CAMPBELL: I do want to ask you the question and, colleagues, the pages aren't numbered on here, but I am fascinated by the innovation you listed. A concept and development of a slide rule device, a "Nebraska Billing Device" for gauging clinical levels of care. Invention marketed and over 14,000 copies sold nationally to more than 80 academic and private medical groups between 2002 and 2008. Oh, Doctor, you have to explain that one. That sounds interesting. [CONFIRMATION]

LAETH NASIR: Well, I'm not sure if you're familiar with the way that now medical bills are paid. So when you see a patient, there are several levels of complexity that you can bill for. And when this first came out, I was really bedeviled by the fact that it was very difficult to keep all of this in your head. So I developed this really just for my own edification and to help me; and it caught on...ended very well. Now, these are all built into computers and so on and so forth. It's the same principle, but at the time just having a slide rule--and being old enough to know what a slide rule was--I was able to build on that and use that. [CONFIRMATION]

SENATOR CAMPBELL: It's amazing. [CONFIRMATION]

SENATOR RIEPE: Isn't that a wheel? [CONFIRMATION]

LAETH NASIR: There are wheels. There are slide rule wheels. [CONFIRMATION]

SENATOR RIEPE: I remember seeing that I think. [CONFIRMATION]

LAETH NASIR: But the classic one was actually like a ruler that you would pull back and forth and you could do your multiplication and your square root on it. That was the big thing in those days. [CONFIRMATION]

SENATOR CAMPBELL: And now we do all that on computers. But I was fascinated by that. So people aren't using your slide rule anymore. [CONFIRMATION]

LAETH NASIR: And that's probably a good thing. It's one less thing that you have to carry around in your pocket, but when this...when we first started, we really didn't use computers in medicine much. [CONFIRMATION]

SENATOR CAMPBELL: Interesting. [CONFIRMATION]

LAETH NASIR: This was almost pre-Internet or around the time the Internet was started. [CONFIRMATION]

SENATOR CAMPBELL: Right. Because of your contacts worldwide, have you been able to recruit some of those students to come to Creighton? [CONFIRMATION]

LAETH NASIR: You know, we have actually a large contingent of students from the Gulf States who do come to Creighton and actually have been coming to Creighton. I have had a number of

people who have come because they've known that I was here, but not to medicine but to other programs. [CONFIRMATION]

SENATOR CAMPBELL: Oh. Colleagues, I would hope that you have a couple of minutes to really thoroughly look through the doctor's vitae and information of curriculum that has been developed. We are very fortunate to have you in the state of Nebraska. And we certainly thank all of the people who come step forward and make our boards and commissions and advisory committees work. And the Rural Health Advisory Committee (sic) is an extremely important committee (sic) and has testified a number of times before the Health and Human Services Committee. So I would invite, at any point if you feel there's information that would be helpful to the Health and Human Services Committee, please forward it on and we would be glad to...articles or whatever you think might be helpful. That's how we learn it and certainly we do a better job at what we do here because of all of you. So thank you very much and thank you for coming today. [CONFIRMATION]

LAETH NASIR: Thank you for inviting me. It's so nice to have met you all. [CONFIRMATION]

SENATOR RIEPE: Thank you. [CONFIRMATION]

SENATOR CAMPBELL: Yes. Thank you. Is there anyone in the hearing room who wishes to provide information on this confirmation? Okay. Thank you very much and we will proceed with the hearings for the day. And, Senator Baker, would you mind being in charge while I introduce? And I'll give you the agenda so you can announce the bill. [CONFIRMATION]

SENATOR BAKER: We will now open the hearing on LB1011. Senator Campbell. [LB1011]

SENATOR CAMPBELL: Thank you, Senator Baker and colleagues. I was reminded the other day that this is my last bill introduction. So it's short and sweet I can tell you. My name is Kathy Campbell, K-a-t-h-y C-a-m-p-b-e-l-l, and I represent District 25. LB1011 was introduced at the request of the Department of Health and Human Services to update provisions regarding managed care contracts in the Medicaid program. Since the department is moving to integrated physical and behavioral health and pharmacy benefit managed care contracts, they felt the existing statutes were outdated and would hinder their ability to contain costs and provide performance incentives. The department is here today. Mr. Lynch, the director, is sitting behind me and will be able to explain the change more fully and answer any questions you may have. I do want you to know that I had a chance this morning to visit a little bit with Senator Krist. Senator Krist was the senator who introduced the original legislation that you look at and can see the changes that are being made. It was Senator Krist's work with Director Vivianne Chaumont, who at that point was the Medicaid director, and put this legislation into effect. I've also had

occasion to visit with the director of NABHO and NABHO has no concerns or brought forth any comments and said it was fine as it was and to go. So with that, I'll finish my opening and encourage you to wait on those technical questions for Director Lynch. [LB1011]

SENATOR BAKER: Thank you, Senator Campbell. Any questions? None. [LB1011]

SENATOR CAMPBELL: Thank you. [LB1011]

SENATOR BAKER: Thank you. All right. First proponent. [LB1011]

CALDER LYNCH: (Exhibit 1) Thank you. Good afternoon, Senator Campbell, Senator Baker, and members of the Health and Human Services Committee. My name is Calder Lynch, for the record that's C-a-l-d-e-r L-y-n-c-h, and I'm the Director of the Division of Medicaid and Long-Term Care within the Department of Health and Human Services. Today I'm here to testify in support of LB1011. Thank you again to Senator Campbell for introducing this bill which will allow additional flexibility for us in contracting for our managed care programs. To provide a little bit of context, Nebraska Revised Statute 71-831 passed in 2012 prescribes financial and operational requirements for the administration of Medicaid behavioral health managed care. This statute was implemented in the context of a stand-alone behavioral health managed care program. That's one where we have a direct contract with an entity to provide for behavioral health services as a carve out. As Nebraska Medicaid moves toward a fully integrated delivery system for medical, behavioral health, and pharmacy services under the Heritage Health Managed Care Program, the provisions required by the statute pose some significant administrative challenges for the state and its contracted health plans. LB1011 will remove these administrative challenges. I want to start by thanking the leadership and the members of the Nebraska Association of Behavioral Health Organizations or NABHO for working collaboratively with us to draft this legislation. The original statutory language was put in place in large part to their efforts and I very much appreciate their willingness to revisit the language in the context of our evolving program. I want to assure the committee that the spirit of the original statute remains. What is more, the Heritage Health plans will be required to meet the proposed requirements of the Centers for Medicare and Medicaid Services, or CMS, for medical loss ratio and actuarially-sound rates that provide further protections regarding the dollars we invest in these services. However, there are three provisions required by the current statute that inhibit our full ability to realize the financial and health outcome advantages of integrating benefits and services through Heritage Health. These provisions include: the incentive requirement, the cap on administrative spending, and the cap on profits and losses. Currently, the statute includes a requirement for a 1.5 percent withhold of the premium payments, the premium payments being the payments we made to the plans. This is also referred to as an incentive requirement. The statute requires that any unearned portion of these funds, when they don't hit those incented

metrics, in addition to other performance contingencies imposed on the plans by the department, such as sanctions, be spent exclusively on reinvesting into behavioral health-related services. We have worked to revise these requirements to give the department greater flexibility regarding the amount of the incentives, clarify that reinvestment funds also include any other remittances that we receive under the new medical loss ratio requirements, meaning any dollars they return to the state because they didn't meet that MLR, and, given the nature of the fully integrated contracts that include physical health, pharmacy, and behavioral health services, permit the use of those reinvestment funds to address a broader array of healthcare needs. The second provision, the administrative cap, as written in the current statute, is out of sync with the new medical loss ratio requirements that are in our contracts and in proposed federal rule. And it restricts the ability to health plans to invest in their care management programs. The proposed language aligns the cap with the MLR provisions and ensures that the health plans are able to adequately invest in quality improvement activities while still providing the necessary protections to ensure that taxpayers are protected and expenses are appropriate. And thirdly, under current law, the insurer is guaranteed that profits and the insurer--I mean the Heritage Health plan--is guaranteed that profits can be up to 3 percent per year and losses cannot exceed 3 percent per year. In addition to the profits, health plans would also be able to earn incentives of 1.5 percent of all income. The total costs of the Heritage Health program will exceed $6.9 billion over five years. Profits over 1 percent for comprehensive integrated contracts is a significant amount and will artificially inflate the overall costs to the program. This provision is also redundant to the medical loss ratio requirements that already provide protections on spending. This bill recognizes this in allowing the department additional flexibility in setting the caps on profits at amount lower than 3 percent but no greater. It also allows us to remove the cap on losses, as this may not be appropriate after the first year of the contracts. Part of the reason for moving into an at-risk contract is to reduce the risk that the state has and transfer that risk to the health plan. The cap on losses maintains some of that risk on the state. Thank you for the opportunity to testify before you today regarding LB1011, which we believe will help us continue our mission of helping people live better lives. I look forward to future conversation with this committee as we work to improve the care of the most vulnerable in our state. And I'm happy to answer any questions that you might have. [LB1011]

SENATOR BAKER: Thank you, Mr. Calder. Any questions? Senator Riepe, do you have a question? [LB1011]

SENATOR RIEPE: Yes, sir, I do. And thank you, Mr. Chairman. Director Lynch, thank you for being here. I have actually two questions right now. And the first one is, I think you said--correct me if I didn't hear this wrong--I thought you said, return funds if they do not meet targets. Does that mean...I always like to hold the funds as opposed to trying to get the funds back. Is that part of the plan that they would have these funds? [LB1011]

CALDER LYNCH: Well, there are really...so we have I think several ways of protecting the dollars that are being...it's a great question. And one of those is the withhold, which is the 1.5 percent investment requirement, which will continue; but this gives us some greater flexibility around...those are dollars that get held to the side that they can't access. [LB1011]

SENATOR RIEPE: Up front? [LB1011]

CALDER LYNCH: Up front. And if they don't meet certain targets, then those dollars have to then be put back into reinvestment spending. They won't earn them unless they hit the quality targets that we set in place. The medical loss ratio then provides a back-end stop to make sure that at least 85 percent of all dollars that are given to them in premium are spent on qualified health services. And if they fall below that amount, any...the difference must be returned to the state. [LB1011]

SENATOR RIEPE: Are all these targets set prior to implementation of services so that everybody knows what the rules are as they go into the game, if you will? [LB1011]

CALDER LYNCH: The contracts spell out the process. And, of course, by bidding on the contracts and signing them they agree to those terms. We've only defined the metrics for the first year of the contract. And we have the flexibility for those to evolve as our priorities change as we look at what areas we really want to focus on. And we're going to be doing that with the help of our quality committee, where we'll be engaging providers and stakeholders and consumer advocates in helping determine what those metrics are in which we're going to put into the incented payment program. [LB1011]

SENATOR RIEPE: Okay, thank you. I have one more. Senator Krist...it's been a couple of...I think I was brand new and he had expressed some concerns that I think an incentive was paid but the incentive never went beyond management in terms of that. And I think he came back with some other language that provided some incentive that went to the staff workers within the contract holder, if you will. That was maybe before your time. Is that just my imagination or is...do you remember that, that he came a couple years ago? [LB1011]

SENATOR CAMPBELL: I'll come back at the closing statement. [LB1011]

SENATOR RIEPE: Oh, good; Senator will come. I think that was before your time. [LB1011]

CALDER LYNCH: And the reinvestment (inaudible)...the requirements that are in the contract require they go back into services to make sure that we're investing those dollars in services. [LB1011]

SENATOR RIEPE: Okay. Again, thank you. [LB1011]

CALDER LYNCH: Absolutely. [LB1011]

SENATOR BAKER: Senator Kolterman. [LB1011]

SENATOR KOLTERMAN: Thank you, Senator Baker. Calder, thank you for coming today. My question deals primarily with...I mean, we're entering into some managed care and we've not had a lot of managed care in the system up until now, as I understand it, other than behavioral health. I know we've done a lot with Magellan. What kind of...at least not to this extent...so what kind of potential savings do you expect by moving in this direction versus what we've had in the past. You would have a little bit of history with Magellan, so if you could just address that. Don't go into a lot of detail, but just brief us on that. [LB1011]

CALDER LYNCH: Absolutely, Senator. I'll tell you we have actually had physical health managed care in Nebraska for nearly 20 years, starting with the first contract with UnitedHealthcare in the mid-'90s in just the Omaha region. It slowly expanded through several expansions of the program a few years ago to being statewide. So the majority of our recipients today are in physical health managed care through one of three other health plans besides Magellan. But there are certain services that are carved out, like pharmacy. And behavioral health is a separate contract. And then there are some individuals in the program who are excluded from physical health managed care that will be coming in as part of Heritage Health. So certainly Heritage Health is an expansion of managed care in that we are bringing pharmacy services in for the first time, integrating behavioral health services, and then bringing some smaller populations in that have previously been excluded. But we're not expecting to see significant initial saving just because we do have such a long history on physical health managed care. And that did include the hospital side, which is where most of those savings would come from. We certainly think it helps us manage the growth of the program and we're particularly interested in some of those...there are savings for some of those new populations that were assumed as part of this. And that was built into the capitation rates up front whenever they were built by our actuary. [LB1011]

SENATOR KOLTERMAN: Correct me if I'm wrong. Did we have capitation rates in the old plans, as well? [LB1011]

CALDER LYNCH: Yes, sir, we did. [LB1011]

SENATOR KOLTERMAN: I didn't think they were as broad as this one is. [LB1011]

CALDER LYNCH: This is certainly broader, but it did include the vast majority of hospital services, which is where your most dollar is going to be. [LB1011]

SENATOR KOLTERMAN: Okay, thank you. [LB1011]

CALDER LYNCH: Absolutely. [LB1011]

SENATOR BAKER: Any further questions of Mr. Lynch? Thank you, Mr. Lynch. [LB1011]

CALDER LYNCH: Thank you very much for your time. [LB1011]

SENATOR BAKER: We'll take the next proponent. [LB1011]

TOPHER HANSEN: (Exhibit 2) Senator Baker, Senator Campbell and members of the committee, my name is Topher Hansen, I'm president and CEO of CenterPointe and a member of the executive committee for the Nebraska Association of Behavioral Health Organizations. Let me just start by saying the reason I stopped before I testified to shake Calder's hand was because I've been doing this 23 years and that was the first time I've ever heard anybody from his seat say something that I completely agreed with. And I hope that doesn't undermine your testimony, but...so that's to... [LB1011]

JOSELYN LUEDTKE: Could you please spell your name before we start. I'm sorry. Thank you. [LB1011]

TOPHER HANSEN: Oh, sure. Nobody ever asks that. T-o-p-h-e-r, and last name is Hansen, H-a-n-s-e-n. Thanks for reminding me. So that's to give you an indication of how we have been able to work with Medicaid and Long-Term Care around this statute. So the Nebraska Association of Behavioral Health Organizations, for those of you who aren't familiar with the organization, is an association of consumers, five of the six regional behavioral health authorities, and providers, including several hospitals and community-based providers. I'm here today on behalf of the 42 members of NABHO. Again, thank you, Senator Campbell, for introducing this bill. And NABHO comes in support of what we believe to be a useful modification of the original statute passed to provide structural guidelines for managed care organizations doing business in

Nebraska, in particular the behavioral health managed care organizations. This law was originally suggested by NABHO and carried by Senator Krist as a structure to assure that MCO's spending, profits, and reinvestments were in line with the intent of the contract awarded. Previous experience with behavioral health in managed care in Nebraska left many providers wanting to pin down the details of the contract so there was no question about the spending, the performance, and the accountability. Most of the current behavioral health managed care contracts emanated--that is, the one that's in play right now with Magellan--emanated from a document developed and submitted by NABHO to the state in response to an RFI, request for information. This statute governing the spending structure was a parallel effort by NABHO to be certain we did not revisit our previous experience with managed care providers. This law set the boundaries on the use of the money awarded in the contract so everyone knew how much must be spent on care, how much administrative money was available, and how much could be lost or earned as profit. NABHO met with Medicaid Director Lynch and his staff and corresponded about the changes to the statute that appear in LB1011. While we did not agree term for term initially, we were able to arrive at an agreement on the language that we believe is realistic to the business environment in managed care and provides protection to the interests of the state, providers, and consumers. LB1011 is our new proposal for a game plan. Of course, great execution is required to bring to life a well-conceived game plan. And NABHO is willing to continue working with HHS and the Division of Medicaid and Long-Term Care to assure there is sufficient execution to meet the intent and the letter of the law. So, again, thank you to Senator Campbell and to each of you for all your support and thoughtful consideration in supporting the behavioral health system. It's been instrumental, I can tell you, to the consumers who receive services, to the providers in being able to deliver those in a reasonable business environment--although, I must say strained--and really helped us to move forward. The current environment is carrying us further in that direction so that we're able to do business in a reasonable manner in ways that make sense to help people get better sooner for longer. And that's the goal of a good health system. Thank you. [LB1011]

SENATOR BAKER: Thank you, Mr. Hansen. Questions? Senator Riepe. [LB1011]

SENATOR RIEPE: Thank you, Senator. My question, which jumps out at me on the first paragraph there says, five of the six regional behavioral health centers. And my Curious George in me wants to know why not six of six? [LB1011]

TOPHER HANSEN: Region 2 has elected not to be part of our group and I couldn't tell you the reasons. [LB1011]

SENATOR RIEPE: How long have they elected not to? [LB1011]

TOPHER HANSEN: Oh, I think a couple of years now. And they have been in previous years, but have elected the last couple of years not to be part of it. I couldn't tell you the reason. Kathy could tell you better. [LB1011]

SENATOR RIEPE: And that is, they don't belong to CenterPointe, is that right? [LB1011]

TOPHER HANSEN: No. They don't belong to NABHO, the statewide organization. CenterPointe is an organization that is one of the members of NABHO. [LB1011]

SENATOR RIEPE: Okay. And CenterPointe is a... [LB1011]

TOPHER HANSEN: We're a private, not-for-profit behavioral health organization here in Lincoln providing an array of services to mostly adults. [LB1011]

SENATOR RIEPE: And you have a volunteer board or you... [LB1011]

TOPHER HANSEN: A volunteer board, yes. [LB1011]

SENATOR RIEPE: Okay. Okay, thank you. [LB1011]

TOPHER HANSEN: Yeah, you bet. [LB1011]

SENATOR BAKER: Any other questions of Mr. Hansen? Thank you. [LB1011]

TOPHER HANSEN: Yep. Thank you. [LB1011]

SENATOR BAKER: Next proponent. Seeing none, any opponents? Anyone in a neutral capacity? Senator Campbell to close. [LB1011]

SENATOR CAMPBELL: I'd better answer the questions. Senator Riepe, I just want to clarify for the record, Mr. Hansen referred to, probably better that Kathy answer that question. That's not me. That would be Kathy Seacrest, who is the regional Region 2 coordinator--director--I'm not quite sure what the term is. And I think Region 2 is around North Platte; it's in a different part of the state than we have. I want to go back to Senator Riepe's question having to do with Senator Krist's bill. The bill that he brought forward was to ensure that the amount of money that was allocated by the Appropriations Committee went to the behavioral health providers as was understood when it went through the appropriations process. He has, I think, had a second bill to

do that, however, since we're going to a whole new contract all of that is probably history and we will be working under this new arrangement. So I don't think Senator Krist will be bringing forward anything other...in future years he may. But with the new contracts it will be totally obsolete. [LB1011]

SENATOR RIEPE: Okay. Thanks for clarifying that. I just remembered parts of it. [LB1011]

SENATOR CAMPBELL: No, great memory on your part. And I appreciate Director Lynch being very thorough in going through this with you so that you have some understanding in the future of how this is going to operate. And no doubt, in the years to come you're going to hear a lot more about the managed care. And so Senator Kolterman's questions about how long has this been in effect and what should we be looking for...you're going to have those questions coming forward, that's for sure. Good job. [LB1011]

SENATOR BAKER: Do you have anything further in closing, Senator Campbell? [LB1011]

SENATOR CAMPBELL: I do not, Senator Baker. Thank you for standing in. [LB1011]

SENATOR BAKER: Thank you. [LB1011]

SENATOR CAMPBELL: Would you call the next bill for me? [LB1011]

SENATOR BAKER: This closes the hearing on LB1011 and now we will open LB1061. Senator Kolterman. Any items for the record? [LB1011]

ELICE HUBBERT: There are no items for the record. [LB1011]

SENATOR BAKER: I knew there weren't. [LB1011]

SENATOR CAMPBELL: Thank you, Senator Baker. I appreciate your designated hitter status here. Senator Kolterman, your bill, I think, is on the Surgical Technology Registry Act, so you go right ahead. [LB1061]

SENATOR KOLTERMAN: (Exhibit 1) You have a new amendment coming around, hot off the press. So let me open and then I'm going to let you ask the difficult questions of those that follow. Senator Campbell and members of the Health and Human Services Committee, my name is Mark Kolterman, M-a-r-k K-o-l-t-e-r-m-a-n, representing District 24, here to open today on

LB1061, the Surgical Technologist Registry Act. Consider this legislation companion legislation to Senator Baker's LB721, which we just advanced to General File with a committee amendment and dealt with licensure of surgical first assistants. Both of these bills are important for public safety in the state of Nebraska. Both have gone through the 407 credentialing and review process. The surgical first assistants are more skilled and experienced operating room technicians that perform several functions including suturing, above what a surgical tech would perform. Almost all surgical first assistants are surgical techs before they attain the higher level skills. Consider surgical techs the entry level to a profession that has become a critical part of every surgical team, directed by the surgeon. LB721 and LB1061 both update our healthcare delivery in the state by putting in statute the reality of what is going on in every operating room in this state. During the LB721 surgical assistant hearing you heard that the bill came from 407 review last fall and was approved by the department last month. That process and report also approved a surgical technologist registry. The two professions were involved in that application process coordinated by the Nebraska Hospital Association. Also during last fall's surgical first assistants 407 review, the problem of physicians delegating tasks to unlicensed personnel was brought to light. Nebraska is the only state in the country that does not have a statute that deals with this delegation issue. Instead, we rely on very old case law from 1898 that seems to tell us that such delegation is not allowed, even though we know it happens every day in hospitals and surgical centers all across the state. In fact, this issue is what required the 407 process for surgical first assistants in the first place. It is also a problem for surgical technologists, the entry level to the profession, and at a much higher degree. There are almost 800 surgical technologists in the state and 16 surgical first assistants. Licensing surgical assistants was necessary not only to regulate an important healthcare provider in the operating room, but also presented the same problem for technologists. If they could not perform with direction from the surgeon as unlicensed personnel, that too could present critical problems in the future. And so when the first 407 was approved, members of the 407 committee suggested that surgical technologists put their own 407 application in for licensure, specifically to deal with the unlicensed personnel designation problem and ensure that they could continue to be working in the operating rooms across the state legally. So a second 407 application was submitted for licensure of surgical technologists in the fall of last year. During that process the physicians determined that dealing with the delegation issue was important for surgical technologists to deliver their service under the direction of a surgeon and that another way should be considered allowing for delegation to unlicensed personnel under the supervision of a physician...again, something that is in statute in every other state but not in Nebraska. Surgical technologists have only wanted a registry with competency requirements. The second 407 application allowed them to work with the Department of Health and Human Services and the 407 committee to fully understand the tasks and functions of the profession and the need to either license a profession or allow for the surgeon to delegate and to establish competencies for the profession. This second 407 review concluded last month with the 407 committee approving the surgical technologist licensure and acknowledging the importance of establishing competencies and oversight by the Board of

Medicine and Surgery. The 407 recommendations were not approved by Courtney Phillips, however, but she did identify a need for a registry for surgery technologists. I believe there's a significant need for both surgical technologists and surgical assistants to be regulated by the state for the safety of our citizens. LB721 deals only with part of the problem. LB1061 closes the circle by establishing a registry with competency and education standards under the Department of Health and Human Services. I've submitted an amendment to LB1061 for the committee's consideration. The amendment was developed after consultation with licensure division of the department and the Nebraska Medical Association. Thank you for your time today. There will be several experts behind me that can go into a great more detail on how we have come to this point. And I would be available for questions that I might be able to answer at this point in time. [LB1061]

SENATOR CAMPBELL: Questions, Senators? Senator Riepe. [LB1061]

SENATOR RIEPE: Thank you, Senator Campbell. Senator Kolterman, good to have you here. The question that I have is, and if we need to we can defer, but when this is a registry act, is that the same as licensure or certification? [LB1061]

SENATOR KOLTERMAN: I think we'll let them address that, because they're going to talk about concerns, both pro and con, of that. This is primarily just a registry, as I understand it. [LB1061]

SENATOR RIEPE: Okay. Would anyone that would qualify here, would they be eligible then for temporary license? [LB1061]

SENATOR KOLTERMAN: I don't believe so, but I don't know the answer to that. [LB1061]

SENATOR RIEPE: I also have a question about, is it...on page 1 of the amendment there it talks about at least 19 years of age. Is that emancipation age? Is that the reason from a liability standpoint? [LB1061]

SENATOR KOLTERMAN: That's the emancipation age in Nebraska, yes. [LB1061]

SENATOR RIEPE: I was just curious. You might have some student that finished high school at 16, yada yada yada, and ended up at 18 they're ready to go. I was just curious. [LB1061]

SENATOR KOLTERMAN: Many and most of these surgical technologists do go through an education process that, I believe, takes 18 months, two years. I think in many cases they get an

associate degree at the entry level and then they sit for some exams just like other...there's some question about the education...there's going to be some questions posed later about the education concerns, probably on an opponent perspective. So I'm sure those questions will be answered for you. [LB1061]

SENATOR RIEPE: Okay. Fair enough, good. Thank you. Thank you. [LB1061]

SENATOR CAMPBELL: Any other questions, Senators? Thank you, Senator Kolterman. And I'm sure you'll be here to close. [LB1061]

SENATOR KOLTERMAN: I'm sure I will. [LB1061]

SENATOR CAMPBELL: Our first proponent. [LB1061]

CASEY GLASSBURNER: (Exhibits 2, 3) Chair Campbell and members of the Health and Human Services Committee, I am Casey Glassburner, C-a-s-e-y G-l-a-s-s-b-u-r-n-e-r. I am currently serving as the president of the Nebraska State Assembly of the Association of Surgical Technologists. This organization is the local chapter of our national association that represents the interests of surgical technologists as well as surgical assistants in the state of Nebraska. Nebraska's 800 surgical technologists are allied health professionals who are integral members of operating room teams across the state. They work under the indirect supervision of the registered nurse and the direct supervision of the licensed independent practitioner to facilitate the safe and effective conduct of surgical procedures throughout the state. Once the procedure is begun, and throughout its duration, the surgical technologist is directed by the surgeon who is scrubbed in at the sterile field standing alongside the surgical tech. Surgical technologists in this state are educated at two accredited surgical technology programs located at Nebraska Methodist College in Omaha and Southeast Community College in Lincoln, which offers their program on-line via distance education, allowing them to serve the entire state. A third surgical technology program at Western Community College in Scottsbluff is likely to achieve accreditation by fall of 2016 as well. Unqualified surgical technologists can cause harm to surgical patients by: poorly maintaining a sterile operating room resulting in an increased number of surgical site infections; poorly assembling sophisticated surgical equipment; improperly decontaminating and sterilizing surgical instrumentation, again, increasing the number of surgical site infections; and by slowing down surgical procedures resulting in unnecessary risk associated with the patient being under anesthesia for an extended period of time or experiencing excessive blood loss. The technical review committee for the surgical technologist 407 agreed that there is a need to establish minimum education and competency standards for surgical technologists in this state. A few of their comments included: From Dr. Gaden--the technical complexity of the functions of surgical technologists has made it necessary to create a more consistent education and training standard;

and from Dr. Sandstrom--there is potential for harm to the public inherent in the current situation of surgical technology services, and there is a need to create consistent education and training standards for those who provide these services. There is a need for some kind of disciplinary process under a regulatory board. Regulation by the state would improve the ability of employers to prevent unqualified, unsafe, or impaired surgical technologists from working in Nebraska. Courtney Phillips, CEO of the Department of Health and Human Services, also voiced her support of minimum competency standards in her review of the application stating, I agree that there is a need to provide greater assurance that surgical technologists are adequately trained and educated to do their job safely and efficiently. A copy of Courtney's review has been provided for your reference as well. The surgical technologist 407 seeking licensure with oversight by the Board of Medicine and Surgery was approved by the technical review committee. The application was unsupported by the Board of Health and Courtney Phillips. The lack of support from the two latter reviewers was related to their belief that a license was not necessary but that, rather, a registry was more appropriate. The Board of Health, as well as Courtney Phillips, agreed and expressed their belief that action was necessary to provide surgical patients better assurance of the competency of every member of their surgical team. LB1061 establishes a registry that will accomplish this, administered by the Board of Medicine and Surgery, with minimum education requirements that will greatly improve surgical patient care. This bill also includes language that will allow delegation to unlicensed personnel as it is allowed in all other states and permit surgical technologists to continue to function as they currently are and have been for several previous years. It allows the interactions that occur every single day in operating rooms across the state between the surgeon and the surgical technologist to continue. A grandfather clause will be included in LB1061, as well, to allow individuals who have been employed as surgical technologists for the five years prior to the effective date who do not meet the education and certification standards to become registered. These individuals will not have to return to school, they will not have to sit for a certification exam. They will simply have to complete the required paperwork proving that they have employment as a surgical technologist in that five-year period. The goal of this registry is not to put individuals out of employment. It is to put necessary education and competency requirements for surgical technologists into statute that will greatly improve surgical patient care. As Ms. Chasek of the surgical technologist 407 technical review committee stated, there is a need for assurance of competent practice in this area of healthcare. Surgical patients are very vulnerable and have no say regarding which surgical technologist is working when their surgery is being conducted. It is the firm belief of our organization that every surgical patient in this state deserves a certified surgical technologist. Thank you for your attention and your time. At this time I'm available for any questions that you may have. [LB1061]

SENATOR CAMPBELL: Questions, Senators? Senator Riepe. [LB1061]

SENATOR RIEPE: Thank you, Senator Campbell. Again, I guess my question comes up when we (inaudible). I'm not sure why we always use the term grandfather. I'm not being critical, I just don't know where we come up with that. But my question gets to be is, when we do this quote unquote grandfathering, do we serve the interest, then, of the patients or do we serve the interests of the individual employee? And, quite frankly, you know, I have to be real honest. I'm more interested in preventing damage or danger to the patient than I am to any individual. And so that's...it's just maybe an editorial comment of little note. But the other question I have regarding the licensing, is there a written test and (inaudible) and sort of an intern oversight so that some people, as you know, test well but can't do the job and vice versa? [LB1061]

CASEY GLASSBURNER: There is a national exam that is utilized that is administered by the National Board of Surgical Technology and Surgical Assisting. It's utilized in every state that has requirements of their surgical technologists. They adopt that national exam and utilize that as the standard that has to be achieved prior to gaining employment in those states that do have that requirement. To answer...sure, somebody could pass the test and then they may...you know, it's just minimum competency that it is attempting to assess. So beyond that there are many technical skills that...surgical technologists can become specialized in certain fields, such as working on a heart team or being on a robot team or doing neurosurgery, that is definitely going to require education beyond the minimum competence. What we're asking for is just the basic safety measures and the basic education that is going to reassure the patients that the people standing in that room know what they're doing and they're not going to be liable to make errors that someone standing in that position shouldn't be making. [LB1061]

SENATOR RIEPE: Do you also ask for maybe even anonymous references from coworkers, people that see them every day? [LB1061]

CASEY GLASSBURNER: As a requirement of the registry or...is that what you're asking? [LB1061]

SENATOR RIEPE: Of being licensed. And do you do drug testing? I'm guessing, of course, you do. [LB1061]

CASEY GLASSBURNER: So the employers do initial drug testing and criminal background checks when...in general, surgical technologists are employed by a hospital or a surgical center. Occasionally, they may be independently employed by a surgeon, but for the most part they're employed by a facility. And, yes, most of those facilities do conduct criminal background checks and drug testing and random drug testing on their employees. [LB1061]

SENATOR RIEPE: And this would also apply for like surgical centers or minor surgery? [LB1061]

CASEY GLASSBURNER: Yes. [LB1061]

SENATOR RIEPE: So it's not tied to the institution, it's tied to the individual? [LB1061]

CASEY GLASSBURNER: Yes, absolutely. [LB1061]

SENATOR RIEPE: Okay. Thank you very much. [LB1061]

CASEY GLASSBURNER: Yes. Thank you. [LB1061]

SENATOR CAMPBELL: Senator Baker. [LB1061]

SENATOR BAKER: Thank you. Ms. Glassburner, are surgical techs now certified? [LB1061]

CASEY GLASSBURNER: Yes, they are by that national organization. However, it's not a requirement so there are some that are and there are some that are not. [LB1061]

SENATOR BAKER: Okay. So, in your mind, would being registered be the same as being certified? [LB1061]

CASEY GLASSBURNER: That's what the base requirement is, is that they have to attend an accredited surgical technology program, sit and pass the national certification exam. [LB1061]

SENATOR BAKER: Thank you. [LB1061]

SENATOR CAMPBELL: Okay. We had some questions when we dealt with surgical first assists on the grandfathering portion of that and spent numerous amendments trying to get the right language. And eventually, it was like a two-year probation. Are you familiar with that...the amendment for that though? [LB1061]

CASEY GLASSBURNER: Yes. [LB1061]

SENATOR CAMPBELL: Okay. How would that...if we tried to make them similar or to ensure...do you have any comment about that? [LB1061]

CASEY GLASSBURNER: I believe the grandfather was mimicked after the one that was finally approved before it was sent to General File, so we did try to mimic that, because it was approved by the department, as much as possible. [LB1061]

SENATOR CAMPBELL: Okay. Okay. Other questions? [LB1061]

SENATOR RIEPE: I have one more, please, Senator. [LB1061]

SENATOR CAMPBELL: Senator Riepe. [LB1061]

SENATOR RIEPE: I want to go back to a question that I had asked maybe earlier to talk about. Do you have any provisions for temporary licensures? [LB1061]

CASEY GLASSBURNER: We do not, yeah. [LB1061]

SENATOR RIEPE: You do not. [LB1061]

CASEY GLASSBURNER: And I guess maybe there's a little bit of discrepancy. We're not asking for a license anymore. Initially, the 407 was seeking licensure for surgical technologists. We are simply asking for a registry with minimum education and competency requirements. The original registry that was approved in the first assistant 407 did not have the education requirements attached to it that we really think are necessary in order to improve surgical patient care in this state. [LB1061]

SENATOR RIEPE: So you're either, you're in or you're not in. [LB1061]

CASEY GLASSBURNER: Right. [LB1061]

SENATOR RIEPE: Bingo. [LB1061]

CASEY GLASSBURNER: Yes. [LB1061]

SENATOR RIEPE: Okay, thank you. Thank you. [LB1061]

SENATOR CAMPBELL: Okay. Anything else, Senators? [LB1061]

CASEY GLASSBURNER: Thank you. [LB1061]

SENATOR CAMPBELL: Thank you. Our next proponent. [LB1061]

JOHN TENNITY: Senators, comic relief time (inaudible). My name is Dr. John Tennity, J-o-h-n T-e-n-n-i-t-y. I'm a foot and ankle surgeon here in Lincoln, Nebraska, for the past 25 years and was asked to testify today. I did serve on the 407 committee for the surgical technologists review. Background on me: I did serve on the Board of Health for eight years as the podiatrist member for the Board of Health. I did...I was chair of the professional boards committee in that...for the Board of Health and I've also chaired two of the 407 committees for genetic counseling and dental assisting. So hopefully some of my testimony today is really more for you guys to ask questions, whether it be about the process, what happened in some of those meetings, and maybe some of the questions that might be burning at your minds. I do think the proposal, as given to you today, is...I do support it wholeheartedly. It is a compromise. Initially, the surgical technologists came for licensure, not for registration. Our 407 committee felt that we voted for licensure. The Board of Health and the medical director thought that registry was the more appropriate way to go. But underlying all of it was the education requirement. I think what people don't really understand in the surgical environment, you have an anesthesiologist, you have a surgeon, you have surgical technologists. And currently right now, there is no minimum education requirement for surgical technologists in an operating room and I don't think that's a good thing. But I would love to hear questions. [LB1061]

SENATOR CAMPBELL: Okay. You can count on Senator Riepe. Senator Riepe. [LB1061]

SENATOR RIEPE: I'm known as Curious George, so there you go. [LB1061]

JOHN TENNITY: Sure, yeah. [LB1061]

SENATOR RIEPE: My question would be is, have you rejected anyone that's applied? [LB1061]

JOHN TENNITY: Well, I do not currently employ a surgical technologist. Surgical technologists are employed by, usually, a facility, whether it be an operating...or a hospital or a surgical center. So that question would be best to ask for someone in charge of that at the hospital. Now, you know, some of this legislation also includes our ability as surgeons to delegate to certain members in the operating room. And the original reason for some of this coming up was that Howard Paul case from 1898 that said physicians could not delegate to unlicensed personnel in

the operating room. From a practical standard that doesn't work. We've been delegating to people for many, many, many years. And often, we're under the guidance of case law that said, the surgeon in the operating room is the captain of the ship. That being said, the department sought--how do you say this?--the department was relying on this old case law for their guidance and this bill does cover that and this bill does alleviate that problem. Did I answer your question? [LB1061]

SENATOR RIEPE: Yes, because you said that you had not rejected anyone because you hadn't had the situation. [LB1061]

JOHN TENNITY: I did own a surgery center at one point. And requirements for my surgery center was formal education and certification. All the facilities that I provide surgery at here in Lincoln or in Crete Area Medical Center, they all do require formal education for their surgical technologists. [LB1061]

SENATOR RIEPE: Part of it I was trying to sort out is, what is the difficulty for becoming registered or licensed? Is the entry point fairly low or that's... [LB1061]

JOHN TENNITY: Well, application...the surgical technologists can tell you about the application requirements for their program. But it is an 18-month program and, at the end of that program, they are tested and certified. There's a lot of vested interests. If there's any questions regarding that, I can provide some insight on that, what the 407 technical review committee came up with and things along those lines if you have any questions in that regard. [LB1061]

SENATOR CAMPBELL: Senator Crawford. [LB1061]

SENATOR CRAWFORD: Thank you, Chairwoman Campbell and thank you for being here to testify. And I apologize if I'm asking you to review something that was already said. I was presenting a bill in another committee. [LB1061]

JOHN TENNITY: No. [LB1061]

SENATOR CRAWFORD: So in the discussion that you had, you said you were on the technical review committee? [LB1061]

JOHN TENNITY: I was on the technical review committee. [LB1061]

SENATOR CRAWFORD: Okay. [LB1061]

JOHN TENNITY: That committee submits its recommendations to the Board of Health. [LB1061]

SENATOR CRAWFORD: Okay. So for that committee, or just in general on the discussion, so there was a request for a licensure. Now what's in the bill is a registry, but also in the bill is a certification requirement. And so I guess my first question is, what do you see as the difference between licensure and certification? Is there something? The bill is not just a registry at this point. It looks like the bill also says that you need to be certified. [LB1061]

JOHN TENNITY: Well, what the bill says now is you have to have a base-line education before you can be hired or utilized as a surgical technologist. There are three schools that do this. They have an 18-month program and, at the end of the program, you sit for your certification exam. So you have to do the program, but you do have to pass the certification at the end of the program. And I think the statistics bear out; if you complete the 18-month program your chances of becoming certified are very, very high. [LB1061]

SENATOR CRAWFORD: Is there a difference in how the technical review board treats licensure versus certification? Is there a difference in what that means to you, or? [LB1061]

JOHN TENNITY: Well, licensure versus registration is probably a better discernment. Licensure is a more restrictive form of oversight versus registration. [LB1061]

SENATOR CRAWFORD: Right. But this is registration plus certification. [LB1061]

JOHN TENNITY: This is registration plus education, where registration alone would be a list of names and licensure would be beyond that. This was the compromise. So our committee voted to advance the more restrictive licensure. The Board of Health and the medical director felt that from the surgical first assistants 407 that registration would be adequate. Okay? But I don't think anybody was against educational component of it. It's like saying you're against puppies, I guess. But I think the educational component, even on my committee, on the committee that I served on...Dr. Sandstrom was an old Board of Health member and teaches physical therapy...and he was very adamant that he thought that education was an important part of whatever moved forward. I don't know if that helps. [LB1061]

SENATOR CAMPBELL: Did you have a follow-up, Senator Crawford? [LB1061]

SENATOR CRAWFORD: Right. No, I think you're saying that you were on the committee that actually would have recommended licensure in the first place. Right. And so requiring education, certification was consistent with your discussion in your group? [LB1061]

JOHN TENNITY: Correct. [LB1061]

SENATOR CRAWFORD: All right. Thank you. [LB1061]

SENATOR CAMPBELL: Other questions? Senator Fox. [LB1061]

SENATOR FOX: Yeah, so I understand that the goal here is to assure that we've got entry level proficiency, but I know a lot of licensed and certified professionals also have to have ongoing continuing education. And so are...I mean is that...I guess I'm not...is that an eventual plan is to outline specific... [LB1061]

JOHN TENNITY: I would imagine continuing...the ladies behind me can tell you differently. It's my understanding that continuing medical education is in the registry. [LB1061]

SENATOR FOX: But was that left...I mean, I'm not seeing... [LB1061]

JOHN TENNITY: I do believe it's in the current one. [LB1061]

SENATOR FOX: Okay. [LB1061]

SENATOR CAMPBELL: Okay. Dr. Tennity, I just want to be clear for the record. You were a part of the second 407 review? [LB1061]

JOHN TENNITY: Correct. [LB1061]

SENATOR CAMPBELL: Not the first? [LB1061]

JOHN TENNITY: Not the first, correct. Those are two different committees. [LB1061]

SENATOR CAMPBELL: Yes. And they recommended somewhat different things, maybe. [LB1061]

JOHN TENNITY: You know, yeah. Our committee recommended...we thought licensure was fine. That's what the proponent group was after, was licensure. The surgical first assistant committee recommended registration for the surgical technologists and that's essentially where we're at today. [LB1061]

SENATOR CAMPBELL: Okay. So the first 407 is the one that really used the word registration on a registry. And you went farther... [LB1061]

JOHN TENNITY: We went licensure. We thought licensure, where Board of Health and the Medical Director felt registration was (inaudible). [LB1061]

SENATOR CAMPBELL: One of the issues is the grandfathering of somebody in. Did you address that? [LB1061]

JOHN TENNITY: We did. [LB1061]

SENATOR CAMPBELL: Can you talk a little bit, just so we're very clear about that? [LB1061]

JOHN TENNITY: Sure. The thought process behind grandfathering, any profession goes through a continuum of education. And there are currently people in the state of Nebraska acting as surgical technologists that have a vast, long history of providing excellent care, etcetera, etcetera. And what I think this group was trying to not do is alienate them and put them out of a job. So some grandfathering was incorporated into the bill, similar to years ago when we changed the scope of practice in podiatry. There was some grandfathering that had to go on because the education in the past wasn't quite to the same level as it is currently. And to ask those that have been practicing for 20 years to go back and do something like that is a little unfair. So I think the committee recognized that the grandfathering would need to be included in that. [LB1061]

SENATOR CAMPBELL: Okay. Any follow-up questions, Senators? Thank you, Dr. Tennity. [LB1061]

JOHN TENNITY: You're very welcome. [LB1061]

SENATOR CAMPBELL: And thank you for your service. [LB1061]

JOHN TENNITY: Oh, thank you very much. [LB1061]

SENATOR CAMPBELL: Many years of service. [LB1061]

JOHN TENNITY: That's where all the hair went. Thank you. [LB1061]

SENATOR CAMPBELL: Our next proponent. [LB1061]

CYNTHIA KREPS: (Exhibit 4) Good afternoon, Senator Campbell and committee members. My name is Cynthia Kreps, C-y-n-t-h-i-a K-r-e-p-s. I have been a certified surgical technologist for 37 years. Seventeen of those years I have also held the certified surgical first assistant credential. My role as a surgical technologist includes, but is not limited to: preparing the surgical suite by opening sterile supplies and instruments; ensuring that septic principles and practices are enforced throughout the entire process of setting up and the duration of the surgical procedure; assembling the instruments and supplies; assisting the surgeon by anticipation; handing surgical instruments and supplies while working with a circulator nurse and under the supervision of the surgeon. When I first started my career in 1978 the most complex cases we did were open bowel resections, gall bladder removals, total joints that consisted of only three options of small, medium, or large implants. We had one or two pans of instruments to open and minimal equipment. Now the cases are so complex we assist in robotic procedures, endoscopic coronary artery bypass, complicated total joints, and multilevel spinal fusions. We can open up to 23 instrument sets for one total joint procedure and it is not uncommon to open 10 to 15 sets of instruments for a single surgery. Not only are there several pieces of sophisticated equipment to prepare, you must also have the technical skills to troubleshoot any problems that may arise during surgery. Twenty years into my career as a surgical technologist I decided to expand my skills and become a surgical first assistant. At that time, the only option was to complete the experience route. I partnered with two trauma surgeons at my facility and they agreed to be my preceptors. Within three years I completed the required 350 cases and then I sat for my boards through the National Board of Surgical Assisting and Surgical Technology. There are basically four skills that a surgical first assistant does that differ from what a surgical technologist can do. A surgical technologist will hold a retractor that has been placed by the surgeon where a surgical assistant may place that retractor independently. The surgical assistant can inject subcutaneous local anesthetic, close the subcutaneous and skin layers of a wound, and approximate skin edges while staples are being placed by the surgical technologist. Throughout my 17 years of practice as a certified surgical or first assistant most of my day was spent in a surgical technologist role scrubbing in, setting up for the case, and handing instruments. When the procedure was completed the surgeon would step away from the table to do their postoperative dictation. I would then step over and finish closing for the surgeon. This is an example of dual roles for the surgical technologist who is also a surgical first assistant. The majority of the surgical first assistants in the state of Nebraska are employed in this dual role capacity. If the surgeon requested a surgical first assistant ahead of time, I would fill that position and then the remainder of the day I would function as a surgical technologist. In the Lincoln hospitals this is common

practice. I was employed by the hospital to function in each role when needed. And I am aware that this may differ in other cities, but all duties are done within the surgical first assistant's recommended practice. Nebraska has 800 surgical technologists, 14 practicing surgical assistants. As previously stated, these two professions are so similar in the skills and duties that it is necessary to regulate both professions to assure the public of quality patient care. Thank you for this opportunity to speak with you and I will be happy to answer any questions you may have. [LB1061]

SENATOR CAMPBELL: Thank you, Ms. Kreps. Questions? Senator Riepe. [LB1061]

SENATOR RIEPE: Yes, thank you, Senator. I guess I'm still trying to get my head wrapped around the duplicity of both the surgical first assistants and licensed surgical technologists. And you know we're talking more about cross-training, not...and the only thing...the image that comes to my mind is the carpenters that one hangs the door but the other one has to be there to put the hinges on. It doesn't make a whole lot of sense to me in terms of...a pet peeve of mine is needless duplication. And it seems to me like the jurisdictional pieces in here are significant and rather meaningless or wasteful or frustrating. Can you help me to better understand, because I even add onto that the third one is, if you're not licensed then it's registry. And I'm kind of going like, you know, you almost have to wear jerseys with numbers on them to tell who's who. [LB1061]

CYNTHIA KREPS: Right. A surgical technologist...to be a surgical first assistant you are a surgical technologist first. And in order to go through the process or to attend a school...there are a few schools out there that are not CAAHEP accredited programs that you can walk in off the street and become a surgical assistant. But the majority of the programs require you to be a surgical technologist first, with several years of experience under your belt. And then you can start the process, like I said, of accumulating your cases and your experience. And then you would qualify to sit for your boards. So the duplication...it is a duplication, it's a dual role. So the majority of the surgical first assistants do function as a surgical technologist. Surgeons...when insurance came to a point where they said that...insurance companies said this to the surgeon: you could not have a second surgeon as an assistant. That's when the surgical first assistants came about. So, say, if they were doing a gall bladder, a laparoscopic gall bladder, the insurance company said you can no longer have a second surgeon and bill for that. And so that's when the surgical first assistants kind of came around, so we were able to step in and fill that role so we had some additional duties and things that we could do that a surgical technologist couldn't do. Does that answer your question? [LB1061]

SENATOR RIEPE: It does in part. The part...I'm frustrated with the idea that the insurance company can come in and determine whether it's in the patient's best interest. [LB1061]

CYNTHIA KREPS: Well, that is totally out of my control. [LB1061]

SENATOR RIEPE: My only inclination is, just for clarification, would be is to have a technologist one, a two, and a three, and if...you know, so that you say...sequentially, from when you're communicating or talking to families where you're trying to explain during a jury trial who's on first and who's on second here, the terminology just...and I worked 30, 40 years in the healthcare business and it's still confusing to me, so. [LB1061]

CYNTHIA KREPS: I understand. [LB1061]

SENATOR RIEPE: I might not be the sharpest knife in the drawer, but you know you kind of... [LB1061]

CYNTHIA KREPS: I would very much like to help you understand that. But it does get...you know, we're not discussed to the family. I mean, when the surgeon talks about anything, we're the unsung hero. [LB1061]

SENATOR RIEPE: So they don't tell the family that you're doing the closing on the case? [LB1061]

CYNTHIA KREPS: No. [LB1061]

SENATOR RIEPE: I see. Okay. That's really good. Thank you. [LB1061]

SENATOR CAMPBELL: Other questions, Senators? So in your description, following up on Senator Riepe's question, a "surgi tech" can hold the instrument that the surgeon may say to them: you can actually apply that instrument. Am I saying that right? [LB1061]

CYNTHIA KREPS: Yeah. And we're talking about, like, a retractor. It's just something as simple as just placing it. A surgeon will place it, get it positioned, make sure that vital structures are protected. A surgical technologist will grab ahold of it. The surgical assistant is expected to have some more expertise. And that's based on the fact that they've been a surgical technologist for three or four years prior, so that base knowledge is already there. We all utilize the same amount of knowledge. I'm going out on a limb here, but as far as I'm concerned--and I am a surgical first assistant--I'm a surgical technologist with added skills. There are things I can do that a surgical technologist can't do. [LB1061]

SENATOR CAMPBELL: And is that laid out in a scope of practice? [LB1061]

CYNTHIA KREPS: Recommended practices set by AST, our Association of Surgical Technologists and Surgical Assisting. There are recommended practices that are set out. And if you look at them side by side they are (hand gestures). Until just a few extra things they're exactly the same. [LB1061]

SENATOR CAMPBELL: So when you're in the operating room, then a surgical first assistant and a surgical tech are both under the direction of the surgeon? [LB1061]

CYNTHIA KREPS: Absolutely. [LB1061]

SENATOR CAMPBELL: Okay. Because I think we're going to hear some other, perhaps, testimony differently than that. Or the question is, should all these surgical techs be under the Board of Nursing rather than the Board of Surgeons? [LB1061]

CYNTHIA KREPS: We are working under the direction of the surgeon. When we are at that OR table, we are being directed by the surgeon. [LB1061]

SENATOR FOX: I do have a question. Since we're getting into layers I'm going to make it a little more difficult. So where does, say, a physician assistant fit in who works in a surgical setting...with the continuum then, the step up from the first assist? [LB1061]

CYNTHIA KREPS: If the surgeon has a physician's assistant, a physician assistant then works in the office and then comes and assists in a surgery and they do the closing and things like that. A surgical first assistant is not needed and so we would not be involved. If...when I'm working, I'll be just working in the capacity of a surgical technologist. [LB1061]

SENATOR FOX: Right. All right. Thank you. [LB1061]

SENATOR CAMPBELL: Now we're all going to know exactly how to identify the people when we go in. [LB1061]

CYNTHIA KREPS: Yes, you are. More than you wanted to know, right? [LB1061]

SENATOR CAMPBELL: Having gone through surgery for...I doubt that we're going to be lucid enough to really say, are you a surgical tech? Yeah, I doubt we're going to have that, but at least we'll know it, won't we? Thank you. [LB1061]

CYNTHIA KREPS: Yes, you will. And they're going to make sure that your procedure is sterile and they're going to make sure your instruments are sterile. They are the last line of defense to keep you safe. [LB1061]

SENATOR CAMPBELL: Thank you for your testimony today. Our next proponent. [LB1061]

MATT SCHAEFER: Chairwoman Campbell and members of the committee, my name is Matt Schaefer, M-a-t-t S-c-h-a-e-f-e-r, representing the Nebraska Medical Association today in support of LB1061. In the 407 process that's been alluded to, the NMA was opposed to licensure of surgical technologists, but we are supportive of the registry component of the bill, versions I've seen before today; I don't think I've seen the amendment that was passed out. But I also want to stress the importance of the language on page 5 of the introduced copy, the inclusion of that so that the state is not relying on an 1898 court case to figure out what is and what isn't unlawful practice of medicine. That's all I have for you. Thank you. [LB1061]

SENATOR CAMPBELL: The amendment strikes the original section, so we will double-check that the original that you talk about is in agreement. [LB1061]

MATT SCHAEFER: Excellent. [LB1061]

SENATOR CAMPBELL: Correct? That's what you're asking of us? [LB1061]

MATT SCHAEFER: Yes. [LB1061]

SENATOR CAMPBELL: Yes. Questions? Senator Howard. [LB1061]

SENATOR HOWARD: Thank you, Senator Campbell. Thank you for visiting with us today. Can you tell me the reasoning behind why the NMA doesn't support licensure? [LB1061]

MATT SCHAEFER: I think it's just an unnecessary step. [LB1061]

SENATOR HOWARD: Sort of a paperwork and administrative burden? [LB1061]

MATT SCHAEFER: I think, yeah. [LB1061]

SENATOR HOWARD: How is that different than the registry then? [LB1061]

MATT SCHAEFER: I think it's a little bit less testing, would be my guess. There would be no state administered board exam for the licensure component, but I'd have to check on that. [LB1061]

SENATOR HOWARD: And we don't accept national exams for licensure currently? [LB1061]

MATT SCHAEFER: It would be probably profession specific on that, would be my guess. [LB1061]

SENATOR HOWARD: Okay. And then right now a surgeon can delegate to an unlicensed individual? [LB1061]

MATT SCHAEFER: Well, according to the 1898 case, you could read it that it wouldn't be allowed to do that. [LB1061]

SENATOR HOWARD: So why wouldn't the NMA support licensure then? [LB1061]

MATT SCHAEFER: Of? [LB1061]

SENATOR HOWARD: Surgical techs. [LB1061]

MATT SCHAEFER: I think it was just kind of an unnecessary step to go that far. Registry is sufficient. [LB1061]

SENATOR HOWARD: But if they're not allowed to delegate to somebody who's unlicensed, then they're not technically licensed under a registry. [LB1061]

MATT SCHAEFER: I think the language would go further than delegating to an unlicensed person. [LB1061]

SENATOR HOWARD: Is a registry a licensure? I apologize. I don't mean to stump you, if you'd like to, sort of, double back with your folks and circle back with us later, that's fine. [LB1061]

MATT SCHAEFER: Yeah. I think the language that I've seen in the introduced copy wouldn't require licensure to be delegated to. [LB1061]

SENATOR HOWARD: So we don't require licensure in order for an MD to delegate specific tasks? [LB1061]

MATT SCHAEFER: Well, I think that's part of the confusion is that it appears that the 1898 case would require licensure or registry. [LB1061]

SENATOR HOWARD: And so do we...or registry. So the case specifically says licensure or registry? [LB1061]

MATT SCHAEFER: I don't think it says registry. And I think this is part of the problem that the language would address on page 5. [LB1061]

SENATOR HOWARD: Which language addresses that problem? [LB1061]

MATT SCHAEFER: Page 5 of the green copy. [LB1061]

SENATOR HOWARD: Is that removed by the amendment, though? [LB1061]

MATT SCHAEFER: I haven't seen the amendment. [LB1061]

SENATOR CAMPBELL: The legal counsel says it's included. Page 6 of the amendment includes the portion that Mr. Schaefer is requiring. Mr. Schaefer, I think part of Senator Howard's...I mean, if the surgeon is the one that's overall directing this and needs the clarification in law to overcome the 1898, then I perfectly well understand the surgical first assist. And we've been...trust me, we've been through that one here. But the testimony is that the surgeon can direct the surgical tech to take an instrument--I'm being very layman terms here, okay?--direct that person to take the retractor...let's...maybe I got that right. Senator Howard's question would be, would not they need licensure for that doctor to direct that? Am I... [LB1061]

SENATOR HOWARD: That is exactly it. [LB1061]

SENATOR CAMPBELL: And so you may want to think about that. I thought that it all had to do with the opening and the closing,... [LB1061]

SENATOR HOWARD: Yes. [LB1061]

SENATOR CAMPBELL: ...not necessarily the actual holding of an instrument. But you may want to think about that. [LB1061]

MATT SCHAEFER: Okay. [LB1061]

SENATOR CAMPBELL: I'd take Senator Howard up on her suggestion to look at that just to make sure, from an NMA standpoint, that's the testimony you want. Would that be accurate? Everybody see that? Mr. Schaefer, am I being obtuse about that or... [LB1061]

MATT SCHAEFER: Say it one more time. [LB1061]

SENATOR CAMPBELL: Well, I just think that you may want to think about, does the NMA support the person holding it or does that need some clarification? That's what licensure would do apparently. And the question is, whether the registry gives enough of a direction for the surgeon to say, hold this retractor in place. I thought it had a lot more to do with opening and closing. But, you know, I'm not a physician, I'm not any medical person, so I may not have understood what was needed in clarification in the '98 case. [LB1061]

MATT SCHAEFER: Okay, I'll take another look. [LB1061]

SENATOR CRAWFORD: Thank you, Chairwoman Campbell. And thank you. I just want to clarify for the record the NMA's support for the registry. Now the bill also requires evidence of holding a credential or certification. So is that important in the NMA's support of the bill as well? [LB1061]

MATT SCHAEFER: I don't know that we've had specific conversations about that, to my knowledge. But I think we wanted to be supportive of the Board of Health and the technical review committee and their suggestions after reviewing all of the evidence that they've reviewed. [LB1061]

SENATOR CRAWFORD: So the registry component, clearly. The component you're addressing then. [LB1061]

MATT SCHAEFER: Yeah. [LB1061]

SENATOR CRAWFORD: Thank you. [LB1061]

SENATOR CAMPBELL: And in all fairness, Mr. Schaefer, when we read through all of the 407 information that we have available, it might clarify that question that we've asked of you. [LB1061]

MATT SCHAEFER: Okay. [LB1061]

SENATOR CAMPBELL: Anything else? Thanks for your testimony. [LB1061]

MATT SCHAEFER: Thanks. [LB1061]

SENATOR CAMPBELL: Our next proponent. Okay. Those who oppose the bill? [LB1061]

ELISABETH HURST: Good afternoon. [LB1061]

SENATOR CAMPBELL: Good afternoon. [LB1061]

ELISABETH HURST: Chairwoman Campbell, HHS Committee, my name is Elisabeth Hurst, E-l-i-s-a-b-e-t-h H-u-r-s-t, I am the director of advocacy with the Nebraska Hospital Association. On behalf of our 90 member hospitals and 41,000 individuals that they employ, we are in on LB1061 in opposition. The primary reasons that we oppose are the formal education requirement and the certification requirement that the registry includes. As Senator Crawford had alluded to, the registry that was originally approved through the surgical first assist 407 process included a simple registry and that's what was affirmed there. And I'm going to read you just a brief excerpt from one of the hospital administrators, Marty Fattig, from Nemaha County Hospital in Auburn to support what that opposition was to those requirements. Surgical technologists are allied healthcare professionals who are trained to support the surgical team, focusing on sterility of the room and monitoring of surgical tools and equipment. Surgery relies on this entry level position to ensure the surgical suite is properly prepared. Many of our rural hospitals rely on these individuals for the scrub tech role, a position that can be accommodated through on-the-job training to fulfill a basic, yet vital, function within the hospital. These individuals generally have a high school degree and do not complete a formal surgical technology program. They are recruited from our communities and their functions do not require the full training regimen that a certified surgical technologist possesses. However, this does not mean they are any less important to the services rural hospitals provide. Requiring that all surgical technologists, even those simply functioning in the scrub tech role, complete a formal surgical technology program and obtain certification will be burdensome for rural hospitals in Nebraska. The cost that would

be attributed to paying for the educational programs and lost wages while obtaining the certification will be a trial for many of our technologists. It will become very difficult for rural hospitals to recruit for this role during a time when we are facing shortages and struggling to build our healthcare work force. I will mention that we did, through the surgical tech 407 process, have a facility from Omaha come and testify that they had currently 15 vacancies for surgical technologists that they're having difficulty, too, to fulfill. Just imagine what it would be like for the rural hospitals to try to draw that work force, someone who pays the minimum, just over $9,000, for the program at SEC taking nearly two years of the lost wages to obtain that to try to get those out to communities like Sidney and Auburn. I know the HHS Committee respects the integrity of the 407 process. Again, we do support a registry that tracks an employable pool of surgical technologists within the state. We do believe that the Board of Nursing is appropriate to review this. Nurses are the ones who supervise the surgical technologists in the surgical suite. I will direct you to one of the comments that CEO, Courtney Phillips, made in her recommendation on the surgical technologist proposal. She said that the proposal has a potential to create economic hardship for surgical facilities in Nebraska and would limit the pool of available employees for surgical technology positions in such facilities, creating a barrier to entry into the profession due to the cost the prospective surgical technologist would have to undergo to get the education and training required for licensure. When the Board of Health and CEO Phillips rejected that portion of the licensure for the 407, one of the primary reasons was because of the educational and certification requirements and the burden that those would pose for anybody entering the field. I also want to point out, finally, that the Board of Health voted, as part of...when they had come together, in supporting a registry. And what they supported from the report on page 14, that the board, forthcoming in its support, was for the original registry for surgical technologists as described in the surgical first assistant proposal that was completed earlier. So do keep in mind that what the Board of Health had confirmed as a registry that they supported, it was that original registry that was a simple registry. And I'm more than happy to give you more details on what that registry looked like. Again, I think what you're seeing here is what was originally licensure for surgical technologists now is just simply being called a registry. [LB1061]

SENATOR CAMPBELL: Okay. Questions? Senator Howard. [LB1061]

SENATOR HOWARD: Thank you, Senator Campbell. Thank you for visiting with us today. Can you tell me a little bit about the scrub tech role that you're talking about? [LB1061]

ELISABETH HURST: Sure. Obviously, the surgical techs can speak more to it and I didn't bring those particular documents with me. But when you look at surgical technology as an entry level, the very first, basic functions, the first 12 on a list of a job description for a surgical technologist would be the scrub tech role. And they're the ones who are setting up the room prior to the surgical procedure, making sure that everything is there, the tools and instruments are there and

the counts and whatnot and preparing for that surgical procedure. That's an oversimplification, but they aren't, as a scrub tech, assisting the surgeon at the table. [LB1061]

SENATOR HOWARD: But a surg tech would be? [LB1061]

ELISABETH HURST: A surgical technologist, right now it's, as you know, currently unregulated in the state and so yeah, they could be using them for that particular role. [LB1061]

SENATOR HOWARD: And then, just to clarify your position, the Hospital Association is opposed to the formal education requirements for surgical technologists who are in the room during a surgery? [LB1061]

ELISABETH HURST: Right. And the certification requirement. That's right. And keep in mind that as it has been unregulated up to this point, there is not one single documented case of any adverse harm to a patient, anything that's come from that. And that was something that came out in the 407. [LB1061]

SENATOR HOWARD: May I follow up on that? When there is adverse harm to a patient, where does the liability go? Does it generally go to the facility or does it go to the physician who's directing the work? [LB1061]

ELISABETH HURST: Currently, under captain of the ship, it is all on the shoulders of the physician, but obviously the facility is going to have some liability there as well. [LB1061]

SENATOR HOWARD: Thank you for clarifying. [LB1061]

SENATOR CAMPBELL: Senator Riepe. [LB1061]

SENATOR RIEPE: Thank you, Senator Campbell. I'm trying to understand some clarification is the registration or registry, if you will. Does that mean that they walk in and say, put my name on a registry because I'm going to do the OJT training in the surgery suite? [LB1061]

ELISABETH HURST: Sure. [LB1061]

SENATOR RIEPE: When you said that, is it that benign that, if there is no formal training, then you just simply put your name in the hat? [LB1061]

ELISABETH HURST: Yeah. What's beneficial about a registry is that you would have a board, the Board of Nursing, for example. They have the Medication Aide and the Nurse Aide Registry currently that they monitor. And what that does is, it creates basically an employable pool for facilities and providers in the state to look up someone's name and say, are you...have you met some base requirements? So for the registry that was approved in the surgical first assistant 407, you would have to fill out an application, submit it. There would be a single background check at that point; there's a fee that's involved there. And then you're put up on the list. What makes it nice is that, if something were to happen during your employment, say some sort of adverse something or other that happened, then a call can be made to the Board of Nursing to report that. And then you are...it's investigated and if it's found that you were in the wrong you're removed from the registry. Then if you go to try to apply at another facility or with another provider they can contact the registry or look on the registry list and see that you're not employable in the state. [LB1061]

SENATOR RIEPE: Are we at risk of having two levels or more than two levels of care across...between urban and rural? [LB1061]

ELISABETH HURST: You know, I think that's definitely a risk if you're not creating a mechanism for work force development. If you're creating barriers to it, I mean, how are you going to be able to offer the services at all? Is it better to offer the services, knowing and trusting that the hospitals have on-the-job training programs and many, many mechanisms in reviewing someone's on-the-job training to ensure that they're meeting the requirements of their position? I think that looking at on-the-job training as meaning that it's absolutely subpar care is flawed. Again, there have been no reported incidents that we've seen in...at least in the last several decades regarding this occupation. [LB1061]

SENATOR RIEPE: Part of my thinking is though, too, there's a lot of on-line training anymore that can serve a lot of areas outside of major urban areas where they would offer formal classes. [LB1061]

ELISABETH HURST: Sure. It's my understanding with surgical technology here in this state that there is still an in-person, kind of a lab type of a requirement is part of the program. And, again, the individuals who are taking these positions in our rural communities aren't going to be able to afford to go down to Lincoln for several weeks and leave their families to get this done. [LB1061]

SENATOR RIEPE: But on-line wouldn't require them to leave home. [LB1061]

ELISABETH HURST: Again, I know that there are on-line options there, but they still require an in-person lab requirement as part of what SEC offers. [LB1061]

SENATOR RIEPE: Okay. Thank you. Thank you, Chairman. [LB1061]

SENATOR CAMPBELL: Questions? Questions? Did Mr. Fattig testify or provide that statement...was he a part of the 407 panel? [LB1061]

ELISABETH HURST: No, uh-uh. [LB1061]

SENATOR CAMPBELL: So he stepped forward to give a comment. [LB1061]

ELISABETH HURST: Right, as well as Sidney...Petik from Sidney Regional Medical Center. [LB1061]

SENATOR CAMPBELL: Okay. Was Mr. Fattig's comment taken in the first...I mean, quite honestly, I deal with this a lot easier when I say first 407. [LB1061]

ELISABETH HURST: True. [LB1061]

SENATOR CAMPBELL: In the first 407 or the second? [LB1061]

ELISABETH HURST: It was brought up in the second, because that's when, again, that educational component... [LB1061]

SENATOR CAMPBELL: Okay. [LB1061]

ELISABETH HURST: ...and requiring licensure, just having to show that burden there. In the first 407, the technical review committee understood very well what the burden was going to be. [LB1061]

SENATOR CAMPBELL: Okay. I'm going to ask this question because it's not probably the major question of the bill. But if the surgeon is the...what did you say, the captain of the ship?...I think you referred to in your testimony to that. Then why would not both of these professions be under the Board of Surgeons and not the Board of Nursing? [LB1061]

ELISABETH HURST: Again, if you look at who is closest to this particular occupation, it's the nurses. They're the ones who are supervising them in their role prior to surgery and then postsurgery. They're the ones who delegate to this individual, because nurses can delegate to unlicensed personnel. So where a physician or surgeon can direct to anybody--I mean, he's supervising the whole suite--when it comes to a surgical technologist they're being delegated to by a nurse, not a physician/surgeon and they're also supervising that individual. [LB1061]

SENATOR CAMPBELL: Okay. Follow-up questions to anything? Thank you, Ms. Hurst, for your testimony today. [LB1061]

ELISABETH HURST: Yeah. [LB1061]

SENATOR CAMPBELL: Our next opponent. [LB1061]

KAREN RUSTERMIER: (Exhibit 5) My name is Karen Rustermier, I am...it's K-a-r-e-n R-u-s-t-e-r-m-i-e-r, and I represent Association of periOperative Registered Nurses. I'm speaking in opposition of LB1061, certain aspects of it. I am not opposed to education; I am not opposed to certification. In fact, we encourage that in nursing and physicians. Certification is not mandatory for licensure, it is just kind of a plus. If you're looking at a surgeon, you're probably looking for a board-certified surgeon. However, the law does not require them to be certified to operate. So there's kind of a...there's some splitting hairs going on here. The remarks that I gave you were prepared before I saw the amendment, so some of these things do not apply because your grandfather clause has taken care of a lot of those problems. However, I do see some problems in the grandfather clause also, and I'll kind of go over that with you. I've been a perioperative registered nurse for 45 years. I have also served as an instructor in the tech program. I've been involved as...in the education department in a hospital, a large hospital. So I'm familiar with on-the-job training and I'm familiar with tech program training. And I can tell you I taught the same either place. So the people that get on-the-job training, it isn't like you got somebody from the lunch line and they're now a surgical tech. So there can be an argument either way. I think it's a lofty goal to work towards having these provisions. It would save a hospital a lot of money to not have to do that initial, up-front training. They could just go straight into orientation to here's our facility. So there's some give and take here. This...there are some things here that are problematic. The first thing is that I really think that it should be under the Board of Nursing. These are nursing tasks. What the surgical technologist does cannot be construed as medical care. That Howard Paul law says they cannot delegate medical care. If they were doing medical care, I can guarantee you a physician would be in that role and there would be an ICD-10 code to bill for it. And there isn't. These are nursing tasks. We delegate that role to that person. We are supervisory. Yes, they do some things independently that they have been trained to do in their education and in their orientation in the hospital. So we've got a problem here understanding the

difference between direction and delegation. The doctor isn't delegating medical care to that person that is scrubbed, whether that be a surgical tech, a nurse practitioner, a nurse, whoever it is. The people that are in the advanced role, which we are having some difficulty understanding...I guess I could explain it as freshmen. We are freshmen, we all do this. These are the seniors, they're allowed to do this because they have additional training and additional skills. Those people are licensed to do that. We are recommending a registry for the surgical technologist because we don't think that's a bad idea. We don't necessarily think it should be...would have to be mandatory, but we don't think it's a bad idea because I think there are some pluses to having the registry which the last people have alluded to that you'd have a clearinghouse to know if there was a problem. I think hospitals are highly motivated to put out a good product because their reimbursement is tied to it. So if there's a problem with somebody, I don't believe they're going to keep them. That's my first thing, the first reason I want this under the Board of Nursing. There is still a problem with supply. We have 31 operating rooms in the facility that I work in. We're moving all the way to 53 within the next two years. I'm already missing...I need six techs, I have five travelers, so that's 11 positions that I don't have filled right now with permanent employees. If I get to 53 operating rooms, I'm going to have a lot more. There's 17 people came out of one class and Methodist graduated 5. Yes, we have on-line. I don't know that that's putting out all that many people, because they're not beating down the door to come to work. We have a big problem with that and I don't think we need to set up more barriers to getting people into this job. The problem I see in the grandfather clause is this: A department may suspend the education and certification requirement. Well, may? Maybe yes, maybe no? Are they going to decide on a case-to-case basis? I'd be much more comfortable if it said, they will. I have five people working currently that would fall into one of these categories that they would no longer work here that are excellent techs. [LB1061]

SENATOR CAMPBELL: I think we'll go to questions. [LB1061]

KAREN RUSTERMIER: Okay. [LB1061]

SENATOR CAMPBELL: I want to ask a clarification question. When you talked about the fact that the Paul case, is that the '98 case? [LB1061]

KAREN RUSTERMIER: Howard Paul, 1898. [LB1061]

SENATOR CAMPBELL: Okay. I'm pretty sure that's what...so you're saying...this may answer it. Mr. Schaefer, you may be off the hook here for getting back to us. So what you're saying is, in that case it really has more to do with medical care delegation than the surgeons direct it. [LB1061]

KAREN RUSTERMIER: Correct. They're not injecting medications. They're not cutting tissue. They are not closing anybody. Those would be considered medical care. Seriously, if the duties that the technician does, the technologist does--we used to call them technicians, now they're technologists--if that was medical care, I'm telling you a doctor would be doing it and there would be a code to bill for it. There is not. So I don't know how you could construe that as medical care. [LB1061]

SENATOR CAMPBELL: So I'm sure you were listening to my exchange here. [LB1061]

KAREN RUSTERMIER: Um-hum. [LB1061]

SENATOR CAMPBELL: And so, obviously, holding that is a surgeon directed. Closing is a surgeon delegated. [LB1061]

KAREN RUSTERMIER: Correct. [LB1061]

SENATOR CAMPBELL: Does that...you want to follow up, Senator Howard? [LB1061]

SENATOR HOWARD: Are nurses able to delegate to an unlicensed professional? [LB1061]

KAREN RUSTERMIER: We are, but we're not delegating medical care. We're delegating nursing care. [LB1061]

SENATOR HOWARD: Okay. So the work of a surgical technologist is not medical care, is essentially what you're saying. [LB1061]

KAREN RUSTERMIER: Correct. [LB1061]

SENATOR HOWARD: See, that's a little bit difficult for me, because I would hope that everybody who's in the surgical suite has some medical training and education and is performing medical...I appreciate there being a scrub nurse. [LB1061]

KAREN RUSTERMIER: Okay, I am a registered nurse. I have a bachelor's degree. And I do not know that I'm not...no medical care. [LB1061]

SENATOR HOWARD: I apologize, I'm not done with my question. I apologize. [LB1061]

SENATOR CAMPBELL: Just wait. Just wait just a minute. Let her finish the question. [LB1061]

SENATOR HOWARD: I'm not quite done with my question. I appreciate that in a scrub role you're making sure that everything is counted and everything is clean and tidy. But it sounds like they're doing things that touch the body or hold things that are important. And so, for me, when I think about that, I would want somebody to have some type of educational background or proof of that educational background. You had mentioned that this creates a barrier to the role. But I guess my question in that regard is, the folks who are doing this work currently are asking for this. And so it's hard for me to imagine that there's a barrier to the role when the people who are performing the function are asking for this licensure. [LB1061]

KAREN RUSTERMIER: I will submit to you it isn't all of them that are asking for that. [LB1061]

SENATOR HOWARD: Okay. [LB1061]

KAREN RUSTERMIER: These people are getting education. Is it provided by a nurse educator, as that's their job at the hospital, or is it provided in a formal setting? Those people still have to come and do a clinical rotation and it is us at the hospital who are supervising that person in their clinical rotation. [LB1061]

SENATOR HOWARD: Is it standardized? Is all of the education the same? [LB1061]

KAREN RUSTERMIER: They have to have...each program has...they have to have so many cases. They have to have a variety. You know, they have so many of this kind, so many of this kind, so many this kind. There are certain skills. Every program has, you know, here's your skills checklist, you got to know how to do this, this, and this. So it's pretty close. What the hospital requires, what this program requires, what this program requires is all going to be pretty much in the ballpark close to the same. [LB1061]

SENATOR HOWARD: So it's in the ballpark, but it's not exactly the same. [LB1061]

KAREN RUSTERMIER: You can't say it's exact. You could not say exact. But from one program to another they're both accredited. You couldn't say it's to the letter the same. [LB1061]

SENATOR HOWARD: Is there any other medical profession where they say they're in the ballpark but they're not exactly the same? So like if you went to a different type of nursing school, they're in the same ballpark but they're not learning the same skills? [LB1061]

KAREN RUSTERMIER: Yep. I would say nursing is, because you have people with associate degrees. I had...originally had a diploma, went back and got another degree. There are people with different levels of education. You know, every school...you know, you've got the basics but every school is just a little bit different. And so I don't think...and I think that's pretty much evidenced by board scores. When you take nursing boards, did every student get about within two points of each other? No, they didn't, because they didn't all learn the same thing. We hope to establish minimum competence so you have to have X for your score, but you could be here. You could have learned that much more. [LB1061]

SENATOR HOWARD: And would this establish your minimum competence? [LB1061]

KAREN RUSTERMIER: I think it would and I think with the hands-on experience teaches you so much. When you just get out of school, I don't care what your discipline is, you've got a basis to get started on. You know, you need to learn from there. And I have to learn every day. I've done this 45 years, I still can learn something. So I don't think it's a bad idea. I think it's almost impossible to get this going in one year. I mean, I think it's a lofty goal. The Institute of Medicine asked nursing to beef it up and to move towards all BSN. They gave us like 20 years to accomplish that. We want to have 80 percent by 2020. They want to do this in one year. See, if there was a phase-in...a longer phase-in period to say everyone must have this education, everyone must be certified; because they don't have a national board, that would be their equivalent. Then if we had a 20-year phase-in it might be workable. [LB1061]

SENATOR HOWARD: Have you brought suggested language or a suggested time line to Senator Kolterman? [LB1061]

KAREN RUSTERMIER: We have not, because we didn't have this. Today, sitting back here, is the first I saw the amendment. There was no grandfather in this, in the original piece that we were given. [LB1061]

SENATOR HOWARD: Okay. Thank you. [LB1061]

SENATOR CAMPBELL: Okay. Follow-up questions or questions? [LB1061]

SENATOR FOX: I have a question. [LB1061]

SENATOR CAMPBELL: Sorry. Senator Fox. [LB1061]

SENATOR FOX: Thank you, Senator Campbell. Just kind of clarification because I don't think this was highlighted. Back to moving the registry from the Board of Medicine to the Board of Nursing. I mean, is that a discussion that's been had with the Board of Medicine? I mean, if they were here testifying, would they agree with you? [LB1061]

KAREN RUSTERMIER: It was had during one of the 407s. At that time, they agreed that those tasks were more in line with nursing. They've evidently since changed their mind. And I think that it is all with confusion around this Howard Paul, which is in case law. Captain of the ship was after Howard Paul, so I don't...I can't speak for them. During the 407 they supported a registry and it wasn't an issue. [LB1061]

SENATOR CAMPBELL: Any...oh, Senator Crawford. [LB1061]

SENATOR CRAWFORD: Thank you, Chairwoman Campbell. And thank you for sharing your experience. I wonder if you could just talk about the primary mechanisms by which you ensure that someone is qualified to be doing the tasks that you're asking them to do. I mean, if there...I think the argument was that licensure is not necessary. So there must be standards or procedures or protocols that you do follow to make sure someone doing these tasks is qualified. [LB1061]

KAREN RUSTERMIER: Are you talking about in regard to this legislation or in regard to what goes on right now? [LB1061]

SENATOR CRAWFORD: I'm talking about in regards to what goes on right now. [LB1061]

KAREN RUSTERMIER: Okay. Each hospital would be responsible for their own employees. It's pretty standard that everybody does annual competencies testing. Some of it may be physical skills, some of it is knowledge. In fact, and even we have, all of us, have to take them every year. The education department of that hospital or whoever--it may just be one person that's in charge of education--will determine, have there been areas? Do we have incident reports? Have there been a lot of problems with this or that? If there is, then we need to have education, we need to go over that, we need to have competencies. And like I said, hospitals are highly motivated to turn out a good product because their reimbursement is tied to that. So if there's problems, they're doing any numbers of things to get people up to speed. And if some people are not, people do get released from employment. [LB1061]

SENATOR CRAWFORD: Thank you. [LB1061]

SENATOR CAMPBELL: Senator Riepe. [LB1061]

SENATOR RIEPE: I have one question. Under the jurisdiction, the Board of Medicine versus the Board Nursing, are there registered nurses that are working in the surgical suite per se? [LB1061]

KAREN RUSTERMIER: Yes. [LB1061]

SENATOR RIEPE: And are they under the direction of the Board of Medicine or the Board of Nursing? [LB1061]

KAREN RUSTERMIER: The Board of Nursing. [LB1061]

SENATOR RIEPE: So that you would have...in a surgical suite you would have some under one jurisdiction and some under another? [LB1061]

KAREN RUSTERMIER: There are no nurses under the Board of Medicine. [LB1061]

SENATOR RIEPE: Oh, even the RNs are under the Board of Medicine in that situation? [LB1061]

KAREN RUSTERMIER: No. No RNs are under the Board of Medicine. The Board of Nursing governs all nurses. [LB1061]

SENATOR RIEPE: Are there then nurses in the surgical suite, RNs? [LB1061]

KAREN RUSTERMIER: Yes. [LB1061]

SENATOR RIEPE: Whose jurisdiction are they under? [LB1061]

KAREN RUSTERMIER: The Board of Nursing. [LB1061]

SENATOR RIEPE: Okay. So then you have some under two jurisdictions. Is that right? [LB1061]

SENATOR CAMPBELL: No, I think he means, would have. Correct? If you followed the bill, the bill would put them under the Board of Medicine in surgery. [LB1061]

KAREN RUSTERMIER: That would put techs under the Board of Nursing, not nurses. [LB1061]

SENATOR RIEPE: That's the way it is right now, it's divided. [LB1061]

SENATOR CAMPBELL: No. That's what she's trying to answer, Senator Riepe. It's not divided now. [LB1061]

SENATOR RIEPE: Oh, okay. Okay. Thank you. [LB1061]

SENATOR CAMPBELL: Am I saying that right, Ms. Rustermier? [LB1061]

KAREN RUSTERMIER: Yeah, I think so. It's kind of...it's confusing to...you know, we all here work in this area and we're having a hard time making you all understand. Does anybody have anything else they need? [LB1061]

SENATOR CAMPBELL: I don't think so. Thank you for your testimony. [LB1061]

KAREN RUSTERMIER: Thank you. [LB1061]

SENATOR CAMPBELL: If you read the amendment, Ms. Rustermier, and you want to have addendum, let us know. [LB1061]

KAREN RUSTERMIER: Thank you. [LB1061]

SENATOR CAMPBELL: All right. Our next opponent is approaching the table. [LB1061]

DON WESELY: Madam Chairwoman, members of the Health and Human Services Committee, for the record, I'm Don Wesely, D-o-n W-e-s-e-l-y. The hat I'm wearing at this moment is the NAIAC, Nebraska Association of Independent Ambulatory Centers. There are 16 of these across the state and they include, for instance, the Advanced Surgery Center in Omaha; the Midwest Eye Surgery Center in Omaha; the Urology Surgical Center in Lincoln; the Surgical Hospital in Lincoln, so that's who we represent. So we're facility-oriented and, as a result, we are in complete agreement with the Hospital Association, what they testified about. Our concerns are

very similar. And one of those concerns as was expressed by Elisabeth Hurst was the lack of surgical techs available to us now and the concern that increasing educational and certification requirements is going to make it even harder for us to find these individuals that we need and we have a shortage of right now. So that's our first concern is, we need surgical techs. We work with surgical techs and we would support the concept of a registry, but we do not support at this time the educational requirements and the certification requirements. I know this is confusing as can be and I've been dealing with this since I got elected in '79 and served on the Health Committee. So these licensure issues and scope of practice issues are very difficult. But I've never seen one as crazy as this one, to tell you the truth. We've been...we've had legislation...Senator Dubas had legislation five or six years ago requiring facilities to hire only certain surgical techs. And the objection was the same, we can't get enough as it is and we don't want to do that. So that didn't advance. And then all of a sudden, honestly, the Hospital Association didn't know this, we didn't know this, there are 800 surgical techs out there. Where were they? Who knew about them? And we didn't know and then we had this Howard Paul case that kind of came out of nowhere and now we're trying to deal with all of it in this scramble. To tell you the truth, the thought I have if you want a way out of this...first off, Senator Baker is gone. I want to thank Senator Kolterman for introducing this bill, even though I'm testifying in opposition. This needs to be talked about. This is going to take us some work to work through this and we've got to start that dialogue. But anyway, Senator Baker's bill, we've reached an agreement. We're okay on that. First assistants needs to happen, it's prioritized, we need to get that through. There is one step we could take now that I think all of us could be in agreement with if we accept some compromise. And that would be to set up a registry and start at least finding out who these 800 people are, where are they, what education do they have, what training do they have and then get that assessment going. We're okay with that, the Independent Ambulatory Centers, and it would start us on the dialogue and have more information right now. We're not sure...the hospitals and the ambulatory centers do provide on-the-job training. We also hire people who are certified or trained and so we have that going. And our argument is, that system...and we take great pride in making sure there is sterile work environments in these operating rooms. We have a responsibility, we take it seriously. What cases have we had where any of these have been found not to be sterile, that the problem that is being brought to the surgical techs has resulted in any harm to the public? And I don't know if you heard anything. I didn't hear anything about what is the problem we're trying to address? So the current system, we feel, is actually working. And we still have a problem with trying to get enough surgical techs in there. And so if we had a registry and we found out who's out there, that would be a first step. The second thing is, on the Howard Paul language that's in this bill--and that's on the last page--that could help, too, but I'm very concerned about moving that forward without a very thorough 407 review. This is a major change. That last paragraph, I don't know if you have it in front of you, on page 6... [LB1061]

SENATOR CAMPBELL: On the amendment or the green sheet? [LB1061]

DON WESELY: On the amendment. I'm talking about the amendment. I did get a copy of that and I thank the proponents of the bill for sharing that with me yesterday, I think it was. But if you look at that language, it talks about a skilled professional or nonprofessional assistant. There's no definition. What does that mean? Who's a skilled professional and who's a nonprofessional assistant? Exactly what does that mean? And then later it talks about accepted medical standards and appropriate to the assistant's skill. This is a very broad grant of authority to delegate to physicians and it may, in fact, help us through a lot of problems. And so I think all of us should be open-minded about it, but not before we know exactly the consequences. This affects all health professions out there. I mean, other people coming in, who would that be? What would they do? How does this work? So I'm suggesting a registry without the education requirements and the certification requirements. Let's get a handle on who's out there. And then, secondly, take this language and the issue of Howard Paul and study it thoroughly and come back next session. I know it doesn't help with some problems that are pending right now. But to show you the situation, if you adopt that language in Section 14, that one paragraph, you don't need the rest of the bill, essentially. I mean, you've taken care of...I'm not even sure about first assists. I mean, you kind of take care of the problem. So combining those two, I don't think it makes a lot of sense at this point. I'd be happy to answer questions and try and clarify things, but I may make things worse because it's complicated. [LB1061]

SENATOR CAMPBELL: Senator Howard. [LB1061]

SENATOR HOWARD: Thank you, Senator Campbell. Thank you, Senator Wesely, for visiting us today. So your suggested solution is the simple registry that still asks for information about what type of education and on-the-job training and how many hours and that sort of thing? [LB1061]

DON WESELY: That's all fair and that would give us at least a basis of information to start making policy from. Right now, we don't know. I mean, every facility is different. I'm sorry. [LB1061]

SENATOR HOWARD: Well, and you mentioned that you haven't heard of any harm to patients. And I think one of the challenges I have with that is that I'm not sure how we would, because that goes back to the captain of the ship. That goes back to the facility's liability. And so I'm not sure...I think we probably haven't heard of any instances because we wouldn't have heard of any instances. [LB1061]

DON WESELY: Oh, I think you would, Senator. I do. I think if there was somebody operated on that the environment wasn't sterile or that a scrub tech made a mistake or something, there are... [LB1061]

SENATOR HOWARD: And that wouldn't go back to the physician or the facility? That would go back to directly to the worker? [LB1061]

DON WESELY: Well, if it wasn't sterile, that's a responsibility for the facility and we'd get sued. I mean, somebody... [LB1061]

SENATOR HOWARD: So it would go back to the facility. [LB1061]

DON WESELY: Yeah. Well, we'd get sued on that. The physician would get sued if the...okay, here's the other thing. Scrub technologists are hired by facilities for the most part. So that's why we're so concerned. When the hospitals come in or the independent ambulatory centers, we hire the surgical technologists, for the most part, to get things clean, to prepare things, to follow up afterwards, and so they're hired by us. So we take a responsibility to make sure they're trained, that the environment is sterile, and that sort of thing. So we're saying we've been doing this and we feel confident that we've done a good job. The surgical first assistants are largely hired by the surgeon. They follow them around. They may go from facility to facility, do their surgery, and they'd like somebody with them following them around, because they have a relationship and they know each other, in some cases for decades. So that's why the surgical first assistant is under the Board of Surgery and Medicine, because that's the relationship. The surgical tech is similar as an entry level type thing that move up to first assist. They are with the facility working with the nurse that's in charge of the operating room and that sort of thing. I'm simplifying I know. People are probably thinking, well, that's not true in all cases. But for the most part, that's my understanding of how it works. [LB1061]

SENATOR HOWARD: Okay. Thank you. [LB1061]

SENATOR CAMPBELL: Isn't that the situation in what, Sidney or Chadron or...I'm trying to think. [LB1061]

DON WESELY: That's exactly right. It was Sidney. [LB1061]

SENATOR CAMPBELL: Where the surgeon...the hospital was having the surgeon from Denver and that person brought their surgical assist with them. That's the example that you're... [LB1061]

DON WESELY: That is. That's how it works. [LB1061]

SENATOR CAMPBELL: ...that you're providing to us. [LB1061]

DON WESELY: That's right. So even though they are similar professions and one leads to the other, they're also very different in what they do and how they're hired and who they work with and so... [LB1061]

SENATOR CAMPBELL: Senator Riepe. [LB1061]

SENATOR RIEPE: Senator Campbell, thank you very much. And, Senator Wesely, thank you for being here. I ask you this in part because you have been here, you have some background and experience. And my question is, does it take statutory language to establish a registry or is that something that could be done administratively by the Department of HHS? [LB1061]

DON WESELY: No, you need to put it in statute. [LB1061]

SENATOR RIEPE: You have a statute requirement? [LB1061]

DON WESELY: Yeah, we do. Also, I think you were asking about the levels of licensure. [LB1061]

SENATOR RIEPE: Yeah. I was trying to get some sequential order. [LB1061]

DON WESELY: The way it goes is licensure is the highest. And your...by the way, physicians, surgeons, medical doctors, have no written scope of practice. They are broadly granted authority to provide care for their patients. Every other health profession has to have a specific language allowing them to do something. And if they don't have that authority, they can't do it. It's totally different. There's a wide-open physicians and surgeons...and now they get board certified and things like that, medical protocols and whatever they have to follow with each hospital. But for the rest of them, they have to have a specific language. Okay, that language can be in a license that they get. And then below that is certification. Certification, they get certified so they're recognized. It's not a license. It's not as exclusive, but you know when somebody is certified they have a high level of training or something like that. And that's why this proposal is a registry, but they're actually being certified. So they call it a registry, but it's really certification. And then it's licensure because the facilities can only hire people that are on the registry. That's licensure. You can only...only certain people can do certain things. So in a way, this bill was called a registry but it actually involves both certification and licensure. Then the lowest is the registry. And that's where, mostly, people just...like medication aides, they sign up, you know who they are, you know where they are. It's more of a tracking mechanism, a registry. This bill isn't...this is a registry, but it's more than that. [LB1061]

SENATOR RIEPE: Okay. Thank you; that's helpful. [LB1061]

SENATOR CAMPBELL: Clarifications, anybody? To your knowledge, Senator Wesely, has anybody done a legal brief on the 1898 case? [LB1061]

DON WESELY: You know, I don't know. It would be probably a wise thing to do. [LB1061]

SENATOR CAMPBELL: At least to look at it from a legal perspective. That's one of the questions you are asking of them...of us. [LB1061]

DON WESELY: I'm pretty sure the department has done that, which is...somebody over there has had to interpret that, calling for the action you're seeing. And there are also other clinics and facilities now coming in. So this is all in the last couple of years. Somebody is defining what that means now and enforcing in a way that it hadn't been before. [LB1061]

SENATOR CAMPBELL: And I'm almost afraid to bring up this example because everybody will laugh. But this reminds me somewhat of eight years ago or seven and a half years ago when we had the dental assistants and all the dentists wanting to train their people. And then over a course of time with discussion among all the professionals we came up with a way in which, yes, they did need the training. And we had the basic...but there was a lot of discussion to get to that point. [LB1061]

DON WESELY: Yeah, exactly. [LB1061]

SENATOR CAMPBELL: Other questions? Thank you. [LB1061]

DON WESELY: Thank you. [LB1061]

SENATOR CAMPBELL: Our next opponent. Good afternoon. [LB1061]

MELISSA FLORELL: (Exhibit 6) Good afternoon. My name is Melissa Florell, M-e-l-i-s-s-a F-l-o-r-e-l-l. I'm speaking on behalf of the Nebraska Nurses Association. The Nebraska Nurses Association is the voice of registered nurses in Nebraska and patient safety and improved health is a priority for our organization. And for these reasons, NNA supports the concept of a registry for surgical technologists but opposes the format proposed in LB1061, specifically that the registry be supervised by the Board of Medicine. It is the position of the NNA that the proposed surgical technologist registry should be supervised by the Board of Nursing. This is consistent

with the findings of Part B of the 2015 407 credentialing review or review one, which recommends licensure for surgical first assistants, but registry for surgical technologists supervised by the Board of Nursing. The report further goes on to recommend that the department use the current medication aide registry as a potential model for creating the surgical technologist registry. And the medication aide registry has functioned successfully for many years and is supervised by the Board of Nursing. The recommendations of the credentialing review committee are also consistent with the supervisory relationship of the circulating RN and the surgical technologist. It is the RN who is responsible for the OR suite when the surgeon is out of the room. It's common during periods of patient prep and positioning as well as during the care and transfer of patient post procedure. While many tasks can be delegated to others in the OR suite, it is the nurse that's responsible for maintaining that safe environment. It appears that LB1061 appears to be an attempt to skirt the 407 process, as it's not consistent with the findings of the review. And while the case law has caused problems recently, as Senator Wesely referred to, it also protects the licenses of RNs and others and the implications of simply adding verbiage at the last moment to get around that case law need to be evaluated carefully. NNA recognizes the valuable role that surgical technologists play in the operating room and the creation of the registry will allow for identification of those working in a surgical technologist role and create a means to establish a minimum level of competency, both which will help ensure patient safety in the OR. Supervision of the registry by the Board of Nursing is the most practical means to achieve this goal. There has been no compelling evidence presented to support placing the registry under the Board of Medicine, as the Board of Nursing is better prepared to manage an unlicensed group of professionals as they already have the experience and the processes in place to manage the registry. We therefore ask that you oppose LB1061 in its current form. [LB1061]

SENATOR CAMPBELL: Questions? Senator Crawford. [LB1061]

SENATOR CRAWFORD: Thank you, Chairwoman Campbell and thank you for your testimony. I wondered if you would help us understand what a registry does, since you've mentioned the medication aide registry as a model. So what can we...what does that allow us to know or to do? How is that helpful to us to have that registry (inaudible). [LB1061]

MELISSA FLORELL: First of all, it lets us know who these individuals are and where they're practicing. The majority of surgical technologists working in the state of Nebraska are hired by their facility and they're on-the-job trained. They may or may not have attended a program in the past, but they're not currently certified. And we don't know who they are or how they entered the occupation. We need to identify these individuals before we move forward with any other level of... [LB1061]

SENATOR CRAWFORD: So I guess my question is, how has that information been helpful to know that for medication aides? [LB1061]

MELISSA FLORELL: For medication aides? First of all, it lets you know who the person is, in what capacity they are working. Medication aides can also, after their additional registration, can also attend a 40-hour course to administer different types of medications in a nursing home. There is not a continuing education requirement. I believe you asked that earlier. But there is a renewal process so that person will have to reapply so that you could see, has there been any action. Any misconduct is then tracked and we get that on a monthly basis through the Board of Nursing report. [LB1061]

SENATOR CRAWFORD: So that's also then helpful to facilities, I suppose, as they're screening someone. [LB1061]

MELISSA FLORELL: Yes, because you can see if there's action against that individual. [LB1061]

SENATOR CRAWFORD: In the registry? [LB1061]

MELISSA FLORELL: Uh-huh. [LB1061]

SENATOR CRAWFORD: Thank you. [LB1061]

SENATOR CAMPBELL: Ms. Florell, I'm going to follow up Senator Crawford's question. Is it laid out in rules and regs or statute what has to be in the registry? Do you know that? [LB1061]

MELISSA FLORELL: I believe the specifics are in rules and regs and the guidance is in the statute. But I will follow up upon that to be sure that I'm answering that correctly. [LB1061]

SENATOR CAMPBELL: We can also have the legal counsel check that for us. But that would be interesting to know if all the registries are set up in the same...and what requirement there is on a registry. Okay. Any other questions, Senators? Thank you for your testimony today. Our next opponent. Anyone in a neutral position? Okay. Senator Kolterman, we're back to you. Letters for the record while the senator is settling in? [LB1061]

ELICE HUBBERT: We have nothing for the record today. [LB1061]

SENATOR CAMPBELL: Okay. Senator Kolterman, go right ahead. [LB1061]

SENATOR KOLTERMAN: Thank you, Senator Campbell. First and foremost, I'd like to thank all the people that testified today, both pro and con. I appreciate the concerns and the dialogue that's been brought forth. As many of you know, and Senator Campbell alluded to early, good legislation doesn't happen overnight. And we just received this amendment yesterday, so that's why many of the people hadn't seen it as well. I brought it to you today partially because we were waiting on HHS to give us their direction on where they were going to go with all this and the Department of Health. And so we'll continue to work on this. I'll dialogue with the people that were in opposition. We know that this is something that we want to continue to work on. It's just a matter of how soon can we do it. And it has not been prioritized by anybody. It won't probably get prioritized by anybody. So from that I will try and take any questions you might have. [LB1061]

SENATOR CAMPBELL: Okay. Any questions for the senator before we close out? I appreciate that, because there's just been a lot of information presented. That's helpful for us to know... [LB1061]

SENATOR KOLTERMAN: For me as well. [LB1061]

SENATOR CAMPBELL: ...that you just got the amendment. It takes time to look at those, too. [LB1061]

SENATOR KOLTERMAN: Exactly. Thank you. [LB1061]

SENATOR CAMPBELL: All right. Thank you very much, Senator. That concludes our hearings for the day. [LB1061]