[LB255 LB267 LB285]

The Committee on Health and Human Services met at 1:30 p.m. on Thursday, January 26, 2017, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB255, LB267, and LB285. Senators present: Merv Riepe, Chairperson; Sue Crawford; Sara Howard; Mark Kolterman; Lou Ann Linehan; and Matt Williams. Senators absent: Steve Erdman.

SENATOR RIEPE: Thank you and welcome to Health and Human Services Committee. I'm Merv Riepe; I'm the chairman of the Health and Human Services Committee. I represent Legislative District 12, which is Millard, Omaha, and Ralston. And I am going to ask my fellow senators here to introduce themselves, and then I will go through some of the rules of engagement, if you will. So starting to my immediate right, my friend...

SENATOR KOLTERMAN: I'm Senator Mark Kolterman from Seward. I represent District 24: Seward, York, and Polk Counties.

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

SENATOR RIEPE: Senator Erdman is going to be joining us in...momentarily. He had to open on a couple of bills.

SENATOR CRAWFORD: Good afternoon. Senator Sue Crawford from Legislative District 45: eastern Sarpy County.

SENATOR RIEPE: And I think Senator Williams had another conflict on his schedule; otherwise he would be here, as well.

SENATOR LINEHAN: I'm Senator Lou Ann Linehan from western Douglas County, District 39.

SENATOR RIEPE: Thank you. To my immediate right is Kristen Stiffler; she's the legal counsel for the Health and Human Services Committee. And to my far left is Tyler Mahood, who is our clerk, committee clerk. And with us today, also serving, we have Jordan Snader from Oakland, Nebraska, and Brianne Hellstrom, who is from Simi Valley, California. So thanks to all of those folks, if you will. Today this is your opportunity to participate; we appreciate that and we encourage you to do that. It's part of our Unicameral legislative process. You will also, at times, see committee members coming and going, and that's not that they have a lack of interest in your particular bill or anything else; they have other bills that they're opening on, or testifying, or they

have some other things that are going on legislatively that they need to step out momentarily. You will also see some with computers in hand, and we encourage that because that information on there is the same information that some of us will have in our paper documents. To facilitate today's process, we have a few very simple rules, and one of those is to silence any cell phones, if you will, please. If you intend to testify, and so that we can move the process along, we would ask you to come up and sit in the front row seats; and that will be very helpful to us. The process is this: the introducer will be made, and then the proponents, followed by the opponents, and then anyone having a neutral position, and then we will read into the record any letters that we may have received. And with that, then we will close out the hearing. When you do come up to testify, we will ask you to state your name, spell your name for the record, and also we will be working on a...what I call a traffic light system. We have five minutes: you'll have four minutes under a green light, one minute under an amber light, and then we will go to a red light and we're asking, then, to try to conclude your remarks in the interest of other people that are wishing to testify. I'm going to read this one in. It says: if you will not be testifying at the microphone, but want to go on record as having a position on a bill being heard today, there are white sign-in sheets at each entrance where you may leave your name and other pertinent information. These sign-in sheets will become exhibits in the permanent record at the end of today's hearing. I wanted to get that in. If you do have written material that may be distributed to the committees as exhibits, only while testifying may you do that. And we ask that you talk with pages, or we'll have to have...we need ten copies of those so that we can distribute those to the committee members for decisions. That stated, we will begin our hearings today. And our first bill is LB255, and Senator Crawford will present that bill. Senator, whenever you're ready.

SENATOR CRAWFORD: Thank you. Good afternoon, Chairman Riepe and members of the Health and Human Services Committee. My name is Sue Crawford, S-u-e C-r-a-w-f-o-r-d, and I represent the 45th Legislative District of Bellevue, Offutt, and eastern Sarpy County. I'm honored to be here today to introduce LB255 for your consideration. LB255 would adopt the Dialysis Patient Care Technician Registration Act. The bill establishes a registry for dialysis patient care technicians, or PCTs. PCTs work under the direct supervision of a registered nurse, who is required to be at the dialysis facility. The registered nurse is responsible for making decisions and providing guidance any time the treatment varies from normal parameters or the patient's condition becomes unstable. Over 1,500 Nebraskans receive dialysis treatment due to kidney failure. All but 254 of these individuals receive hemodialysis at outpatient clinic...at outpatient dialysis facilities. There are currently 37 of these outpatient dialysis facilities in Nebraska, all of which employ...all of which employ patient care technicians. Altogether they employ over 90 dialysis patient care technicians, who make up approximately 50 percent of the workforce in dialysis facilities across the state. Since most patients dialyze three times a week, over 194,000 hemodialysis treatments are performed each year in Nebraska. Diabetes and hypertension are the main causes of kidney failure for those receiving dialysis. LB255 resolves an issue that started in May 2015. At that time there was a Board of Nursing staff challenge to the status of a 1991

Board of Nursing advisory opinion which outlined the duties that may be performed by dialysis patient care technicians or PCTs and licensed practical nurses in the dialysis setting, under the delegation of a registered nurse. Dialysis centers in Nebraska had been operating under this advisory opinion since its adoption in 1991. The challenge centered on the legal issue of delegation of care to patient care technicians in Nebraska without a form of licensure or credentialing for the profession. This led to conversations about the best path forward among stakeholders, and LB255 is the result of these conversations. I'm gong to provide a time line, just for the record and for your information, of some of those conversations and that process. In July 2015 the Board of Nursing asked stakeholders to look into developing a credentialing process for PCTs to track and clarify their role. In October 2015 the Board of Nursing voted to officially retire the 1991 advisory opinion. On November 20, 2015, the Nebraska Kidney Coalition submitted a letter of intent for a credential review process for PCTs to the Department of Health and Human Services. On February 23, 2016, the Nebraska Kidney Coalition submitted their credential review application, requesting registration of dialysis patient care technicians. On August 29, 2016, the Dialysis Technologists' Technical Review Committee approved the application, as amended through the 407 process, amended to licensure. On October 13, 2016, the Board of Nursing adopted the following motion: The Board of Nursing recommends that the registered nurse in the dialysis setting retains the authority to safely delegate tasks, based on nursing judgment, to dialysis patient care technicians, based on the PCT's education and training. The Board of Nursing supports the registration of certified dialysis PCTs. On January 23, 2017, the State Board of Health unanimously approved the application, application for registration. In closing, it's been recommended by the Board of Nursing and the State Board of Health that dialysis care technicians be registered with the requirements for registration outlined in LB255. LB255 ensures that an updated record of registered dialysis patient care technicians is created and maintained. It also ensures: that PCTs can enter the workforce and advance their training and certification safely on the job; that practicing PCTs maintain their certification; and that PCTs can continue to serve Nebraskans receiving dialysis in a safe and effective way. After my opening remarks, you will hear testifiers in support of the bill representing Nebraska Hospital Association, the Nebraska Medical Association, the Nebraska Nursing Association, the Nebraska Kidney Coalition, and the Nebraska Kidney Association. I appreciate the time, your time and attention to this issue, and I will try to answer any questions that you may have. [LB255]

SENATOR RIEPE: Thank you, Senator Crawford. Are there questions? Senator Howard. [LB255]

SENATOR HOWARD: Thank you, Senator Riepe. Thank you, Senator Crawford, for bringing us to...this to us today. I did speak with you on the floor about some... [LB255]

SENATOR CRAWFORD: Yes. [LB255]

SENATOR HOWARD: ...questions that I had about the language in the legislation. And so I was hoping that we could just get them into the record. I didn't see a date of implementation for this legislation. When do you feel as though the state would have to start implementing the registration? [LB255]

SENATOR CRAWFORD: So, absent a date in the bill, it would be the date that the...the standard date that the bill goes into implementation. [LB255]

SENATOR HOWARD: And there is no E clause or anything. [LB255]

SENATOR CRAWFORD: Right, so there is not currently an E clause. But I appreciate you raising that question. So I will raise that with stakeholders to see if they think that that is important to add that and, if so, I'll bring that to the committee as an amendment; thank you. [LB255]

SENATOR HOWARD: Otherwise, do you think it's July 1 probably? [LB255]

SENATOR CRAWFORD: That would be my sense. [LB255]

SENATOR HOWARD: Okay. And then, the other question I had was on page 3, line 13, where an applicant or a dialysis patient care technician "may" report any pardon or setting aside of a conviction to the department. Why did you choose "may" versus a "shall" reporting? [LB255]

SENATOR CRAWFORD: Sure, thank you. Well, the...if you...if others are following along on page 3, line 13, what we're talking about here is something that's really to the advantage of the technician. [LB255]

SENATOR HOWARD: Um-hum. [LB255]

SENATOR CRAWFORD: You have a registry to keep track of any concerns or information about the technicians, and so that language is permissive... [LB255]

SENATOR HOWARD: Um-hum. [LB255]

SENATOR CRAWFORD: ...because it's allowing the technician to improve their standing on the registry by reporting that information; so it would be in their incentive to do so. And so we didn't

think it needed to be "shall." It's really an opportunity, in permissive language, to allow them to improve or correct their record, to their favor. [LB255]

SENATOR HOWARD: Okay. And then the last one I have, in the language, is also on page 3, the paragraph that starts...well, Section...well, I guess line 18 to 22. Can you talk to me about--and you did talk about how an RN has to be on site to oversee a PCT? [LB255]

SENATOR CRAWFORD: Um-hum. [LB255]

SENATOR HOWARD: But tell me a little bit more about how, as they move up in licensure, they would no longer need to be registered. [LB255]

SENATOR CRAWFORD: Sure. The underlying issue that drove this conversation was a...was an opinion that, in order to have delegation of care, the person to which the care is delegated needed to have some kind of registry credentialing or licensure. And so the PCT registration we have in this act... [LB255]

SENATOR HOWARD: Um-hum. [LB255]

SENATOR CRAWFORD: ...provides that structure. So an RN would be delegating care to someone who is on a registry. They...if someone is a licensed practical nurse or a registered nurse, they have that credential, so they don't really need to maintain this registry as a credential, because they have another credential that...it is perfectly acceptable in that environment. [LB255]

SENATOR HOWARD: Okay, perfect. And then, so this was a 407 process, and we're still waiting on the chief medical officer's decision on the 407? [LB255]

SENATOR CRAWFORD: That is correct. [LB255]

SENATOR HOWARD: Okay. And so...and so there's some dispute between the Technical Review Committee and the Board of Health. The Technical Review Committee recommended licensure, and the Board of Health recommended just the registry. [LB255]

SENATOR CRAWFORD: So I will allow others behind me to, who were in that process, to speak to it, as well. Here is my understanding of that dynamic that happened. It is my understanding that, as the Technical Review Committee was debating--the proposal was for registry. [LB255]

SENATOR HOWARD: Okay. [LB255]

SENATOR CRAWFORD: And as the Technical Review Committee was debating, there was staff advice recommending licensure instead. And so the licensure was required. And so I believe, if you look through the comments and recommendations and...of the Technical Review Committee, there was a preference for registration... [LB255]

SENATOR HOWARD: Um-hum. [LB255]

SENATOR CRAWFORD: ...but they felt they had to go toward licensure. And then that...so that's what their vote ended up being...was amended to licensure, because they felt they had to go that way because of a legal opinion about delegation of care. [LB255]

SENATOR HOWARD: Okay. [LB255]

SENATOR CRAWFORD: Since that, there have been other conversations about that issue, and so that's why the Board of Health then, after those conversations about that legal setting and bringing stakeholders together... [LB255]

SENATOR HOWARD: Um-hum. [LB255]

SENATOR CRAWFORD: ...the Board of Health felt that it was not required that it had to be licensure, but that registration would be sufficient. [LB255]

SENATOR HOWARD: Okay. [LB255]

SENATOR CRAWFORD: The Board of Nursing then confirmed that choice. [LB255]

SENATOR HOWARD: Okay. [LB255]

SENATOR CRAWFORD: So that's where it...so that is how that process rolled out... [LB255]

SENATOR HOWARD: Okay. [LB255]

SENATOR CRAWFORD: ...is their...the Technical Review Committee had comments then in preference of registration, but did not vote that direction, under staff advice. And then, since

then, that part...meetings to bring the stakeholders together and the Board of Health then confirmed registration as an appropriate choice... [LB255]

SENATOR HOWARD: Um-hum. [LB255]

SENATOR CRAWFORD: ...and the Board of Nursing also confirming registration as an appropriate choice in this healthcare setting. [LB255]

SENATOR HOWARD: Okay, thank you. Thank you. [LB255]

SENATOR RIEPE: Thank you very much. Are there other questions? Hearing none, we will go to the proponents. Doctor? [LB255]

DR. LESLIE SPRY: (Exhibit 1) Good afternoon, Chairman Riepe and members of the Health and Human Services Committee. Thank you for allowing me to testify today. My name is Leslie Spry, L-e-s-l-i-e, Spry, S-p-r-y. I'm a physician, and I reside at 7520 North Hampton in Lincoln, Nebraska. I appear here today in support of LB255, the Dialysis Patient Care Technician Registration Act. By way of history, the first successful hemodialysis treatment was performed by Dr. Willem Kolff in Germany in World War II in 1943. She was a young lady that developed kidney failure and she actually survived the therapy. The first hemodialysis in Nebraska was actually performed by Dr. Francis Neumayer, a surgeon here in Lincoln, on March 13, 1957. Parenthetically, Dr. Neumayer subsequently found out that he had genetic kidney disease and ended up on one of these dialysis machines himself and lived to the ripe old age of 92 while on one of these machines. Since that time, many people have benefited from dialysis treatments here in the state of Nebraska. Dialysis has been performed by physicians, nurses, and technicians since those very early days. Dialysis technicians have been trained to assist in the dialysis process since the early days of dialysis. The National Kidney Foundation first convened a task force to review the tasks performed by dialysis technicians in 1990. The first recommendations for that task force were published in 1993. You'll notice that the Nursing Advisory Commission (sic: Committee) opinion occurred in 1991, which would be in that same time line. The Centers for Medicare and Medicaid Services, CMS, published the Conditions for Coverage of Dialysis Facilities (sic: Conditions for Coverage for End-Stage Renal Disease Facilities) in the United States in April 2008 that included standards for dialysis technicians in the United States. A dialysis technician is an entry-level position that takes a high school graduate and trains him or her to perform routine tasks that include: dialyzer processing, equipment maintenance and repair, water treatment monitoring, participation in quality improvement, vascular access monitoring, and direct patient care. This includes the placement of dialysis access needles into a fistula access and performing the routine dialysis procedure, as prescribed by a physician, and is supervised by nursing staff. After a course of study and direct, on-the-job training...this typically

lasts about 18 months; it takes 18 months for us to train our PCTs...and then they undergo a national certifying examination that is administered by one of three national organizations. Recertification then occurs at regular intervals if the patient care technician completes continuing education credits and maintains employment in a dialysis facility. LB255 would provide state of Nebraska registration for this group of individuals. The state interest is to provide recognition of these individuals and provide for public and welfare of dialysis patients who are receiving dialysis treatments. We provide dialysis treatments as a part of a team of professionals that include: registered nurses, licensed practical nurses, dialysis technicians, social workers, dieticians, and office staff. Dialysis technicians develop skills that, in many cases, cannot be taught. The ability to place two needles into a fistula cannot be performed without some natural skill or dexterity. I often observe that, if I were a dialysis patient, I would not know how brave I might be to allow someone to place two 15-gauge needles into my arm three times a week, in order to undergo the dialysis treatment. Believe me that dialysis patients know who are the good stickers, if you will, and who are not. Our dialysis technicians become very adept and proficient at this practice, with time. Those who do not, do not remain employed for long. Since I have been at the Dialysis Center of Lincoln, this is a testament to the natural ability of our dialysis technicians in that two of them have now become surgeons. The system that is in place for training dialysis technicians is well developed, and LB255 would serve the state purpose for registering these individuals and monitoring the public health and welfare of individuals...of these individuals. I encourage the committee to support this bill and recognize the distinct abilities of these talented individuals. I am pleased that the Board of Nursing has seen fit to permit registered nurses to supervise these individuals and, thus, contribute to the concept of team care of dialysis patients in the state of Nebraska. I'm also proud that we can offer training to these entry-level workers into our job pool for the state of Nebraska. Thank you. [LB255]

SENATOR RIEPE: Thank you, Dr. Spry. Your timing was perfect. Committee members, do you have questions for Doctor? Hearing none, thank you very much; we appreciate your being with us today. [LB255]

DR. LESLIE SPRY: Thank you. Thank you. [LB255]

SENATOR RIEPE: More proponents. [LB255]

TRACI IRLMEIER: Senator Riepe and members of the Health and Human Services Committee, my name is Traci Irlmeier, T-r-a-c-i, and the last name is I-r-l-m-e-i-e-r. I'm a registered nurse that has been working the dialysis industry for over 24 years, and I am currently the president of the Nebraska Kidney Coalition. Our coalition includes dialysis providers across the state and the Nebraska Kidney Association. We are here today to ask you to support LB255, to adopt the Dialysis Patient Care Technician Registration Act. In addition to our coalition organizations, the

National Association of Nephrology Technicians supports the registration of dialysis patient care technicians. Over 90 dialysis PCTs across Nebraska provide excellent care to over 1,500 people with kidney failure who receive a total of over 194,000 dialysis treatments each year. Although no specific public safety issues have been identified in Nebraska, our coalition agrees that registration will ensure the public that dialysis patients will receive safe and excellent care through the approval of a standardized core curriculum and training programs and a nationally certified PCT program. As required by the Centers of Medicare and Medicaid Services, the federal regulations for a dialysis facility includes a multi-disciplinary care service team, which includes: nephrologists, nurses, dieticians, social workers, and patient care technicians, and sometimes licensed practical nurses. Because PCTs are nationally certified, there's an additional assurance that dialysis patients are being served by well-trained and competent technicians who are periodically assessed through evaluations and skill reviews. PCTs work under the supervision of RNs, who follow strict policies and procedures and protocols for each dialysis treatment. While each treatment is somewhat customized for the patient's specific needs, the functions of the PCT are relatively standard from treatment to treatment. RNs are there to supervise and intervene in the case of any emergency or a change in the patient's condition. The Nebraska Kidney Coalition submitted the 407 credential review application last February and, since then, have participated in meetings that were held throughout the year of 2016. There were several issues that were brought up regarding RN delegation of unlicensed personnel and whether PCTs should be licensed or registered. Ultimately all parties involved in the 407 process, including the Board of Nursing and a unanimous vote by the Board of Health, agreed that the lowest level of regulation--that being registration--would be the most appropriate for dialysis PCTs. The Board of Nursing's motion is as follows: Noncomplex nursing interventions can safely be performed according to exact directions, do not require alteration of the standard procedure, and the results of the client and patient responses are predictable. The nursing...the registered nurses may delegate authority, responsibility, and accountability to provide selected noncomplex nursing interventions to a qualified, unlicensed person. Noncomplex interventions become complex interventions when nursing judgment is required to safely alter standard practice procedures, in accordance with the needs of the patient, or require nursing judgment to determine how to proceed from one step to the next, or require multidimensional application of the nursing process. The registered nurse does not delegate complex nursing interventions to an unlicensed person. Further, the Board of Nursing recommends the nursing...registered nurse in the dialysis setting retains the authority to safely delegate tasks, based on nursing judgment, to patient care technicians, based on their education, knowledge, training, and skills. The Board of Nursing supports registration of certified PCTs. Good, safe practice and the PCT registration will ensure protection for the public. I am here to answer any questions you would have; thank you. [LB255]

SENATOR RIEPE: Thank you very much. Are there questions from the committee members? Hearing none, thank you very much for being with us. [LB255]

TRACI IRLMEIER: Okay; thank you. [LB255]

SENATOR RIEPE: More proponents? [LB255]

MELISSA FLORELL: (Exhibit 2) Good afternoon. My name is Melissa Florell, M-e-l-i-s-s-a F-l-o-r-e-l-l, and I'm speaking on behalf of the Nebraska Nurses Association, in support of LB255, the Dialysis Patient Care Technician Registry (sic: Registration) Act. The Nebraska Nurses Association is the voice of registered nurses in Nebraska. This bill is the result of significant dialogue, research, and cooperation among key stakeholders working toward a common goal; and the goal is to deliver safe, cost-effective care for patients receiving outpatient hemodialysis. And the primary consideration in credentialing roles integral to the delivery of healthcare services is patient safety and our ability to maintain public trust in our profession. This is a well-designed patient care dialysis technician registry and will maintain safety and public trust, as well as facilitate the team-based care that's necessary in the dialysis setting. As my colleagues spoke about, initial discussion regarding dialysis patient care technicians focused on the tasks appropriate for delegation to unlicensed staff. And this stems from current regulatory language defining complex versus noncomplex nursing interventions. Complex nursing interventions may only be performed by a registered nurse; noncomplex interventions may be delegated to unlicensed staff. The bill addresses the concern that complex interventions must be performed by registered nurses, and that the noncomplex tasks may be delegated to the trained dialysis patient care technician. It also outlines the process for national certification and recertification, and this ensures that Nebraska's dialysis patient care technicians follow recognized best practice standards. And, during the 407 process, we outlined priorities for a dialysis patient care registry. And those were: that clearly define standardized training and competencies would be in place for the role of dialysis technicians; that those competencies would emphasize training around the routine, but high-risk tasks of Heparin administration and central lines; and that the scope would be limited to community settings; the requirement of facility-approved protocols that are specific and not...don't require interpretation or assessment to implement; and require delegation of those tasks that do require interpretation or assessment be done by a registered nurse; registrations should be administered by the Board of Nursing; and that mandatory reporting for those individuals registered would be in place. NNA feels that these priorities have been met in the language of LB255, and that the bill will work to protect patient safety by identifying dialysis patient care technicians working within the state, set forth mandatory reporting requirements, and ensure national certification within 18 months after initial employment. The bill also facilitates team-based care in the dialysis setting by recognizing the essential role of the assessment of the dialysis patient and delivery of complex care. It is for these reasons that the Nebraska Nurses Association asks for your vote in support of LB255, the Dialysis Patient Care Technician Registry (sic: Registration) Act. And I'd be happy to answer any questions. [LB255]

SENATOR RIEPE: Thank you very much. Are there questions from the committee? Senator Williams. [LB255]

SENATOR WILLIAMS: Thank you, Senator Riepe. Thank you for being here today. [LB255]

MELISSA FLORELL: Yep. [LB255]

SENATOR WILLIAMS: Can you describe to me, if you know--and if you don't, maybe someone else that's coming up could let me know--what type of emergency care training is given to these technicians? If... [LB255]

MELISSA FLORELL: You're... [LB255]

SENATOR WILLIAMS: ...if something... [LB255]

MELISSA FLORELL: You're talking about if something (inaudible)... [LB255]

SENATOR WILLIAMS: I am...I'm...what I'm understanding is they are highly trained... [LB255]

MELISSA FLORELL: Um-hum. [LB255]

SENATOR WILLIAMS: ...in administering the dialysis. But under the supervision that's happening in the dialysis center, other emergencies could happen with that patient. [LB255]

MELISSA FLORELL: Well, part of definition between complex or nursing judgment or care situations that require assessment would roll up to the registered nurse who is there. And when a patient would change in status, they become not stable any longer...and then that would mean that the care, then, would be provided either through protocols that are in place at all dialysis facilities, because they all follow CMS guidelines. And if a patient was needing to be transferred from that, then the registered nurse would work with the physician who's in charge of that, you know, patient's care, to move them either out of that setting or to make sure that they're stabilized in...within the care setting. [LB255]

SENATOR WILLIAMS: So the patient care technician themselves do not have training or skills necessarily in emergency treatment of a patient. [LB255]

MELISSA FLORELL: They...anyone working in a facility, and I will let the folks coming behind me, but would have CPR; they would know how to recognize those instances. [LB255]

SENATOR WILLIAMS: Okay. [LB255]

MELISSA FLORELL: And it's important to note my colleagues had been talking earlier. There has not been any safety issues with dialysis patient care technicians, even in the long history of them providing care in the state of Nebraska. So that would tell me that there are always steps that they know how to take to take care of emergency situations and to move those patients either from their stable status into a higher level of care or to deal with those in house, using the registered nurse and the physician who are supervising. [LB255]

SENATOR WILLIAMS: Thank you. [LB255]

SENATOR RIEPE: Thank you, Senator Williams. Any additional questions? Hearing none, thank you very much for being with us. [LB255]

MELISSA FLORELL: Um-hum. [LB255]

SENATOR RIEPE: Additional proponent, please. [LB255]

ELISABETH HURST: Good afternoon, Chairman Riepe and members of the HHS Committee. My name is Elisabeth Hurst, E-l-i-s-a-b-e-t-h H-u-r-s-t, and I'm director of advocacy with the Nebraska Hospital Association. I'm here testifying on behalf of Nebraska hospitals and the more than 40,000 individuals that they employ. You've already heard the time line of the efforts that went into this process, as well as the very detailed processes that occur in the dialysis centers. What I will tell you today is there are five hospital units that are specific to the facility. Otherwise these patients and their providers are relying on the independent centers from across the state. So it's very important that we ensure that the PCTs are able to function under the registry so that we can ensure that there isn't an interruption in care for these very vulnerable individuals. So with that, just letting you know that the NHA does support this effort and thanks the other stakeholders who have been part of this process, including the department. I am open to any questions that you may have. [LB255]

SENATOR RIEPE: Are there questions from the committee? And these standards of the registration apply to the for-profit and the not-for-profit equally? [LB255]

ELISABETH HURST: Absolutely. [LB255]

SENATOR RIEPE: Okay, just wanted to make sure. Okay. Hearing no other questions, thank you very much for being here. [LB255]

ELISABETH HURST: Thank you, Senator. [LB255]

SENATOR RIEPE: Any additional proponents? [LB255]

TIM NEAL: Senator Riepe and members of the Health and Human Services Committee, my name is Tim Neal, T-i-m N-e-a-l; I reside at 10322 Broadmoor Court in Omaha, Nebraska. I'm the chief executive officer of the Nebraska Kidney Association and also a member of the Nebraska Kidney Coalition. On behalf of the patients we serve across Nebraska, we are asking you to support LB255, to adopt the Dialysis Patient Care Technician Registration Act. The Nebraska Kidney Association has been serving Nebraskans since January 1969. In our mission it states that we are...will improve the lives of all Nebraskans through advocacy, education, early disease detection, and patient services. We are not on the front line in direct patient care of providing dialysis, but we're only one step removed. One in six Nebraskans are at risk of developing chronic kidney disease, or just over 314,000 people. The two leading causes of chronic kidney disease are diabetes and hypertension. With this in mind, we spend a lot of time and resources in early disease detection and education--education of patients, healthcare professionals and the general public. Our hope is that, with early detection, people can either prolong or avoid the onset of kidney disease. However, if a person finds out that they need to be placed on dialysis, we want to make sure that they get the best care possible. The patient care technician is just one of many on the dialysis healthcare team. We feel that registration will ensure the public that dialysis patients will receive the best care possible. With that, I would entertain any questions you might have. [LB255]

SENATOR RIEPE: Thank you very much. Are there questions from the committee members? Hearing none, thank you very much. [LB255]

TIM NEAL: You bet. [LB255]

SENATOR RIEPE: Additional proponents. Any more proponents? Any opponents? None in opposition? Any in neutral positions? Hearing none, Senator Crawford, would you like to close? [LB255]

SENATOR CRAWFORD: Thank you, Committee. And thank you, Chairman Riepe. So I will, and just in closing, note the hard work that's gone on between all of the stakeholders of the various professions...try to make sure that we move forward in a way that ensures we have safe

and effective care, but also trying to do so in a way that has the lowest level of regulation required to ensure that. And that was an important part of that conversation. And so the bill, then, is the result of those conversations, and I would encourage your support of the bill, and be happy to try to answer any additional questions that members might have at this time. [LB255]

SENATOR RIEPE: Very good; thank you. Questions from the committee? Hearing none, thank you very much. Oh, Senator Williams. [LB255]

SENATOR WILLIAMS: Not that lucky (laughter). Thank you, Senator Riepe. Senator Crawford, I wondered if you would be willing to comment on the fiscal note that's attached to this. It appears that they are suggesting there's about 100 of these dialysis care technicians that would need to go through this process on a biannual basis. I'm wondering if that number stays the same. The second go-around, the fiscal note for '18 and '19 shows an increase and it does not show--at least what I'm looking at--the revenue side of that coming back down. Am I missing something there? Or... [LB255]

SENATOR CRAWFORD: Well, the fiscal note says the estimated revenue is $8,000 every other year. And so I will follow up to see...so that's consistent with the narrative under the fiscal note, but I will follow up, in terms of... [LB255]

SENATOR WILLIAMS: What's not consistent? [LB255]

SENATOR CRAWFORD: ...seeing what...yes. [LB255]

SENATOR WILLIAMS: ...is the...if it's a... [LB255]

SENATOR CRAWFORD: Oh, here we go... [LB255]

SENATOR WILLIAMS: ...total of 100... [LB255]

SENATOR CRAWFORD: ...here. [LB255]

SENATOR WILLIAMS: Okay. [LB255]

SENATOR CRAWFORD: So the department...the fee is $80 per credential over a two-year cycle. So it looks like they've put that in the fiscal note just as putting in once. [LB255]

SENATOR WILLIAMS: In one. [LB255]

SENATOR CRAWFORD: In one lump sum there. But it says $80 per credential or $8,000 per two-year cycle... [LB255]

SENATOR WILLIAMS: I'm more... [LB255]

SENATOR CRAWFORD: ...with minimal revenue in the off years, so a two-year cycle of renewal on it. [LB255]

SENATOR WILLIAMS: What I'm questioning by that, if there's minimal revenue, that would mean that there are very few licenses being renewed, yet the expenses go up the second year. And we can talk offline about that, but... [LB255]

SENATOR CRAWFORD: Sure, sure. [LB255]

SENATOR WILLIAMS: ...I would like to get some explanation for that. [LB255]

SENATOR RIEPE: I think the other... [LB255]

SENATOR CRAWFORD: Sure. [LB255]

SENATOR RIEPE: ...important point here is this is the cash fund as opposed to the General Fund, as well. [LB255]

SENATOR WILLIAMS: Yes. [LB255]

SENATOR CRAWFORD: So...well, it is...it is actually only the cash fund. [LB255]

SENATOR RIEPE: Um-hum. [LB255]

SENATOR CRAWFORD: So it is just the cash fund that is...that the money is coming out of, not the General Fund. [LB255]

SENATOR RIEPE: That's right. [LB255]

SENATOR CRAWFORD: Just to be clear and on the record. And so, actually, if you look further on that--the second page, I mean the second page of the fiscal note--the fiscal note actually, from the Department of Health and Human Services, at the bottom of that page you'll see why that cost goes up. So in '17-18, they're projecting less than a .5 number of positions and it goes fully to .5 positions in '18-19. And so that...I'm assuming that's...getting people on board in that process is part of what that estimate is about. And so... [LB255]

SENATOR WILLIAMS: Okay. [LB255]

SENATOR CRAWFORD: ...they will be, then, on board as the new round of applications...as the applications are coming in. So does that answer your question? Or I can follow up. [LB255]

SENATOR WILLIAMS: That...that's good enough for now; thank you. [LB255]

SENATOR CRAWFORD: Okay, thank you. Um-hum. [LB255]

SENATOR RIEPE: Are there other questions? I'm always amused that the fiscal notes are on pink slips. That is...I hope that is not some indication for all of us. Thank you very much for being with us. [LB255]

SENATOR CRAWFORD: Thank you; thank you. [LB255]

SENATOR RIEPE: With that, that concludes the hearing. Oh yes, Tyler, the read-ins. [LB255]

TYLER MAHOOD: (Exhibit 3) Yes, I have a letter of neutral testimony from the State Board of Health, signed by Diane Jackson. And that's the only letter for LB255. [LB255]

SENATOR RIEPE: Thank you; thank you very much. With that, that now concludes the hearing on LB255. Thank you all for attending that are interested in that particular...this bill. We will now move on to LB267, and that is Senator Linehan. And she will be presenting the opening remarks. [LB267]

SENATOR LINEHAN: (Exhibit 1) Good afternoon, Mr. Chairman; thank you, to you and the rest, for holding this hearing. My name is Lou Ann Linehan, L-o-u A-n-n L-i-n-e-h-a-n. In order to prevent the spread of highly contagious illnesses, current law requires that hospitals and nursing facilities make influenza and pneumonia immunizations available to patients and residents. Furthermore, hospitals must offer influenza and immunizations to their employees.

These requirements are based on recommendations from the Centers for Disease Control. For those 65 years of age or older, influenza and associated complications can be especially serious. It is estimated that 90 percent of seasonal, flu-related deaths and more than 60 percent of seasonal, flu-related hospitalizations in the U.S. each year occur in people age 65 or older. Over the last dozen or so years, studies have been done to determine how to curb the number of influenza and pneumonia cases in nursing facilities. Those studies have shown that the best way to prevent influenza outbreaks in nursing facilities is to ensure that both residents and staff are immunized. LB267 requires nursing facilities and skilled nursing facilities to offer on-site vaccinations for influenza disease to all employees and residents. Only the offer to employees is a new addition to the law. I would also like to point out that this is not a mandate, but an offer. Employees would still have the ability to decide for themselves whether they wanted to be immunized. Furthermore, facilities would not be required to offer vaccines in individual cases when not medically advised or if a national shortage of the vaccine exists. Nor would it be required...excuse me...nor would it require any facility listed to cover the cost of the vaccination provided. Thank you, and I would take any questions. [LB267]

SENATOR RIEPE: Questions. Senator Howard. [LB267]

SENATOR HOWARD: Thank you, Senator Riepe. Thank you, Senator Linehan, for bringing this bill. I wanted to ask a question about...so the statute that you're changing talks about acute hospitals and intermediate care facilities offering vaccinations to their residents and inpatients. And then you're taking out nursing facilities and skilled nursing facilities and adding employees to that. Do we have a statute that requires hospitals to offer them to employees already? [LB267]

SENATOR LINEHAN: It's my understanding what we do, yes. [LB267]

SENATOR HOWARD: Okay, great; thank you. [LB267]

SENATOR LINEHAN: You're welcome. [LB267]

SENATOR RIEPE: Are there additional questions? Hearing none, thank you. [LB267]

SENATOR LINEHAN: Thank you very much. [LB267]

SENATOR RIEPE: You'll be here for the closing, we know, (inaudible) the committee. [LB267]

SENATOR LINEHAN: I will be. [LB267]

SENATOR RIEPE: So thank you. Are there proponents? [LB267]

DR. LAZARO SPINDOLA: (Exhibit 2) Good afternoon, Chairman Riepe. Thank you, and all the members of the committee; thank you for receiving me this afternoon. For the record, my name is Lazaro Spindola; that's L-a-z-a-r-o S-p-i-n-d-o-l-a. I am the executive director of the Latino American Commission. Nevertheless, I must clarify that I am not testifying in the name of the commission, but as a private citizen. In fact, I hadn't even met Senator Linehan until this afternoon. So you might wonder what am I doing here...or why. Well, for those who don't know me, in a previous life I was a trauma surgeon for 20 years. And then I did my studies on public health, and I was a public health officer for the next 12 years before coming here today...Capitol. I am here in support of LB285. According to the National Institute of Health...oops, I got the wrong bill. [LB267]

SENATOR KOLTERMAN: That one is next. [LB267]

DR. LAZARO SPINDOLA: It should be LB267, right? [LB267]

SENATOR KOLTERMAN: Yeah. You get the next one. [LB267]

SENATOR HOWARD: Do you want to come back then? [LB267]

DR. LAZARO SPINDOLA: Okay, you can keep this for--what I gave you--for later. [LB267]

SENATOR WILLIAMS: Keep this for later (laughter)? [LB267]

DR. LAZARO SPINDOLA: According to the CDC, in the 2015-2016 influenza season, an estimated 25 million individuals were sick with influenza: 310,000 influenza-related hospitalizations, 11 million influenza-associated medical visits, and 12,000 influenza-associated deaths. Think about this number. More people died this year in the United States than they died in the current wars that our country is fighting. In Nebraska during these same...the 2016-2017 season, the current season, on January 14, 253 patients have been hospitalized, and six patients have died. Influenza vaccination during the 2015-16 season prevented an estimated 5.1 million illnesses, 2.5 million medical visits, 71,000 hospitalizations, and 3,000 deaths. Increasing vaccination coverage will further reduce the burden of influenza, especially among working-age adults younger than 65 years of age, who continue to have the lowest influenza vaccination coverage. I understand that the nursing and skilled nursing facilities may have some difficulties offering and persuading their staff to take the influenza vaccine; if this is the case, the CDC has a link, which is in my handout, that provides a wonderful guidance about when to offer the vaccine

to healthcare staff. I encourage you to approve LB267 out of committee. Influenza is an expensive and potentially deadly condition that can be prevented with the simple application of the vaccine. And having said this, I will be happy to try to answer any questions that you might have. [LB267]

SENATOR RIEPE: Thank you very much. [LB267]

DR. LAZARO SPINDOLA: And I offer this testimony. [LB267]

SENATOR RIEPE: Okay, thank you. Are there questions from the committee members? No? Let me ask this question: Are there cultural concerns that would preclude individuals from wanting to receive the vaccine? [LB267]

DR. LAZARO SPINDOLA: Senator, stupid knows no boundary lines (laughter). [LB267]

SENATOR RIEPE: Put that in... [LB267]

DR. LAZARO SPINDOLA: Whether they be ethnic or national, some people simply refuse to get...have the vaccine given to them for whatever reasons. It's up to the healthcare providers to try to persuade and educate individuals about the convenience of doing this. One great thing about this country is that we are free to take whatever vaccination is offered, and we are also free to refuse it. And I have seen a lot of bad signs behind the vaccine debate, so as I said before, there is nothing cultural; it's mostly an educational issue. [LB267]

SENATOR RIEPE: Okay, thank you very much. [LB267]

DR. LAZARO SPINDOLA: You're welcome. [LB267]

SENATOR RIEPE: Any additional questions? If not, we'll go on to more proponents. Thank you very much. [LB267]

ANNABELLE KEENE: (Exhibit 3) Good afternoon. I'm here representing Immunization Task Force of metro Omaha. My name is Annabelle, A-n-n-a-b-e-l-l-e, Keene, K-e-e-n-e. I reside at 210 Sandi Court in Bellevue, Nebraska. I have a letter that has been prepared by the task force, that I would like to read to the committee; and copies should be circulating to the members. Senator Merv Riepe, Chair, and Committee people, good afternoon. We are writing on behalf of the Immunization Task Force-metro Omaha, in support of LB267, introduced by Senator Lou

Ann Linehan, of Legislative District 39. This bill seeks to require nursing facilities and skilled nursing facilities to offer influenza and pneumococcal vaccination to all employees, residents, and inpatients with an indication for one or both vaccines. This bill extends strategies to promote influenza and pneumococcal vaccination at long-term care, LTC, facilities, and also targets healthcare workers, HCWs, who represent a significant source of transmission to infection for vulnerable patients. It is consistently documented each year that influenza and pneumonia, combined, are the seventh through ninth leading cause of death across the U.S. population, and various sources have listed them as the third through fifth leading cause of death in elderly patients, depending on age group. During the week ending January 14, 2007, Nebraska influenza surveillance indicated multiple "reports of influenza outbreaks in long-term care facilities across the state." So far, during the 2016-17 season, Douglas County Health Department has confirmed six influenza outbreaks in metropolitan area long-term care facilities. There are also tremendous economic costs of influenza and pneumococcal disease for Nebraska. A 2014 economic modeling presentation to the Immunization Task Force on the economic burden of adult vaccine-preventable diseases, VPDs, in Nebraska, reported a total calculated cost of $40 million, based on a 2010 incidence of 22,201 flu cases in the state for those at least 65 years of age. Based on 2,583 pneumococcal disease cases in the same age group, an additional total cost of $19.8 million was estimated for 2010. This adds up to $59.8 million in costs to care for seniors who experience one or both of these VPDs. This does not consider the human costs, where it is common for such patients to end of having to move to a next level of care, if they survive the influenza or pneumonia illnesses. Published evidence shows that expanding access and system-based vaccination interventions to facility workers can increase immunization rates and protect vulnerable long-term care populations. Therefore, in summary, our member groups support the passage of LB267 to better protect our Nebraska seniors residing in long-term care facilities, as well as the dedicated healthcare workers who provide them. We have included a number of citations at the conclusion of this letter that support our recommendation. Thank you for attention to our comments. And the letter is signed by Linda K. Ohri, PharmD., MPH, chair of the legislative committee of the Immunization Task Force; Sharon Wade, RN, BSN, MA, the chair of the Immunization Task Force; and myself, Annabelle Keene, RN. My other credentials are BSN and MSN, co chair of the Community Liaison Committee for the ITF. Thank you very much. I'd be glad to... [LB267]

SENATOR RIEPE: Thank you for being with us. Are there questions from the committee? Seeing none, thank you very much. [LB267]

ANNABELLE KEENE: Thank you. [LB267]

SENATOR RIEPE: Additional proponents? [LB267]

KORBY GILBERTSON: (Exhibit 4) Good afternoon, Chairman Riepe, members of the committee. For the record, my name is Korby Gilbertson--it's spelled K-o-r-b-y G-i-l-b-e-r-t-s-o-n, appearing today as a registered lobbyist on behalf of Sanofi Pasteur, in support of LB267. Before I start my prepared comments, I want to answer Senator Howard's question first, just so I don't forget to do it. The hospital requirements are specifically located in Section 71-467; and under that statute they are required to do influenza vaccines, also give a...what's called a Tdap shot, which includes tetanus, pertussis, and diphtheria. So immunizations...so just for that information...I know that there is some confusion about where that all fell into different statutes early on, after this got introduced. First of all, as we know, anyone can get flu, but it can be very much more serious for some people. Currently in Nebraska, hospitals require access flu...or provide access to flu vaccines for their employees and patients. Nursing facilities are currently required only to offer them to their residents. LB267 would just increase that offer and, again, it's just an offer if an employee decides they do not want to take...have the shot, they do not have to take it, but obviously, hopefully education and making it easily available will increase the use of that. And a lot of people ask why this is important. I've worked on immunization bills in the past, and get asked why do we need to do this and, if it affects me. I don't think I should have to do it. There have been multiple studies trying to figure out why they haven't been able to reduce the number of influenza outbreaks in nursing facilities, even though they have increased the number of...the rate of immunization in those populations. And every study has led them to see that it's really the fact that the staff members are not getting immunized. And one problem is that, with the flu, you can spread the flu virus for up to a day before you feel any symptoms. You can actually carry the flu virus for up to four days before you get any symptoms, and then you can also pass on the virus for up to a week after you start showing symptoms. So this just shows you how dangerous the flu virus can be when you're working with populations that already have high risk for catching things and then having associated diseases, like the pneumonia, which is also required for nursing facilities under a current law. People who are 65 years and older and people with any chronic medical conditions, very young children, are more likely to get complications from the flu. The CDC estimates that between 71 percent and 85 percent of seasonal, flu-related deaths occur in people over 65 years of age. And between 54 percent and 70 percent of seasonal flu-related hospitalizations have occurred among people in that same age group. The most recent Nebraska influenza surveillance report, which I provided you a copy of, showed that 149 out of 253, which would be almost 60 percent of hospital inpatient admissions for influenza, were for those who are 65 or older. In the past week, there have been multiple outbreaks in long-term care facilities and there have been four influenza-associated deaths in Nebraska so far this season. They were all adult cases, with the median age being 87. And all that data is located on page 7 of that report. The CDC and the Advisory Committee on the Immunization Practices, or ACIP, which this bill refers to and are the recommendations that are required to be followed, not only by this statute, but other statutes that require immunizations, recommends that all U.S. healthcare personnel get vaccinated. For years, and a number of years ago we worked on the legislation to make sure that the hospital employees were getting vaccinated...I don't...it was, I would say,

more of an oversight that the nursing facilities weren't added at that time, maybe because of the specific statute that we were looking at, at that time. But one of the biggest things that the CDC, in their recent findings and their recommendations, say there that the higher influenza vaccination levels among healthcare personnel can reduce influenza-related illness, and even deaths, in settings like nursing homes. Also in your packet you'll see that I provided a copy of a proposed amendment. After we got the bill drafted, the final draft back from bill drafting, we were asked to remove the requirement for nursing homes to also make an offer for the pneumococcal vaccine, because it is not specifically enumerated in the recommendations for the CDC. Because of that, this amendment, which you have in your packet, would take out that language. The second change, and I'll shut up unless somebody wants to let me keep talking. [LB267]

SENATOR RIEPE: I'm sorry. [LB267]

KORBY GILBERTSON: I see my time is up, so I didn't want to keep going. [LB267]

SENATOR RIEPE: You can go ahead and finish up if you want. [LB267]

KORBY GILBERTSON: Okay. The second change would make a change to strike the word "inpatient," because nursing home residents are typically referred to as residents, not inpatients. That language had come from the earlier area of Section 71-468, where the old...or the old requirement was, and so, by adding this amendment, we would just specifically say the nursing home residents, instead of saying inpatients. [LB267]

SENATOR RIEPE: Okay. [LB267]

KORBY GILBERTSON: So that would be the two changes. And with that, I'd be happy to try to answer any questions. [LB267]

SENATOR RIEPE: Thank you very much. Are there questions? Senator Howard. [LB267]

SENATOR HOWARD: Thank you, Senator Riepe. Thank you for talking with us about this. Is this the right place for...if we're going to include employees, should we be putting it with the hospital employees? [LB267]

KORBY GILBERTSON: Well, the hospital employee section is specifically just talking about...it's just acute care hospitals. [LB267]

SENATOR HOWARD: Okay. [LB267]

KORBY GILBERTSON: And so the only place in statute right now that requires nursing facilities or skilled nursing facilities to do anything was here in 71-468. [LB267]

SENATOR HOWARD: Okay, okay. [LB267]

KORBY GILBERTSON: And so what this amendment did--or what this statute change would do--is, instead of just having it in one section, we separate it out, the acute hospital and the nursing home language, just to make it more clear and, hopefully, easier to follow, since they're not all...so they're not all bunched together. [LB267]

SENATOR HOWARD: Okay. [LB267]

KORBY GILBERTSON: So this is really the only place they're referenced in the other Sections. [LB267]

SENATOR HOWARD: And then I wanted to ask about the amendment. So your amendment would remove the pneumococcal vaccine? [LB267]

KORBY GILBERTSON: Right. And it would, just for the employees. It would leave it...it would leave it...leave status quo... [LB267]

SENATOR HOWARD: Leave it for... [LB267]

KORBY GILBERTSON: ...for the residents. But then it would just say "influenza to all employees." [LB267]

SENATOR HOWARD: Okay. And then do we have a definition of a resident versus an inpatient elsewhere in the statute? [LB267]

KORBY GILBERTSON: That, you know, I don't know the answer to that question. They are already...it's already referred to in statute before. [LB267]

SENATOR HOWARD: Right. [LB267]

KORBY GILBERTSON: So that was the existing language... [LB267]

SENATOR HOWARD: Okay, all right. [LB267]

KORBY GILBERTSON: ...in the law. So I don't know if we need to add a specific, since it's already in statute. I don't really know. [LB267]

SENATOR HOWARD: Well no, since we're removing "inpatients," I just wanted to... [LB267]

KORBY GILBERTSON: Right. We don't... [LB267]

SENATOR HOWARD: ...check the reference. [LB267]

KORBY GILBERTSON: ...we don't remove it; it's still in Section 1. You'll see it's still there... [LB267]

SENATOR HOWARD: Right. [LB267]

KORBY GILBERTSON: ...if you're looking at the statute. And the second part...they just don't...I was told... [LB267]

SENATOR HOWARD: They just don't have it. [LB267]

KORBY GILBERTSON: ...that they don't have in..."inpatients" in nursing facilities; they're referred to as residents. [LB267]

SENATOR HOWARD: But are they referred to in statute as residents? [LB267]

KORBY GILBERTSON: Yes; that's my understanding; that's what I was told and asked to take out the "inpatient" because there is no such thing. [LB267]

SENATOR HOWARD: Okay, thank you. [LB267]

SENATOR RIEPE: In the interest of good management... [LB267]

KORBY GILBERTSON: Um-hum. [LB267]

SENATOR RIEPE: ...what do you think the percentage of nursing homes that don't already subscribe or provide this on a voluntary basis because they, too, want to keep their residents healthy? That keeps their occupancy up, selfishly. Number 2, they do have an interest in maintaining a staff that will show up and be well to take care of patients. I'm just...I'm a little bit surprised if... [LB267]

KORBY GILBERTSON: I think... [LB267]

SENATOR RIEPE: ...if there wasn't a high percentage that already do this. [LB267]

KORBY GILBERTSON: Right. I think there is a high percentage that already does do it but, obviously, you'll always have outliers that need some assistance in doing it. And so, when we...I know when we worked on this with the hospitals, a great number of hospitals were already doing it. But this would just make it...it offer, so that when they're having the annual flu shot day, they can offer it both to employees and to the residents that are there. [LB267]

SENATOR RIEPE: Okay. Are there... [LB267]

SENATOR WILLIAMS: Go ahead. [LB267]

SENATOR RIEPE: Senator Crawford and then Senator Williams. [LB267]

SENATOR CRAWFORD: Thank you, Senator Riepe. And thank you for your testimony. [LB267]

KORBY GILBERTSON: Um-hum. [LB267]

SENATOR CRAWFORD: I wondered if the...what the conversation or logic was behind emphasizing influenza and not having the pneumococcal be included for the employees. [LB267]

KORBY GILBERTSON: I think the basis of that argument is if you look at the CDC recommendations, which I decided not to kill several trees because the actual recommendations run about 70 pages and just the summaries 18. But they go through, and it does not specifically mention pneumococcal for the employee side of it. Pneumococcal is specifically for people at higher risk or that age group. [LB267]

SENATOR CRAWFORD: Excellent, thank you. [LB267]

KORBY GILBERTSON: Um-hum. [LB267]

SENATOR RIEPE: Senator Williams. [LB267]

SENATOR WILLIAMS: Thank you, Senator Riepe. And thank you, Korby. Has the amendment that you're offering...has that been talked to with the introducer of the legislation? [LB267]

KORBY GILBERTSON: Yes, I have. [LB267]

SENATOR WILLIAMS: And she is... [LB267]

KORBY GILBERTSON: Yes, I have vetted it with her. And I...but I told her I would try to explain it since, obviously, it's kind of...it... [LB267]

SENATOR WILLIAMS: Okay. [LB267]

KORBY GILBERTSON: ...since it's only a few words, it's rather hard to understand unless you know exactly where it's getting put then. [LB267]

SENATOR WILLIAMS: Thank you. [LB267]

KORBY GILBERTSON: Um-hum. [LB267]

SENATOR RIEPE: Okay. Other questions? Hearing none, thank you very much. [LB267]

KORBY GILBERTSON: Thank you very much. [LB267]

SENATOR RIEPE: Additional proponents. [LB267]

DR. ANNA DALRYMPLE: Okay. Well, good afternoon, Chairman Riepe and other members of the HHS Committee. My name is Dr. Anna Dalrymple. I'm one of the residents at the Lincoln Family Medicine Center here in Lincoln. I'll be practicing in Gothenburg, Nebraska, when I'm finished this year. And I'm here on behalf of the Nebraska Academy of Family Physicians, as the... [LB267]

SENATOR RIEPE: Would you spell out your name, too, for the record? [LB267]

DR. ANNA DALRYMPLE: I'm sorry; oh, yes. A...sorry, it's A-n-n-a D-a-l-r-y-m-p-l-e. [LB267]

SENATOR RIEPE: Thank you. [LB267]

DR. ANNA DALRYMPLE: So I'm here on behalf of the Nebraska Academy of Family Physicians, as a resident member. And so a lot of people have already talked about some things I was going to discuss, so I won't repeat those things because you've heard those things. We did want to be here in support of this bill; we thought it was something that could help bridge the gap, in certain areas, for bringing this to other people. Very briefly, just to go over these again, the pneumonia vaccine...there's actually two, and you're covering for a lot of certain strains of the bacteria. The types of infections that are caused by this bacteria are blood infections, brain infections like meningitis, and pneumonia. So these are pretty significant infections that cause a lot of morbidity and mortality. Influenza--same thing as we've heard from previous testimony--we do see significant hospitalizations, as well as death, from influenza. And they're...coming from a primary-care perspective; we have a lot of people who aren't vaccinated yet. Whether it's a patient or people working in facilities, it would be good to do that. Again, we've heard already about the updates recently in Nebraska. Like to just go over a few more. Just last week, as of this year, we've had 14 schools that had over 10 percent absences across the state because of influenza. And I would strongly suspect that these numbers are underrepresented, because we have a lot of people who don't get tested. And so again, just to reiterate that whether it's in a nursing home or somewhere else, it's a widespread problem. And then, again, to kind of talk about that, if we're talking about vaccinating employees, that is also helpful to everyone that they're in contact with, whether it's their family or others. So it's a preventive measure that can really cause a lot of good outcomes in the state. I think that's really the main things. I have a lot of things that everyone else said, so I think that that's...that kind of adds a few more things. So I'd be happy to answer questions or talk about the vaccine schedules or anything else, from a primary-care standpoint, as well. [LB267]

SENATOR RIEPE: Thank you; thank you very much. Are there questions from the committee? Senator Williams. [LB267]

SENATOR WILLIAMS: Senator Riepe. Thank you, Dr. Dalrymple, for being here. I think you mentioned, in your opening, you are going to be practicing family practice somewhere in central Nebraska. [LB267]

DR. ANNA DALRYMPLE: Yes. [LB267]

SENATOR WILLIAMS: Where was that again? [LB267]

DR. ANNA DALRYMPLE: Gothenburg (laughter). [LB267]

SENATOR WILLIAMS: No further questions (laughter). [LB267]

SENATOR RIEPE: Thank you. [LB267]

DR. ANNA DALRYMPLE: Okay; thank you very much. [LB267]

SENATOR RIEPE: Thank you very much. Okay. Any additional proponents? Any opponents? No opponents. Any neutral that want to testify in a neutral position? Hearing none, Senator Linehan, would you like to close, please? [LB267]

SENATOR LINEHAN: Certainly. Thank you. I just want to add that, when this was brought to me, I thought it was a good idea for a couple of good reasons. When I was running for the Legislature, I visited several nursing homes in my area; and they're not all the same. So I think what we can do to encourage this would be good. And secondly, I think, when you look at people who have worked at nursing homes, the young parents--busy all the time, always know they need to get the shots, but just never have the time to go do it--so however we can make it easier for them, it would be better. So thank you very much. [LB267]

SENATOR RIEPE: Thank you. Are there questions from the committee? I know that there...I noticed there's no cost. There is a cost, but it's not a cost to the state, so there's no fiscal note, so... [LB267]

SENATOR LINEHAN: I know; I was very happy about that. [LB267]

SENATOR RIEPE: That's very good. Okay. [LB267]

SENATOR LINEHAN: Okay. [LB267]

SENATOR RIEPE: Thank you very much for being here. [LB267]

SENATOR LINEHAN: Thank you very much. [LB267]

SENATOR RIEPE: Tyler, do we have any letters that have come in? [LB267]

TYLER MAHOOD: (Exhibit 5) Yes. I have a letter, with a neutral position, signed by Heath Boddy of the Nebraska Health Care Association. And that is the only letter for LB267. [LB267]

SENATOR RIEPE: Very good; thank you very much. That will conclude the hearing on LB267. Thank you very much for coming and sharing with us. And thanks to the doctor from Gothenburg. [LB267]

BREAK

SENATOR RIEPE: Thank you very much. Now we're going to open on LB285 and, again, this is Senator Linehan. We will ask for your opening comments, please. [LB285]

SENATOR LINEHAN: (Exhibit 1) Thank you again. Mr. Chairman and committee members, my name is Lou Ann Linehan, L-o-u A-n-n L-i-n-e-h-a-n. LB285 makes two changes to Nebraska Public Health statutes. First, it outright repeals Section 71-531 and, second, it adds a requirement for physicians to add an HIV test to the currently-mandated blood test for pregnant women. As background, Nebraska passed a law more than 20 years ago that required special treatment for human immunodeficiency testing--or HIV testing. That law, Section 71-531, states that: no person may be tested for the presence of HIV infection unless he or she has given written informed consent for the performance of such test, and is given an explanation of the meaning of both positive and negative test results. That means the law requires, any time a physician or healthcare provider performs an HIV test, a special written consent has to be produced, signed, and maintained, and an explanation given about what the test is and what could happen in the event of a positive result or a negative result. The law made sense in the 1990s. It was discovered that HIV caused AIDS, in 1983. In the 1980s and '90s, even into the 2000s, a positive HIV test could have negative consequences, potentially including the loss of employment and community ostracism. It made sense then to require an opt-in to HIV testing. Fast forward to 2017. Physicians' offices, hospitals, and community healthcare facilities are still required to take special time and keep special documentation for an HIV test, even though the need for specialized testing does not exist. I introduced LB285 to address this problem. As I stated, LB285 first repeals the statute that requires healthcare providers to give HIV special treatment--Section 71-531. You may ask why we should repeal this section. Isn't it still a good idea to inform a patient about an HIV test? Of course it is. Physicians do inform patients. But the need for special treatment for HIV testing no longer exists, on a broad scale, today. The benefits of HIV testing outweigh the potential for discrimination. In 2006 the Centers for Disease Control recommended that states no longer need to provide separate, written consent for HIV testing. In fact, the CDC specifically stated that HIV opt-out laws are not recommended. Nebraska is the

last state that still requires an opt-in for HIV testing. Repealing Section 71-531 will put Nebraska in line with the CDC recommendations and remove burdensome government mandate. Second, LB285 will require that a pregnant woman receive an HIV test. I was concerned, when asked to introduce this legislation, about adding another governmental mandate. Do we really need to mandate that pregnant women get an HIV test? I learned that blood tests are generally performed in groupings and the best practices for pregnant women to have blood...it is best practices for a pregnant women to have blood test early in her pregnancy. Currently, pregnant women are tested for: RH factor, hemoglobin levels to determine anemia, hepatitis B, syphilis, and HIV. Nebraska law specifically mandates a pregnancy blood test for syphilis. These tests are conducted in order to treat the mother and protect the baby, but HIV is the only one of this list that requires an opt-out. The CDC recommends that every pregnant woman get tested for HIV. If she is tested, the chance that HIV infection will be transmitted from the pregnant woman to her child can be reduced to 1 percent or less. But first, the pregnant woman and her doctor must know if she is infected with HIV. LB285 would require that pregnant women in Nebraska be tested for HIV along with the requirement for a syphilis test. LB285 puts Nebraska in line with CDC requirements and best practices for medical care. Others who follow me will give more information about the need for LB285. I'm happy to try to answer any questions. [LB285]

SENATOR RIEPE: Thank you very much. Are there questions? Senator Howard. [LB285]

SENATOR HOWARD: Thank you, Senator Riepe. Thank you for bringing this bill today. You know I care very much about pregnant women and maternal and infant health policy. So this is a really interesting and good idea. I wanted to learn more about the section that's repealed, 71-531, and ask you, first, who brought this bill to you? [LB285]

SENATOR LINEHAN: Mueller Robak. [LB285]

SENATOR HOWARD: A particular client of Mueller Robak? [LB285]

SENATOR LINEHAN: Where is...you know, I didn't really ask her because, when I looked at it, I thought it was such a good idea. I was like, okay, that makes sense. [LB285]

SENATOR HOWARD: Right. [LB285]

SENATOR LINEHAN: And I should admit here that I have five grandchildren and their moms, and it is...a healthy baby is always... [LB285]

SENATOR HOWARD: Right. [LB285]

SENATOR LINEHAN: ...in everybody's best interest. [LB285]

SENATOR HOWARD: Right. And so did you get the letter from the ACLU... [LB285]

SENATOR LINEHAN: I don't think so. [LB285]

SENATOR HOWARD: ...about this? I can give your staff a copy. They indicated concerns about Section 71-531, the repeal, more because it gets rid of some requirements about referrals when you're found to be HIV positive. And then it also gets rid of some requirements that are on corrections. But I will give this letter to your staff, and then you'll have an opportunity to comment. [LB285]

SENATOR LINEHAN: Well, I can...I think I know the same subject because, as a new senator, I probably didn't read the repeal part of the law, not realizing that was important until two or three days ago. And when I did, I realized that Senator Chambers might not like it. So I took the repeal part to him yesterday... [LB285]

SENATOR HOWARD: Okay. [LB285]

SENATOR LINEHAN: ...and discussed it with him and said that we would need to do some work to address, I'm guessing, the same concerns that are in that letter. [LB285]

SENATOR HOWARD: Some of the corrections pieces right here... [LB285]

SENATOR LINEHAN: Right. So that...I have already spoken to him, and I've spoken to people who have brought it to me, and we've got to work those issues out; I realize that's a problem. [LB285]

SENATOR HOWARD: Great. And I'll make sure you get a copy of this letter. [LB285]

SENATOR LINEHAN: Okay; thank you very much. [LB285]

SENATOR HOWARD: Thank you. [LB285]

SENATOR LINEHAN: Other questions? [LB285]

SENATOR RIEPE: Are there other questions of the committee? Okay. And we will probably, before the hearing is over, understand exactly who had brought the bill to you, that will explain it, so... [LB285]

SENATOR LINEHAN: Yes, we will. [LB285]

SENATOR RIEPE: More proponents. [LB285]

ROBERT LOGAN JONES: (Exhibit 2) Thank you, Chairman Riepe and members of the committee. My name is Robert Logan Jones, for the record R-o-b-e-r-t L-o-g-a-n J-o-n-e-s. I was born and raised in Omaha, Nebraska, and I am currently a fourth-year medical student at the University of Nebraska Medical Center, with the goal of becoming an infectious disease specialist. I'm here to testify in support of LB285, to change provisions regarding current state policy on human immunodeficiency virus, or HIV. I also represent the support for this bill from the Nebraska Medical Association, a organization representing nearly 3,000 active and retired physicians, residents, and medical students from across the state of Nebraska, as well as the support from the UNMC Student Delegates, which is an interprofessional student advocacy organization composed of students from the many different colleges at UNMC. While others today will provide testimony on other aspects of this bill, my focus is on Section 4, that repeals Revised Statute 71-531. In its current form, 71-531 requires medical professionals to obtain written consent specific to HIV testing. In medicine today, no other infectious disease is currently subject to these same legislative regulations, the result of which has profound implications. Restrictive policies surrounding HIV testing have a negative impact on the medical community's ability to treat and control HIV infections. Specifically, policies that require written consent for HIV testing have been shown to be substantial barriers to testing. As a medical and public health concern, this is troublesome, as the scientific literature has demonstrated that early identification and treatment of HIV not only improves patient prognosis, but also has been shown to reduce or even eliminate the possibility of disease transmission. Nebraska is the last state in the U.S. to still have an active policy that imposes these written consent requirements for HIV testing. Other states have either opted to include language to accommodate verbal consent while many others have chosen to remove the specific policies altogether. The latter of these is what we are hoping to accomplish for Nebraska with LB285. While I could continue to recite medical and public health literature that describes the theoretical impact the current law has on the medical practice in Nebraska, I would be remiss if I did not also share with you the tangible barriers that I have encountered in my short time at UNMC because of statute 71-531. In my precious free time away from studies and clinical responsibilities, I am a volunteer at the UNMC RESPECT Clinic--a free and reduced-cost sexually transmitted infection clinic. We are located at 15th and Ames and service an area of Omaha that has rates of STIs greatly above national norms. All of our patients are offered full screening evaluations for possible STIs; all of these tests are covered under general-consent testing except for HIV. Because HIV requires us to

obtain additional written consent, many patients, who are already feeling embarrassed and uncomfortable due to their social situation they find themselves, feel further stigmatized and judged regarding their situation. For such a delicate subject, this additional barrier to testing, unfortunately, leads to patients to forgo HIV testing, representing 10 to 20 percent of my patients, by rough estimate. In addition to the stigma that the written consent creates, the act of obtaining written consent can be a time-consuming step. The medical community has watched as increasing documentation burdens are slowly smothering the joy doctors derive from caring for patients. As a student, I have watched the residents I work with struggle to find five minutes for a lunch break or even a bathroom break. Having an interest in HIV medicine, it saddens me to report that, too often, I have watched as opportunities to follow guidelines on HIV screening have often been avoided, often as a consequence of the time burden. To spend five minutes to find the consent form, walk back to the patient's room, and discuss testing, can be too great a barrier when you consider it should be as simple as asking, "Ma-am, have you ever been tested for HIV? It is recommended that all sexually active adults be tested at least once. Would you be interested in this testing while you are in the hospital?," and dropping a quick order in the hospital medical record. Finally, I do not pretend that the diagnosis of HIV is to be taken lightly, but I do believe it carries more negative stigma than is warranted. My heart breaks when I hear of the personal hardships my HIV patients face from the stigma this disease still carries. I have sat at the bedside with a mother of three, in critical condition because two years prior she stopped seeing her HIV specialist. A member from her church learned of her diagnosis, and the gossip spread like fire. The patient felt targeted and ostracized. After finding another faith community, she swore she would not seek HIV treatment if it meant potentially facing that loss again. Repealing statute 71-531 is something tangible that can be done to chip away at the stigma these patients face every day living with HIV. The continued existence of statute Section 71-531 is, for Nebraska physicians and the patients we serve, a source of continued stigma, distrust, and failed opportunity to improve the health of our state. I thank Senator Linehan for introducing LB285, and I urge the members of the committee to support the repeal of Section 71-531 contained in this bill. Thank you for your time, and I will gladly address any questions you may have. [LB285]

SENATOR RIEPE: Are there questions? Senator Crawford. [LB285]

SENATOR CRAWFORD: Thank you, Senator Riepe. And thank you for this excellent testimony; I appreciate that, Doctor. In the testimony you lay out what it might look like when you're with a patient. [LB285]

ROBERT LOGAN JONES: Um-hum. [LB285]

SENATOR CRAWFORD: And what you have... [LB285]

ROBERT LOGAN JONES: Um-hum. [LB285]

SENATOR CRAWFORD: ...in the testimony is an example of verbal consent. Would that be...are there particular guidelines or statutes or regulations that shape what that verbal consent looks like? [LB285]

ROBERT LOGAN JONES: It's generally...there are recommendations from the CDC contained the document that Senator Linehan was referring to, the 2006 guidelines that talks about what a test might look like, positive or negative, but just a screening as well. It falls to medical communities to enter a practice. And then, when it comes to screening, if patients would like more information, we always offer that to them. By no means are we trying to just pull a fast one on them or just sneak a test in there for the sake of testing. But, in terms of just verbal consent on screening tests, a simple, "This is what the recommendations are; would you be interested?," and getting that affirmation from the patient documented as such. [LB285]

SENATOR CRAWFORD: That is the guideline... [LB285]

ROBERT LOGAN JONES: Um-hum. [LB285]

SENATOR CRAWFORD: ...that medical practice would recommend. That's what we would expect doctors to do in the absence of this...if we change the statute. [LB285]

ROBERT LOGAN JONES: Exactly. [LB285]

SENATOR CRAWFORD: Thank you. [LB285]

ROBERT LOGAN JONES: Um-hum. [LB285]

SENATOR RIEPE: Senator Howard. [LB285]

SENATOR HOWARD: Thank you, Senator Riepe. And nice to see you again. [LB285]

ROBERT LOGAN JONES: Yes. [LB285]

SENATOR HOWARD: Can you tell me what else requires written consent? [LB285]

ROBERT LOGAN JONES: In terms of infectious agents right now? [LB285]

SENATOR HOWARD: Or in terms of anything when somebody comes to the doctor. [LB285]

ROBERT LOGAN JONES: Written consent...so typically we consider this to be when you arrive for medical treatment, there's a general consent for medical tests and procedures. If somebody was admitted to the hospital, additional procedure that might need to be obtained, beyond that general consent when you arrive, would be things like: blood transfusion; if they were going to undergo any invasive diagnostic testing, such as lumbar puncture, which is when we place a small needle into somebody's back to obtain spinal fluid; if they were to undergo any type of procedure that would require us to place a scalpel or any type of sharp instrument to a patient; placing large bore IV needles into someone's neck or arm that would be used for special medicines if somebody was in the ICU; some of those types of things. But diagnostic testing, if it were just a simple blood test...nothing else, to my knowledge, would require additional consent to this nature. [LB285]

SENATOR HOWARD: Okay. And so do those written consents for the other procedures sort of slow down the work, as well? Is that something that a physician is administering the written consent, or is a nurse going over it with the patient? [LB285]

ROBERT LOGAN JONES: It has to be a physician, as part of the care team, so it requires us to get the consent form, to sit down to go over all the positive and negative risks associated with each thing. Each different procedure has their own inherent risks and benefits. You have to overgo what a patient could expect if they didn't undergo that procedure or test--diagnostic test. And it does...it does slow things down, especially to have something that is...we're trying to include in just a more less-stigmatized, less-isolated, and we are hoping to get universal screening to require something for a screening test such as this, would be...is proportionately...is disproportionate to requiring consent to the inherent concern from the general medical community at this time. [LB285]

SENATOR HOWARD: And part of the repealed section requires a referral. [LB285]

ROBERT LOGAN JONES: Um-hum. [LB285]

SENATOR HOWARD: And that's something that you would do in general practice anyway? [LB285]

ROBERT LOGAN JONES: That is absolute standard medical practice. [LB285]

SENATOR HOWARD: And there's no possibility that there would be a physician who would want to conscientiously object to assisting a patient or offering them those referrals because of some sort of moral issue? [LB285]

ROBERT LOGAN JONES: I would be hard pressed to give you a concrete answer on that; there are definitely instances. But the general consensus, I would perceive at this point, would be you would have a duty to at least inform another that your patient, that you're uncomfortable treating them at this point, due to their condition, and make an appropriate referral on to somebody else who could assume that care. [LB285]

SENATOR HOWARD: Okay, thank you. [LB285]

ROBERT LOGAN JONES: Yeah. [LB285]

SENATOR RIEPE: Any other questions? I have a question. [LB285]

ROBERT LOGAN JONES: Absolutely, sir. [LB285]

SENATOR RIEPE: You're what, within months of becoming an official MD? [LB285]

ROBERT LOGAN JONES: That is true. [LB285]

SENATOR RIEPE: Well then, this should be an easy question. When will this test occur? I mean, at what point in time, regarding a pregnancy, would this test occur? [LB285]

ROBERT LOGAN JONES: Oh, for the testing for the obstetrical components of this? [LB285]

SENATOR RIEPE: Yes. [LB285]

ROBERT LOGAN JONES: I do not plan on taking care of pregnant women (laughter); I would defer this question to the people that do, behind me. [LB285]

SENATOR RIEPE: Okay. [LB285]

ROBERT LOGAN JONES: Yeah. [LB285]

SENATOR RIEPE: I am going to let you off with that. [LB285]

ROBERT LOGAN JONES: There you go. [LB285]

SENATOR RIEPE: Are there any other questions? Thank you very much; good to see you again. [LB285]

ROBERT LOGAN JONES: Thank you. [LB285]

SENATOR RIEPE: Thank you. More proponents. Doctor? [LB285]

DR. LESLIE SPRY: (Exhibit 3) Good day again, Senator Riepe and members of the committee. My name is Leslie Spry; I am...I spell it L-e-s-l-i-e, Spry, S-p-r-y. I am here representing the Nebraska Medical Association, and I reside at 7520 North Hampton, here in Lincoln, Nebraska. I appear here today in support of LB285 and for repeal of Section 71-531 of the Revised Statutes Cumulative Supplement, as of 2016. This bill, among other things, repeals Section 71-531 that was enacted in 1994, requiring specific, written, informed consent for the performance of human immunodeficiency virus, or HIV, testing, except in the case of organ and tissue donation, certain insurance underwriting, and certain instances that occurred in the Department of Correctional Services. This section mandated a separate, written, informed consent be obtained from each and every individual before any HIV testing could be performed. Since this statute was passed, there have been many changes in the public perception of HIV and acquired immunodeficiency syndrome, or AIDS. The stigma and legal repercussions of HIV testing are no longer prevalent in the United States. One in five infected, HIV-infected individuals living in the United States remain completely unaware of their infection. Early HIV screening allows the institution of antiretroviral and other appropriate therapy for the treatment of AIDS, as well as the prevention of HIV transmission. Many studies have shown that the old risk-based testing that we used to do, based upon a subject having risk, has not diminished the incidence of new cases of HIV or AIDS. In 2006 the Centers for Disease Control and Prevention, CDC, recommended routine, voluntary HIV screening for all patients between the ages of 13 and 64, as a normal part of medical care. They recommended that this testing be done without requirement for informed, signed consent. The American College of Physicians, ACP, in 2009 also endorsed universal screening and recommended expanding the age range up to age 75. In 2013 the United States Preventative (sic: Preventive) Services Task Force recommended universal screening among patients between ages 15 and 65. The USPTF (sic: USPSTF) also found growing evidence that antiretroviral therapy could reduce the risk of HIV sexual transmission and also reduce the morbidity and mortality associated with HIV-infected individuals. In my practice, we meet with patients in our office and discuss testing and the reasons for such testing. When we see the patients, our front office staff usually provide a general consent document that permits us to see,

perform testing, and treat patients. This is signed by the patients before we see the patient. Again, this is a general consent. However, my front office staff is not competent to provide informed consent on the nuances of HIV testing. There is no other infectious disease or other blood test that requires me to sit with the patient and obtain informed consent before I actually administer the test. The verbal consent that is obtained by the patient or the practitioner who is seeing the patient in their office at that time is usually the legal precedent and, then, documentation thereafter is the legal precedent that is required for informed consent. The requirement to obtain a separate informed consent leads to delay and excess paperwork that does not benefit patient care and, I would submit, is not necessary. I encourage the committee to support the repeal of Section 71-531 contained in LB285; this will lead to greater efficiency and more effective patient care. This is the right thing to do. Patients (sic: physicians) and other practitioners will always work in the best interest of the patient in mind. We will discuss proposed testing during the visit and document that the patient agrees to that proposed testing. Maintaining a separate form is not necessary. And I would be happy to answer any questions. [LB285]

SENATOR RIEPE: Thank you; we'll probably have some. Are there questions of the committee? [LB285]

DR. LESLIE SPRY: Yes. [LB285]

SENATOR RIEPE: Senator Crawford: [LB285]

SENATOR CRAWFORD: Thank you, Senator Riepe. And thank you, Dr. Frye (sic: Spry). The...in one of the letters that we have in our...that has been submitted to the committee, it talks about the fact that the bill, and part of the part that it changes, is also taking out a guarantee that the person has a right to anonymous...excuse me, to have their referral be confidential. And I just wondered if...we talked quite a bit about the testing side of it; I wondered if you could speak to privacy protections... [LB285]

DR. LESLIE SPRY: Um-hum. [LB285]

SENATOR CRAWFORD: ...in terms of referrals...the absence statute, what that would look like. [LB285]

DR. LESLIE SPRY: In 1993, that was prior to the time of HIPAA, or the portable... [LB285]

SENATOR CRAWFORD: Oh, oh sure. [LB285]

DR. LESLIE SPRY: Okay. So the informed and patient protection that, as afforded under HIPAA, was not available at that time. I'm not sure I can tell you exactly when that was passed, but I know it was post 1993. There are now protections in place that we have in our office that absolutely guarantee the patient privacy in all endeavors, including referrals, including any documentation that they may have that they...a particular disease. And we do not impart that or release that information to anyone, on anybody's request, unless we get the specific written consent of the patient to do so. [LB285]

SENATOR CRAWFORD: Excellent. Thank you; that's very helpful. [LB285]

SENATOR RIEPE: Okay. Are there other questions? I have a question. And is this a mandatory for all pregnant women? Is that the... [LB285]

DR. LESLIE SPRY: No. This would be what we call an opt out. So what would happen is, is that usually...and I'm not an OB, so there's an OB coming up here in just a minute who will answer your question about when this is done. But I just do know that this is an opt out. So it means that it is suggested and it would be required that, under statute, that this be offered to women. They can opt out of this but, as I think it was previously testified to, the...usually a panel of these things are done and there's a routine panel, and if you do them as all of a routine panel, they're cheaper than to do them individually, and so that's why they're done in, usually, in an OB's office or a family practice or someone who's going to act as the supervisor of that pregnancy for that young lady. [LB285]

SENATOR RIEPE: Dr. Spry, do you know if the HIV, the test window and how that will reflect, positive or negative, on the diagnosis for pregnant women? What's that... [LB285]

DR. LESLIE SPRY: Well now, I'm not...I can't...I won't be able to speak to the absolute nuances of HIV testing. HIV testing is quite sensitive now. I mean, the HIV...we now use DNA techniques that are extremely sensitive. We used to use much more gross techniques, and those techniques now include specific DNA testing of the virus and virus present. [LB285]

SENATOR RIEPE: Um-hum. [LB285]

DR. LESLIE SPRY: That used to rely upon, sometimes, antibody testing, which is not very good. And we used to rely upon western blot testing, which also wasn't very good. But now, with some of the newer testing, they can specifically test the virus. We can test it very early on, and that's some of the information that has come from the United States Preventative (sic: Preventive)Services Task Force, is that, with these new tests, early identification...it wasn't

clear...previous treatment used to wait until the...until certain lymphocyte counts got low enough before you initiated treatment. Even though you may have virus in your blood, if your counts weren't low enough, we didn't initiate treatment. Now it has been shown by scientific studies, that you can treat them very early on, and avoid all those secondary complications, including mortality and morbidity. [LB285]

SENATOR RIEPE: So it is safe to say that testing would occur early in the pregnancy with the agreement of the patients. [LB285]

DR. LESLIE SPRY: Yes. [LB285]

SENATOR RIEPE: Okay. A question that you may or may not be familiar with, but what about illegal immigrants? Who pays on that? Do you happen to know? [LB285]

DR. LESLIE SPRY: Well again, these tests...someone would have to come in to be seen in the office. All this does is just says that if, in my judgment, a test should be administered and, again, remember that this is being recommended for all age groups from age 13, in some cases, all the way up to 75. It's being recommended for all individuals, in other words, universal screening. Now that doesn't mean that we screen all immigrants, as far as I know. But then I don't screen immigrants very often, so... [LB285]

SENATOR RIEPE: Okay. I had the same thing about those without insurance, if that was an automatic screen or if...whether that was discriminatory in that regard, or how that works. [LB285]

DR. LESLIE SPRY: I don't know that specifically. Again, the goal here is that studies in early, 10,15 years ago, showed that risk-based testing--in other words, identifying hemophilia, men who have sex with men, patients who have potential sexual transmission, IV drug abusers--those kinds of risk-based screening was not effective in decreasing the new population of HIV/AIDS that were coming out. Now that there has been universal screening, early studies have...are demonstrating: Number 1, improved mortality/morbidity over the long course of time with early treatment and early intervention before counts start to drop, the lymphocyte counts start to pop; and secondarily, that the prevalence of the disease has been declining, a little blip down, so that's... [LB285]

SENATOR RIEPE: Are there other questions? And if not, thank you very much; I think we're probably going to hear some more here soon. Other proponents. [LB285]

DR. LAZARO SPINDOLA: (Exhibit 4) Good afternoon, Chairman Riepe. For the record, my name is Lazaro Spindola; that would be L-a-z-a-r-o S-p-i-n-d-o-l-a. I am the director of the Latino American Commission, but I have the same disclaimer as previously; I'm here as a private citizen. I am here in support of LB285. According to the National Institutes of Health, all HIV-exposed infants should receive postpartum antiretroviral drugs to reduce the risk of perinatal transmission of HIV. These antiretroviral prophylaxes should be initiated as close to the time of birth as possible, preferably within 6 to 12 hours of delivery. That is the window, the optimal window--6 to 12 hours. We cannot wait to test the infant before initiating the treatment. We need to know, beforehand, whether the infant has been exposed to the virus or not. The Pediatric AIDS Clinical Trials Group proved that the administration of antiretroviral therapy to pregnant women and their infants could reduce the risk of perinatal transmission by nearly 70 percent. The only way to determine if an unborn child has been exposed to the HIV virus is by testing the mother because, as I said before, if we wait to test the infant, we're wasting the time, or that golden window of opportunity that we have. Not providing neonatal treatment to a child will determine the odds of developing HIV infection increase dramatically. Without insurance...and this kind of goes to your question about individuals who are not here illegally...without...who are not here legally. Without insurance, the annual HIV/AIDS treatment costs can go as high as $14,000 to $20,000 per year. This is according to Michael Kolber, a professor at the University of Miami Miller School of Medicine. The mother could be here undocumented, unauthorized. But we're talking about the child who will be an American citizen and, if untreated, will incur into this kind of expense. You might wonder why am I so interested in HIV, because part of my public health term of 12 years included supervising an HIV prevention program. And that's how I became acquainted with our national deceit in that we have become increasingly used to the idea that HIV is no longer a problem because treatments have been so successful. It is a problem; it is a problem and, as soon as we lower our guard in this sense, it will come back to haunt us. Testing the mother makes sense from both the human and economic aspects, so I encourage you to approve LB285 out of committee. Now regarding another comment that you made in my previous testimony, there is definitely a cultural stigma associated with HIV testing, especially with the hospitals. When you have to sign the consent form, previously to coming inside the doctor's office, previously, before being seen by the doctor, women will mostly go over it with their husband, and husbands are very reluctant to admit that they...there is a possibility of an HIV infection happening to them. So I think this bill makes sense. One side effect would be an increase in the rate of divorces (laughter) among couples, but we are...let's remember we're talking about the unborn child here, not about the mother. That's the one that we want to prevent from getting the infection. Thank you, and I'll be happy to try to answer any questions that you may have. [LB285]

SENATOR RIEPE: Thank you. Are there questions? Seeing none, thank you again. [LB285]

DR. LAZARO SPINDOLA: You're welcome. [LB285]

SENATOR RIEPE: I appreciate it. Okay. [LB285]

DR. SHELLEY NELSON: (Exhibit 5) Hi. Thank you for having me. My name is Shelley Nelson, and it's S-h-e-l-l-e-y N-e-l-s-o-n, and I am a pediatrician here, locally, in Lincoln. And I am here representing the Nebraska Medical Association and the American Academy of Pediatrics, and I support bill LB285, brought forth on behalf of the Nebraska Medical Association. As far as my back story, I was raised here in Lincoln; I did my medical training up in Omaha, for medical school. And then I did my residency out in Indiana, in Indianapolis, and I lived there for the past five years and practiced for two of those there, and then moved back here six months ago to continue practicing. So prenatal HIV screening became very important to me as I was practicing in Indianapolis for the last few years, but also as my time as a newborn hospitalist at a busy urban hospital in Indianapolis. Indiana screened every pregnant woman, with each pregnancy, for HIV. And we had very, very few women decline this testing. Our hospital had protocols for HIV-positive deliveries that went really smoothly. They were very smoothly followed by nurses, doctors; everybody felt fairly comfortable with how patients were tested and then treated. I personally was tested during both of my pregnancies in Indiana, along with my other routine blood screening, including my hemoglobin, my syphilis screening, my hepatitis B status, my gonorrhea and my chlamydia statuses, all just a routine panel done in my first trimester, actually at my very first OB appointment. But our...Dr. Van Pelt will speak more to that. The importance of prenatal HIV screening, HIV screening in general, became even more important in the spring of 2015 in a small community outside of Indianapolis, where an HIV epidemic had started. Over 190 cases of newly-diagnosed HIV were diagnosed in a few month's time. In part, the situation was created from defunding of needle exchange programs and the very low cost of heroin at present. However, the state responded quickly to intervene and put in place screening programs, education, and needle exchange programs, which all but had halted the spread of cases. However...and this greatly affected me; it was about 80 miles south of Indianapolis. So I definitely took care of moms that, you know, were from rural communities. And it's hard to say who was closely affected by this, so thank goodness all of our screening programs were in place with this. However, when I moved back to Nebraska this last summer and I began rounding in the hospitals, seeing brand new, newborn babies, I was noticing that very few pregnant moms here had ever been tested for HIV, and that was really concerning to me. In fact, I have been losing sleep on this the last six months, just because I have been so worried. I came to discover that Nebraska had opt-in testing, requiring the specific written consent for this specific infectious disease testing to be done, outside of all the other routine panel. As far as a pediatrician and a primary care physician, I carry about every aspect of newborn health, from safe sleep to good nutrition to good parent dynamics and...but screening for infectious disease passed from mother to baby in utero is of utmost importance. If a woman is treated for HIV early in her pregnancy, the risk of transmitting HIV to her baby can be 1 percent or less. Without treatment early in her pregnancy, the risk of transmitting HIV to her baby is vastly higher. And in the spirit of preventative care, Nebraska does a newborn state

screen that we screen for any congenital conditions that we can intervene on at an early age and prevent long-term poor outcomes; so we can change the long-term outcome of that condition. And I view this screening, so HIV screening, in the very same sense so, if we can intervene early enough in the pregnancy or even in the first 12 hours of the baby's life, we can essentially eliminate the transmission of this disease. And even if we can screen early in the baby's life and find them to be positive, the earlier we treat, the better their outcome. So this move to do opt-out testing incorporates the same spirit of this preventative care. The prevention of transmission of the HIV virus to infants, but also, if identified early and started on appropriate therapy, will give the baby the best chance to live a long and healthy life. It is clear that early identification of all pregnant women with HIV is the best way to prevent neonatal infection and improve the women's health. Truly, it's one test that can save two lives. This test should be performed as early as possible in pregnancy; usually it's done with the first prenatal panel in the other routine blood work that is obtained. It is also important for all women, since the estimated 1.1 million adults living in the United States with HIV at the end of 2009...18 percent were unaware of their infection. Approximately 8,500 women living in the United States with HIV give birth every year. Of the 40,000 new HIV infections that occur in the U.S. each year, women are 11,000 of those new-diagnosed cases. Approximately 200 of those are still babies born to infected mothers. 88 percent of the estimated 104 children in the United States that go on to have the advanced stage of HIV, also known as AIDS , got their HIV test...or got their HIV through a perinatal transmission. So it has been since 1995 that the CDC has recommended that all pregnant women be tested for HIV and, if found to be infected, be offered treatment to prevent passing the virus to their infant. Currently the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the CDC, and the Institute of Medicine all recommend the universal HIV testing as a routine component of prenatal care. Furthermore, this opt-out testing that's part of LB285 has been shown to be vastly more effective than the opt-in testing approach that's currently the law in Nebraska. Data from medical record surveys show that requiring specific, informed, written consent results in lower testing rates than does the recommended opt-out testing approach. And to give you some numbers, in 2002 a study was done in opt-in states, which Nebraska is, and they show that the rates of this women signing the consent and getting the test done, was anywhere from 25 to 69 percent. In an opt-out state, with that approach, it was 85 to 92 percent of women ended up getting the HIV test done prenatally. So efforts to implement this test and testing laws across the nation have been very effective, and rates of perinatal transmission have dropped dramatically. However, new perinatal infections still occur in the U.S., and this is because women are not aware of their diagnosis, are not in prenatal care, immigrate after pregnancy, from another country, or are unable to adhere to care and treatment. And if you reference on the CDC Web site regarding HIV testing laws, it states: all but Nebraska have laws that are consistent with CDC recommendations, in the second part... [LB285]

SENATOR RIEPE: Are you done with... [LB285]

DR. SHELLEY NELSON: ...and there's a source down here below that says that. [LB285]

SENATOR RIEPE: Are you close to... [LB285]

DR. SHELLEY NELSON: Oh, sorry. [LB285]

SENATOR RIEPE: Okay. Are you close to finishing? Are you closing up? [LB285]

DR. SHELLEY NELSON: Okay, yeah. I have about two sentences; sorry. So I support changing to opt-out testing, mostly because opt in is a barrier to testing. And I think opt out is special because it preserves the woman's right to refuse the test, while protecting her autonomy as a patient, but it also helps protect the health of both woman and child, so that's it. I welcome any questions. [LB285]

SENATOR RIEPE: Okay, thank you very much. Committee members, questions? I have a question. [LB285]

DR. SHELLEY NELSON: Yes. [LB285]

SENATOR RIEPE: If the opportunity of that window of needing to treating a child very early, if that's missed, what is then the prognosis for the child going forward? [LB285]

DR. SHELLEY NELSON: So if there is reason to suspect, we have testing that can be done at various intervals after the child is born. However, for a while after any infant's blood carries a lot of maternal antibodies and antigens, so it will hard, at that point, to differentiate whether it's mom's infection still, or baby's. So they have to be followed for some months until it can be decided whether they are truly infection free or whether they do have HIV. However, if it's unsuspected that the child has HIV, mom has either, you know, refused or declined this testing for whatever reason or not come up into care...a lot of women, you know, arrive with very little prenatal care and just deliver in the hospital. So sometimes very little is known. It's essentially just up to the pediatrician to have close followup, as we usually would be for our well-child checks. And unfortunately, it's not usually recognized until something really drastic or dramatically changes in their health status. So usually they start getting unusual infections or they have a series of infections that would bring the suspicion. [LB285]

SENATOR RIEPE: Would that usually show up in the first six months or a year? [LB285]

DR. SHELLEY NELSON: Yes, and actually many of them, if they're undiagnosed and we don't suspect and do testing early enough, they actually pass away, probably, in that time frame. So... [LB285]

SENATOR RIEPE: Okay. Other questions? Hearing none, thank you very much. Thank you for coming down here and talking to us today. [LB285]

DR. SHELLEY NELSON: Okay, thank you. Thank you very much for having me. [LB285]

SENATOR RIEPE: Other proponents. [LB285]

DR. JENNA VAN PELT: (Exhibits 6-8) Hello everybody. Thank you for having me. My name is Jenna Van Pelt, J-e-n-n-a V-a-n P-e-l-t, and I'm an OB/GYN here in Lincoln, Nebraska. I did medical training up at UNMC, went to Columbus, Ohio, to the Ohio State University and had to watch those Buckeyes play for four years (laughter). But I'm happy to be back home in Lincoln. I am with Women's Clinic of Lincoln, OB/GYN. I'm testing today in support of LB285. HIV has been around for over 30 years. We've heard the numbers; over 1 million people here in the United States are living with HIV, 40,000 to 50,000 new infections every year, and one in five do not know that they are actually infected. The American College of OB/GYN, or ACOG, as I'm going to go from here on, states very clearly--it's black and white--HIV testing is to be made readily available to patients. Its language is intentionally gray on most topics because it gives positions leeway to practice, because everybody practices in different settings. But regarding HIV testing, especially in the obstetrics population, the language is black and white. They highly recommend opt-out testing to not create any barriers and to not make a patient sign any special forms that are not otherwise signed for the rest of prenatal screening tests. So you've heard what we do. We see a patient. The first time we see them, we do an ultrasound to confirm that they're pregnant. Then we also draw a blood test. That test has a panel with their blood type, their hemoglobin, syphilis, which is as common as HIV--also a sexually-transmitted infection, hepatitis. HIV is on that panel, but we have to give them that extra sheet of paper to sign. And patients don't; from experience, my patients will not sign it. I don't know why. I think that they see it as an extra test that is optional. We live in Nebraska; a lot of us are very conservative people and, when thinking of pregnancy, we don't necessarily want to do the extra things. If something, you know, looks like it's optional, usually they decline. And that is just really unfortunate because I think that we could...you don't know who has HIV. And when I was out in Columbus, we had a 20-year-old, otherwise completely healthy person, walk into labor and delivery. She had had no prenatal care because she was only 20 years old and didn't have very many resources. So we were able to screen her, at that time, for HIV. We did a rapid test that actually came back positive in a 20-year-old with one previous sexual partner. Our management changed dramatically. We had to do a C-section at 38 weeks instead of letting her do a vaginal

delivery, because she was not controlled. Had we known that at the onset of pregnancy, we would have been able to get her on medication right away, potentially, you know, go on to have a vaginal delivery, which is best for mom and baby, if the viral load was less than 1,000. So because if viral load is controlled to less than 1,000, rate of transmission is less than 2 percent. So you can either do a C-section or vaginal delivery, but do something that is less invasive. And also, as a healthcare provider who performs surgery, it's also nice to know HIV status in a patient because we take extra precautions in the OR to avoid needle sticks and dangers to the OR staff, surgeons, and anesthesia team. And then another point I wanted to address briefly was cost. I spoke with LabCorp--that's where we run our blood work. Currently most insurance agencies cover HIV testing as part of STD screening for both pregnant and nonpregnant women. Cost to the patient would not be altered, especially because, if it was going to her deductible and she's pregnant, she's paying that anyway the minute she walks into the hospital for delivery. But if they were to pay out of pocket just for HIV, currently it's $54.00, which is a very reasonable price, considering long-term outcomes. So please consider passing this bill. When I wrote my testimony, I thought we were one of only two states, with New York being the other one with the opt out, but they've already changed it. So they're an opt-out state as well, and we are the only ones that are making people sign this extra paper, which is creating a barrier. So I'd be happy to take any questions that you guys have at this time, and thank you for having me. [LB285]

SENATOR RIEPE: Are there questions from the committee? I have a question. [LB285]

DR. JENNA VAN PELT: Um-hum. [LB285]

SENATOR RIEPE: If you would test the mother at the initial determination of the pregnancy, do you then test sometime in midpregnancy? If you... [LB285]

DR. JENNA VAN PELT: So that's another recommendation. If you have a high prevalence, if you're living, you know, in the inner city...Columbus, Ohio, we did. We performed HIV and syphilis at that 28-week mark, as well. Here the prevalence is not that high, so we would not perform it again. A one-time screening, I think, would be sufficient. [LB285]

SENATOR RIEPE: So it's kind of on a probability factor that is going... [LB285]

DR. JENNA VAN PELT: Yeah, a little bit. And if risk factors change, if I have a patient who I know is, you know, in an unstable relationship or with a new partner during pregnancy, I would offer it to her again. [LB285]

SENATOR RIEPE: Okay. [LB285]

DR. JENNA VAN PELT: But it also takes a...you know, it takes some time, too, for that test to turn positive, if you have been recently infected. I'm not sure exactly, but I usually recommend coming back six months later, if you have been exposed, again, just to make sure that that test is still negative, because it doesn't seroconvert right away. [LB285]

SENATOR RIEPE: I suppose a part of that is taking care for the history and physical, too, of the... [LB285]

DR. JENNA VAN PELT: Um-hum. [LB285]

SENATOR RIEPE: ...multiple partners, and that kinds of numerous questions that come up. [LB285]

DR. JENNA VAN PELT: Yes. And we see... [LB285]

SENATOR RIEPE: Okay, well. Thank you very...oh, Senator Crawford, do you have something? [LB285]

SENATOR CRAWFORD: Thank you, Senator Riepe. And thank you, Doctor, for being here today. [LB285]

DR. JENNA VAN PELT: Um-hum. [LB285]

SENATOR CRAWFORD: I wondered if you could talk to us about what that verbal consent, what the consent looks like when it's a panel of tests. So one of the previous testifiers indicated what the language was like if he was asking for verbal consent for someone for the HIV test alone. I think what you are...you and a couple other testifiers have talked about this being in a panel of tests. So when you're interacting with a patient, I come in, what would you tell me, in terms of... [LB285]

DR. JENNA VAN PELT: Um-hum. [LB285]

SENATOR CRAWFORD: ...informing me about the tests that are in that panel, and ask me for my consent of that? [LB285]

DR. JENNA VAN PELT: Just what I said. So thank you for coming to our OB office; congratulations on your pregnancy. The first thing that we do is a blood draw, and that blood

draw has your blood type, it tests your hemoglobin level, and it tests for several infections, including hepatitis, syphilis, and HIV. Is that okay to proceed with this test? [LB285]

SENATOR CRAWFORD: Okay, thank you. [LB285]

DR. JENNA VAN PELT: And I think it can be as simple as that. [LB285]

SENATOR RIEPE: Okay. Thank you. Any additional questions? Okay; thank you very much. [LB285]

DR. JENNA VAN PELT: Thank you very much. [LB285]

SENATOR RIEPE: More proponents? [LB285]

ERIC DUNNING: Good afternoon, Mr. Chairman and members of the Health and Human Services Committee. My name is Eric, E-r-i-c D-u-n-n-i-n-g, Dunning. I appear here today on behalf of Blue Cross and Blue Shield of Nebraska. I am a registered lobbyist, and we're here to go on record in support, in particular, of Section 1 of the bill. The...we cover these tests as part of the preventative services under the Affordable Care Act, so they're covered at 100 percent in the case of pregnancies. And that's even before the application of copayments and other cost sharing. Okay. [LB285]

SENATOR RIEPE: Thank you very much. [LB285]

ERIC DUNNING: Thank you. [LB285]

SENATOR RIEPE: Are there..let me...let's see if there are other questions here. You're not getting off that easy. [LB285]

ERIC DUNNING: Just my luck. [LB285]

SENATOR RIEPE: Senator Kolterman? I saw you move your mic, so... [LB285]

SENATOR KOLTERMAN: Thank you, Senator Riepe. How are you, Eric? Do you know... [LB285]

ERIC DUNNING: Nervous, actually. [LB285]

SENATOR KOLTERMAN: I like that. Do you know, are all policies...do all policies, under the Affordable Care Act, they do require this at a (inaudible)... [LB285]

ERIC DUNNING: Right. This is a federal requirement. [LB285]

SENATOR KOLTERMAN: Are there any old policies out there any longer that wouldn't require... [LB285]

ERIC DUNNING: Under the...under the so-called "grandmothered" policies... [LB285]

SENATOR KOLTERMAN: Grandfathered? [LB285]

ERIC DUNNING: I don't actually know how that's handled. [LB285]

SENATOR KOLTERMAN: Okay. Okay. [LB285]

ERIC DUNNING: That was something that occurred to me as I was sitting in the audience, actually. [LB285]

SENATOR KOLTERMAN: I had the same question; that's why I asked. [LB285]

ERIC DUNNING: Okay. [LB285]

SENATOR KOLTERMAN: I figured you would know. [LB285]

ERIC DUNNING: Well, we'll...I know the right people to ask, and I'll look it up, and I'll get back to you. [LB285]

SENATOR KOLTERMAN: Thank you. [LB285]

SENATOR RIEPE: Any other questions from the circuit? Okay; thank you very much, Mr. Dunning. Other proponents of the bill. [LB285]

ELISABETH HURST: Good afternoon, Chairman and members of the HHS Committee. My name is Elisabeth Hurst, E-l-i-s-a-b-e-t-h H-u-r-s-t, and I am director of advocacy with the Nebraska Hospital Association. I'm here simply to say that we also are in support of LB285, recognizing that the universal panel is more comprehensive and, therefore, more beneficial in the long run, also knowing that it's a more efficient means of conducting the test, both for the providers and the facilities, as far as streamlining the process. Early HIV testing is essential for ensuring the most positive health outcomes, and outcomes are why we support this effort. And we thank Senator Linehan for bringing LB285 and ask you to advance the bill. [LB285]

SENATOR RIEPE: Okay. [LB285]

ELISABETH HURST: And I'm happy to answer any questions you have. [LB285]

SENATOR RIEPE: Any questions? Hearing none, thank you very much for being here. More proponents? Proponents? Not seeing any more, do we have any opponents? None in opposition? Any in the neutral capacity? Hearing none, Senator Linehan, would you like to close? [LB285]

SENATOR LINEHAN: I'd like to very much. I actually did...was aware that Nebraska Medical Association brought the bill forth, but it slipped my mind when Senator Howard asked me. [LB285]

SENATOR HOWARD: That's okay. [LB285]

SENATOR LINEHAN: I was excited to bring this bill to the committee but now, after hearing the testimony, I'm even more convinced that we need to move it. We're talking about moms, and I was not aware, until the testimony, that we had so many people walking around at risk that were unaware. And anything that we can do...not only is it the right moral thing to do, but it's also a cost savings. So thank you. [LB285]

SENATOR RIEPE: Are there questions? Is it fair to say that this is basically switching from an opt in to an opt out, so it fits the burden of doing it, just in the opposite position? [LB285]

SENATOR LINEHAN: Right. [LB285]

SENATOR RIEPE: To be in short order? [LB285]

SENATOR LINEHAN: Right. And I was especially taken by the woman who practiced in...I think she said Ohio; you don't know if you don't know. And if they ask you, you're like okay, well, of course I don't need that test. So it is...it seems, at this point, after listening to testimony, a little irresponsible. [LB285]

SENATOR RIEPE: Thank you very much. [LB285]

SENATOR LINEHAN: Thank you. Oh. [LB285]

SENATOR WILLIAMS: I do have a question. [LB285]

SENATOR RIEPE: Oh. Yes, Senator Williams. [LB285]

SENATOR WILLIAMS: Now that I think about it and it's...thank you, Senator Riepe, and thank you, Senator Linehan. How are we going to proceed forward? And will your staff proceed forward, addressing the concerns of the ACLU and those issues that are encompassed with that, that are really outside of what our testimony is here about pregnancy and you know, when we're talking corrections and other issues? [LB285]

SENATOR LINEHAN: Yes, I will; I'm going to. I told...I think...it's my understanding that I might...I was certain of this, that part of the language that's there now is...Senator Chambers supported that language, so I will work with him. And I think it also would be very helpful if some of the testifiers today, especially the young man that goes to medical school, if he could maybe go with me to talk to the ACLU and Senator Chambers and others with the concerns, to see that this is, this is an issue that affects the people that they, you know, are particularly concerned about, too. [LB285]

SENATOR WILLIAMS: Sure. Thank you. [LB285]

SENATOR LINEHAN: You're welcome. [LB285]

SENATOR RIEPE: Some other questions? Thank you very much. [LB285]

SENATOR LINEHAN: Thank you very much. [LB285]

SENATOR RIEPE: And with that, that...oh. Anything, any letters? I'm sorry, Tyler. [LB285]

TYLER MAHOOD: (Exhibits 9-12) Yes. I have a letter signed by Traci Bruckner of the Women's Fund of Omaha, in support; a letter from Dr. Jason Coleman, representing himself, in support; a letter from...signed by Jordan Delmundo of the Nebraska AIDS project, in support; and one letter signed...from the ACLU, signed by Amy Miller, in opposition. [LB285]

DR. JENNA VAN PELT: And Rachel Swim has a letter in support, as well, from the Women's Clinic. [LB285]

TYLER MAHOOD: And we just have that (inaudible) in the record. [LB285]

SENATOR HOWARD: Good morning, (inaudible); we just finished. [LB285]

SENATOR ERDMAN: It was so exciting over there. [LB285]

SENATOR HOWARD: Where were you at? [LB285]

SENATOR RIEPE: Is that it? Okay; thank you very much. That concludes the hearing on LB285. [LB285]