[LB391 LB466 CONFIRMATION]

The Committee on Health and Human Services met at 1:30 p.m. on Friday, March 3, 2017, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB391, LB466, and gubernatorial appointments. Senators present: Merv Riepe, Chairperson; Steve Erdman, Vice Chairperson; Sue Crawford; Sara Howard; Mark Kolterman; Lou Ann Linehan; and Matt Williams. Senators absent: None.

SENATOR RIEPE: There we go. I am Merv Riepe. I am chairman of the Health and Human Services Committee. I represent District 12, which is Omaha, Millard, and Ralston, in the greater Omaha area. The committee today will be taking up bills in the order posted. We're going to have some hearings and some reappointments. And this is your part to...your role or your opportunity to be part of the public process and the opportunity to express your opinions and be engaged. The committee members will be coming and going at times during the hearing. This is introducing other bills, testifying in other bills. So do not take it as a personal offense. We will also...you'll see some of them working on computers, on their laptops; we encourage that. Some are highly into the technology age, and some of us not as much. I would like to take the pause now and ask all of the members of the committee and the staff to self-introduce. I am going to start to my extreme right over here. Senator.

SENATOR KOLTERMAN: Senator Mark Kolterman, District 24: Seward, York, and Polk Counties.

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

SENATOR ERDMAN: Steve Erdman, District 47: ten counties in the Nebraska Panhandle.

KRISTEN STIFFLER: Kristen Stiffler, legal counsel.

SENATOR CRAWFORD: Good afternoon. Senator Sue Crawford, my district...District 45, which is eastern Sarpy County, eastern Bellevue, and Offutt.

SENATOR WILLIAMS: Matt Williams, District 36: Dawson, Custer, and the north part of Buffalo Counties.

TYLER MAHOOD: Tyler Mahood, committee clerk.

SENATOR RIEPE: And I would like to introduce our wonderful pages, and which is Brianne Hellstrom, who's from Simi Valley, California, and Jordan Snader, who is from the lovely Oakland, Nebraska. And they have been very helpful for us all session, and we do appreciate it. I am going to go ahead with some of the details. These are the rules of engagement, if you will. We're going to ask you and all committee members to silence or turn off your cell phones. We would ask you, if you are going to testify, to move forward as your time would come, so that we can move the process along and get as many witnesses, in favor or opposed, as we possibly can. The testifiers will be asked to sign in, hand your orange sheet to the committee clerk at when you come up to testify. The process, as it works here in the committee, is the senator who is making the introduction, or the person in this...today's case, that one being either reappointed or appointed, will be coming up to the mic and being making their comments. For those that are introducing bills, the senator will introduce, and we will follow then by proponents, opponents. We will go to those that are testifying in a neutral capacity. Following that, we will go to Tyler, who will read any letters that we may have received to be part of the official record. And we will then ask the introducing senator to come up, if he or she so chooses, to make any closing remarks. We ask people, when they do come up, to state their name and to spell it out; and that's for the purposes of the record. We are being recorded. Today we're going to be working on a four-minute clock. It'll be...or a five-minute clock...it's going to be four minutes on the green, one on the amber, and then you'll get a red light. We'll ask you to try to pull your comments together when you hit the red, just like a stop sign. And if it goes beyond that, I may interrupt and ask you if you can...to conclude. Senator Linehan just joined us. Senator, you're from which district?

SENATOR LINEHAN: District 39, thank you...western Douglas County.

SENATOR RIEPE: Thank you. I did want to read into the record, too, that 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. The sign-in sheets will become exhibits in the permanent record at the end of today's hearing. If you have...if you are testifying, written materials may be distributed to committee members as exhibits only while testimony is being offered. Hand them to a page for distribution to the committee and staff when you come up to testify. We would ask you to provide us with ten copies for all of the members and staff. And if you don't happen to have ten members (sic: copies), we would ask you to, please, make note to that with the pages, and they're very good about getting that information for us. Today we are going to start with some reappointments for the Nebraska Rural Health Advisory Committee. And our first reappointment is the CEO of one of our community hospitals, and that is Mr. Martin Fattig. Did I get that right, Marty? [CONFIRMATION]

MARTIN FATTIG: Well, close. [CONFIRMATION]

SENATOR RIEPE: Well, close...close doesn't count. How...you'll tell us when you get up there. I apologize. [CONFIRMATION]

MARTIN FATTIG: (Exhibit 1) Good afternoon, Senator Riepe and all of you, the rest of you. I consider many of you personal and professional friends, so it's great to see you again. My name is Marty, or Martin, M-a-r-t-i-n Fattig, F-a-t-t-i-g. [CONFIRMATION]

SENATOR RIEPE: Okay; thank you. Please go ahead. [CONFIRMATION]

MARTIN FATTIG: I have... [CONFIRMATION]

SENATOR RIEPE: Tell us a little bit about yourself, because this is a reappointment. [CONFIRMATION]

MARTIN FATTIG: Well, I am a rural hospital CEO, serving in Auburn, Nebraska, Nemaha County Hospital. I have served on the Rural Health Advisory Commission since 2004 and, for the last six years, I have served as the chair of that group. I really enjoy my work with the Rural Health Advisory Commission. We are a body of 13 people who inform the Legislature, the administration, the Department of Health and Human Services, and the public on all things dealing with rural health and healthcare. And we really have a dedicated group of individuals that serve on that. We have great staff from the Office of Rural Health, as well, and I really appreciate having the opportunity to continue my work with that auspicious group and hope that we can continue to serve this fine state. [CONFIRMATION]

SENATOR RIEPE: Well, we appreciate your service, and I know you've done service on the national level, as well, and some speaking. And are there questions from the committee? Yes, Senator Howard. [CONFIRMATION]

SENATOR HOWARD: Thank you, Senator Riepe. Thank you for visiting with us today. [CONFIRMATION]

MARTIN FATTIG: Certainly. [CONFIRMATION]

SENATOR HOWARD: You've been on the Rural Health Commission for a while now. [CONFIRMATION]

MARTIN FATTIG: I have. [CONFIRMATION]

SENATOR HOWARD: Can you tell us what the biggest issues are facing rural Nebraska in terms of healthcare? [CONFIRMATION]

MARTIN FATTIG: I believe that probably the biggest issues in rural healthcare in Nebraska are probably staff, personnel. We have a terrible time recruiting providers to come to, especially, western Nebraska and most places rural. That is why the...this legislative body saw fit, back in the early '90s, to establish a loan repayment program where we can...where rural providers that are willing to serve in a medically underserved area can get help with their student loans. And that is one distinct advantage that rural has over urban, when it comes to recruiting staff. So we really appreciate that, having that ace in our pocket. [CONFIRMATION]

SENATOR HOWARD: Thank you. [CONFIRMATION]

MARTIN FATTIG: Certainly, Senator Howard. [CONFIRMATION]

SENATOR HOWARD: Um-hum. [CONFIRMATION]

SENATOR RIEPE: Are there other questions? Senator Erdman. [CONFIRMATION]

SENATOR ERDMAN: Thank you, Senator Riepe. Maybe you could just define western Nebraska for me. [CONFIRMATION]

MARTIN FATTIG: Well, I grew up in southwestern Nebraska, south of Sutherland, so...and I lived in Scottsbluff. So to me Nebraska really starts where that arch is over the Interstate. Everything from there west is Nebraska (laughter). [CONFIRMATION]

SENATOR ERDMAN: Thank you for your comments. [CONFIRMATION]

MARTIN FATTIG: I've been by your place up by Bayard many times, so. [CONFIRMATION]

SENATOR ERDMAN: Thank you. [CONFIRMATION]

SENATOR RIEPE: Can you give us some insight in terms of the replacement for the Accountable Care Act (sic: Affordable Care Act) for rural Nebraska? [CONFIRMATION]

MARTIN FATTIG: I wish I could. I have a terrible time reading those tea leaves. I just hope that we end up with something that we can all live with and that will benefit most people, that is

practical. You know, we have to understand budgets and everything as well, but we need to have something that benefits all people. [CONFIRMATION]

SENATOR RIEPE: Okay. Are there other questions? I did have the opportunity to review your profile information. It's very impressive. [CONFIRMATION]

MARTIN FATTIG: Thank you. [CONFIRMATION]

SENATOR RIEPE: For a guy who was never allowed to sing in the church choir, you're impressing me with...everything short of being an Eagle Scout, I think, was in there, so. [CONFIRMATION]

MARTIN FATTIG: Oh. [CONFIRMATION]

SENATOR RIEPE: Again, thank you for your service. [CONFIRMATION]

MARTIN FATTIG: Thank you, Senator Riepe. [CONFIRMATION]

SENATOR RIEPE: We seem to not have questions, and so we appreciate your coming in today... [CONFIRMATION]

MARTIN FATTIG: Thank you. [CONFIRMATION]

SENATOR RIEPE: ...to be with us, as well. [CONFIRMATION]

MARTIN FATTIG: For those of you that I've known personally, thank you. [CONFIRMATION]

SENATOR CRAWFORD: Thank you, thank you. [CONFIRMATION]

SENATOR ERDMAN: Thank you. [CONFIRMATION]

SENATOR RIEPE: Thank you, Mr. Fattig. Okay, our next reappointment is Jessye Gortez (phonetic). [CONFIRMATION]

JESSYE GOERTZ: Goertz. [CONFIRMATION]

SENATOR RIEPE: Goertz. I am doing great on names today (laughter). I usually have Tyler read the names. That's the most difficult job in the room. [CONFIRMATION]

JESSYE GOERTZ: Do you want me to come up here? [CONFIRMATION]

SENATOR RIEPE: Yes, would you please come up to the mic? And if you'd be kind enough to tell us your name, how to spell it, so we get it into the record, as well. [CONFIRMATION]

JESSYE GOERTZ: Okay. [CONFIRMATION]

SENATOR RIEPE: And then you just go ahead and tell us a little bit about... [CONFIRMATION]

JESSYE GOERTZ: Okay. [CONFIRMATION]

SENATOR RIEPE: ...your background and... [CONFIRMATION]

JESSYE GOERTZ: Hi, Senator. [CONFIRMATION]

SENATOR RIEPE: ...you are a reappointment and why you're seeking reappointment... [CONFIRMATION]

JESSYE GOERTZ: Sure. [CONFIRMATION]

SENATOR RIEPE: ...and things that maybe you've accomplished or felt like you need to, or whatever you want to do. [CONFIRMATION]

JESSYE GOERTZ: (Exhibit 1) Okay, all right. My name is Jessye, J-e-s-s-y-e Goertz, G-o-e-r-t-z, and I've been on the...on this commission now for three years. And it's really been informative for me because I didn't know that a lot of what went on, you know, as far as the makings or, you know, how kids got their money in order to go to school, for one thing. And I grew up not too far from here, so I wouldn't have been on the Rural Health Advisory Commission, but I've lived out in Bayard, in fact, for ten years. And then I moved to the Custer County area. And I am an extension educator, but I am also a registered dietician, so I work with the University, and I also work with the healthcare and different things like that. So I am a member of the Nebraska Dietetic Association and the American Dietetic Association. And I don't know...what else did you say? [CONFIRMATION]

SENATOR RIEPE: Well, we'll throw it out here and see if we have some questions... [CONFIRMATION]

JESSYE GOERTZ: Okay. [CONFIRMATION]

SENATOR RIEPE: ...that maybe you can respond (inaudible). [CONFIRMATION]

JESSYE GOERTZ: All right. [CONFIRMATION]

SENATOR RIEPE: Senator Crawford, please. [CONFIRMATION]

SENATOR CRAWFORD: Thank you, Chairman Riepe. And thank you for your service. We really appreciate it, and for being here. [CONFIRMATION]

JESSYE GOERTZ: Sure. [CONFIRMATION]

SENATOR CRAWFORD: So one question is, since it is a reappointment... [CONFIRMATION]

JESSYE GOERTZ: Yes. [CONFIRMATION]

SENATOR CRAWFORD: ...maybe just tell us a little bit about what you see as some of the major accomplishments of the Advisory Commission since you've been there. Like what do you think are the most important things that the commission has done in your time? [CONFIRMATION]

JESSYE GOERTZ: Well, I think that just the fact that we decide who is going to get the funding for the positions for the schooling. Some of the people who...I don't know that they would go to rural Nebraska if they didn't have that commitment in order to, you know, to fulfill their requirement. Other than that, I mean there's always representatives from different organizations that speak to us at the meetings. There's four meetings a year, and so, you know, we get the impression of, you know, what's going on in the healthcare of Nebraska. And I'd have to say that the person that spoke before me really pretty much summed it up in the fact that the people need to bring about and to serve the people of Nebraska. So... [CONFIRMATION]

SENATOR CRAWFORD: Thank you. [CONFIRMATION]

SENATOR RIEPE: Are there other questions? Senator Williams. [CONFIRMATION]

SENATOR WILLIAMS: Thank you, Chairman Riepe. And thank you... [CONFIRMATION]

JESSYE GOERTZ: Hi. [CONFIRMATION]

SENATOR WILLIAMS: ...for being here from Custer County. [CONFIRMATION]

JESSYE GOERTZ: Sure. [CONFIRMATION]

SENATOR WILLIAMS: With your background as an extension educator and nutrition and going into the schools, does your group get involved with nutrition issues as they affect rural Nebraska? [CONFIRMATION]

JESSYE GOERTZ: Well, I think that we serve the whole state, you know, that we try to bring...wherever we are, we try to bring that information back to the people in our area. So yeah, I think we do focus on that. [CONFIRMATION]

SENATOR WILLIAMS: Thank you. [CONFIRMATION]

SENATOR RIEPE: Senator Crawford, please. [CONFIRMATION]

SENATOR CRAWFORD: Can you...do you see that the commission does that in a particular way? Is that what meant when... [CONFIRMATION]

JESSYE GOERTZ: No. [CONFIRMATION]

SENATOR CRAWFORD: ...you meant when you answered that question? [CONFIRMATION]

JESSYE GOERTZ: No. I was answering it from the standpoint of extension education. [CONFIRMATION]

SENATOR CRAWFORD: Oh, okay. [CONFIRMATION]

SENATOR RIEPE: Senator Erdman. [CONFIRMATION]

SENATOR ERDMAN: Thank you, Senator Riepe. Good to see you again. [CONFIRMATION]

JESSYE GOERTZ: Um-hum. [CONFIRMATION]

SENATOR ERDMAN: Being an extension educator, you'll probably agree with this statement, that extension is the best kept secret in Nebraska. [CONFIRMATION]

JESSYE GOERTZ: Yes, that's true. [CONFIRMATION]

SENATOR ERDMAN: And to speak to Senator Williams' comments, the extension does a lot more than we understand that it does. [CONFIRMATION]

JESSYE GOERTZ: Um-hum. [CONFIRMATION]

SENATOR ERDMAN: And it's an opportunity for Nebraskans to be served by extension far greater than they take advantage of, so I appreciate your service. [CONFIRMATION]

JESSYE GOERTZ: Great. Thank you; thank you. [CONFIRMATION]

SENATOR ERDMAN: Thank you. [CONFIRMATION]

SENATOR RIEPE: Are there any other questions? Seeing none, thank you so very much; we do appreciate it. [CONFIRMATION]

JESSYE GOERTZ: Sure; thank you. [CONFIRMATION]

SENATOR RIEPE: In our sequence in order, we do have one additional reappointment, but he's traveling in, so we're going to defer on that. And we have an appointment, a new appointment, that we're under consideration for. And that is a dentist by...who is Benjamin Iske. Dr. Iske, is he present? Evidently not. Let's go on to another new appointment, which would be April Dexter. Now see, there was a name I can pronounce. [CONFIRMATION]

APRIL DEXTER: You got it. [CONFIRMATION]

SENATOR RIEPE: Thank you very much. Welcome. [CONFIRMATION]

APRIL DEXTER: (Exhibit 1) Good afternoon. [CONFIRMATION]

SENATOR RIEPE: If you'd be kind enough to just state your name and spell it for the record, please. [CONFIRMATION]

APRIL DEXTER: Sure. My name is April Dexter. April, A-p-r-i-l, and Dexter, D-e-x-t-e-r. [CONFIRMATION]

SENATOR RIEPE: Thank you. If you'd just tell us a little bit about yourself, we're really pretty friendly, and... [CONFIRMATION]

APRIL DEXTER: Sure. I am a family nurse practitioner. I live on a ranch near Chambers, Nebraska. I work full-time at a rural health clinic in Atkinson, Nebraska. A little bit of my background: I am married; I have four children of my own and two stepchildren. And I worked for eight years at a critical-access hospital, as an RN, in O'Neill. I then went back to school. I worked then as a family nurse practitioner for five years at a physician-owned private practice in O'Neill and then recently spent the last two years working at a rural health clinic in Atkinson. It's also attached to that critical-access hospital there in Atkinson. [CONFIRMATION]

SENATOR RIEPE: Very good. You'll find friends with a nurse practitioner (inaudible). Senator Crawford. [CONFIRMATION]

SENATOR CRAWFORD: Sure. [CONFIRMATION]

APRIL DEXTER: Sure. [CONFIRMATION]

SENATOR CRAWFORD: Absolutely. [CONFIRMATION]

SENATOR RIEPE: Are there questions that the committee might have? Senator Crawford. [CONFIRMATION]

SENATOR CRAWFORD: Thank you, Chairman Riepe. So what do you most look forward to, in terms of serving on the commission? [CONFIRMATION]

APRIL DEXTER: I think I look forward to just being able to give firsthand information from rural Nebraska, because I live it every day. [CONFIRMATION]

SENATOR CRAWFORD: Um-hum. [CONFIRMATION]

APRIL DEXTER: You know, living in rural Nebraska, I am sure, as everyone knows, that it really has its advantages, but it also has its--especially in healthcare--its struggles. And so in working as a nurse and a nurse practitioner in the emergency room and inpatient and the clinic, as well, I think I can provide firsthand knowledge. [CONFIRMATION]

SENATOR CRAWFORD: Okay. And we appreciate both your healthcare service... [CONFIRMATION]

APRIL DEXTER: Good. [CONFIRMATION]

SENATOR CRAWFORD: ...but also your willingness to bring that expertise to these discussions, because I think that's really...we rely on that and rely on people on these commissions, to bring that experience. And I know it's...takes time and effort on your part. And so I appreciate your willingness to serve. [CONFIRMATION]

APRIL DEXTER: Thank you. [CONFIRMATION]

SENATOR RIEPE: Thank you. Senator Williams. [CONFIRMATION]

SENATOR WILLIAMS: Thank you, Chairman Riepe. And thank you, Ms. Dexter, for your willingness to do this. When you mentioned the struggle part of it, can you go into a little depth about what you see as the primary issues that face you and your association? [CONFIRMATION]

APRIL DEXTER: Sure. Just as Mr. Fattig had said before, staffing is always big, you know. Whether it's at...from assisted living, nursing home, clinic, hospital, staffing is always an issue. It seems like we hear that in every medical staff meeting we sit in...not every, but frequently, as well as policy meetings. Staffing is a problem. Other thing is just the distance from specialists. You know, we do have outreach providers that come, but that's always a struggle, as well. You know psychiatric care is also...I think we could probably go down the line, as far as different professions, but being in rural Nebraska, being four hours from Omaha, Lincoln, where there's a lot of specialists, is an issue. And then, in the emergency department, you know, we're three hours from a...the nearest trauma center...those kind of things. So distance is often a problem, as well. [CONFIRMATION]

SENATOR WILLIAMS: Thank you. [CONFIRMATION]

APRIL DEXTER: Sure. [CONFIRMATION]

SENATOR RIEPE: I have a question. [CONFIRMATION]

APRIL DEXTER: Yes. [CONFIRMATION]

SENATOR RIEPE: Telemedicine is one that Senator Kolterman, here, has talked about. [CONFIRMATION]

APRIL DEXTER: Um-hum. [CONFIRMATION]

SENATOR RIEPE: And how do you use telemedicine in your community, in the hospital or for a center? How does that work for you or what could it do? [CONFIRMATION]

APRIL DEXTER: I think telemedicine is...hopeful will become bigger and bigger in the future. We don't use it a lot now, but I definitely think it has a lot of capabilities. In Atkinson, myself, the only thing that we use telemedicine for is psychiatric care out of Kearney right now. But I understand that Norfolk has a behavioral health program that's getting started, so there's potential there, as well. So psychiatric benefit, you know, that with telehealth would help. In O'Neill, oncology, I believe, out of Yankton, telehealth sent to O'Neill. But as far as I am aware, those are the only two specialists right now that do that. I know technologywise, it was brought to our medical staff not very long ago, the equipment for telemedicine. For instance they've talked about ENT, the ear, nose, and throat physicians doing some telemedicine. That equipment, you know, is very expensive, and that kind of thing. But it's out there. To be able to do a full assessment, you know, a provider doing the assessment on one end and being able to, via telemedicine, see the specialist. [CONFIRMATION]

SENATOR RIEPE: Is that as a result of just lack of education or the fact that it's...it sounds like it's more behavioral than in, say, physical health with ENT. And is it...is that partly a matter of educating the community? Or just...is it a reimbursement thing, as well? Or... [CONFIRMATION]

APRIL DEXTER: That and... [CONFIRMATION]

SENATOR RIEPE: Maybe I should have asked the CEO up here when I had him up here. But... [CONFIRMATION]

APRIL DEXTER: Probably so. [CONFIRMATION]

SENATOR RIEPE: About the reimbursement, at least. [CONFIRMATION]

APRIL DEXTER: Right. I think finding specialists who are willing to do it, and then coordinating that with finding the finances for the technology...when you have a critical access hospital finding the funds to do that is...I know it's in the works though. [CONFIRMATION]

SENATOR RIEPE: Okay. Well, we read a lot about it, we see a lot about it, we...here we talk about it a lot. [CONFIRMATION]

APRIL DEXTER: Um-hum. [CONFIRMATION]

SENATOR RIEPE: We're trying to take some action and then improving that situation. [CONFIRMATION]

APRIL DEXTER: Sure. [CONFIRMATION]

SENATOR RIEPE: Are there other questions? Again, we thank you very much... [CONFIRMATION]

APRIL DEXTER: Thank you. [CONFIRMATION]

SENATOR RIEPE: ...for coming in today and talking to us and sharing with us. So thank you. We will now...we may interrupt...I am sorry. [CONFIRMATION]

MARTIN FATTIG: We have a meeting to attend, so thank you. [CONFIRMATION]

SENATOR RIEPE: We're not going to take it personally. Thank you for coming. Thank you very much for giving your time. That's...we're going to defer on the other two in hopes that they will appear. One we expect to arrive later, and we may put that in between some of the hearings on the bills. With that on the agenda, we are now going to move to LB391. That's Senator Watermeier. And... [LB391]

SENATOR WATERMEIER: Like magic. [LB391]

SENATOR RIEPE: You know the drill, so we'll just leave you alone. [LB391]

SENATOR WATERMEIER: I do. Chairman Riepe and members of HHS, I am Senator Dan Watermeier, W-a-t-e-r-m-e-i-e-r. I represent District 1 in the southeast corner of the state. I am here to do...excuse me. I am here today to introduce LB391 at the request of the Nebraska Optometric Association. LB391 would update the scope of practice for optometrists licensed by the state of Nebraska. Scope enhancements, although usually controversial, are necessary because the practice of healthcare is not static, and professions evolve. As training and knowledge advance, our laws that govern certain practices must evolve as well. As senators, we must evaluate such proposals, weighing benefits to the public against any risk. Our constituents deserve to benefit from the advancements in their profession. The scope of practice for Nebraska optometrists has been advanced multiple times by the Legislature. Optometrists have been licensed to prescribe medications since the 1970s, when the law first allowed topical drops for diagnostic purposes. In the 1980s, the law was amended to allow topical medications for treatment of ocular conditions. In 1993, the Legislature authorized prescriptive authority for virtually all oral medications for the treatment of conditions related to the eye, as well as minor procedures required to remove foreign bodies from the eye. Again in 1998, the Optometric Practice Act was amended to include the use of topical drops for the treatment of glaucoma. In 2014 the law was updated to remove the remaining limitations on oral medications. Each time, the records of our state's licensing body indicate that the Legislature's confidence in granting new authority to the profession, is well founded. LB391 proposes, once again, to update the optometrists' scope of practice to reflect the continuing evolution of the profession in order to best meet the healthcare needs of the citizens of our state. LB391 would authorize optometrists to perform certain procedures that are categorized as surgery, based on the numerical codes that are used by healthcare professionals to track and bill for these services. Authorizing these particular procedures requires striking a categorical prohibition in statute on optometrists performing surgery. But the intent of this bill is to authorize just specific types of procedures. There are optometrists that will follow me who will explain this in more detail, but it is important for the committee to understand that the procedures envisioned in this bill are not what you and I would typically consider surgery. These are procedures that would be performed in the optometrist's clinic with a local anesthetic, and they are intended to relieve and address some pretty common problems, such as sties. The procedures that would be authorized in LB391 involve the eyelids and tissues surrounding the eye, not the eyeball itself; we are not talking about eye surgery. The bill would also authorize injections into the eyelids or surrounding tissue, related to these procedures, so that anesthetics could be used during these procedures, in keeping with the standard of care. Again, we are not talking about injections into the eyeball. I think it's important that we keep the training and education components of this bill in perspective. The legislation does not allow people with no training or experience to do these procedures. It proposes to authorize highly trained healthcare professionals with a four-year doctoral degree, who already work with instruments in and around the eyes, who are already highly trained as primary healthcare providers, and who are already trained in the risk of primary healthcare. The authority in this bill is a logical extension of the training and present-day clinical experience that

Nebraska optometrists already have. But in order to increase the assurance of public safety and make sure that all licensed Nebraska optometrists have the same basics of knowledge and training, LB391 establishes educational standards that every licensee would need to meet. This would mean that many optometrists would be getting some additional education and training related to these procedures, to supplement what they're already being taught. LB391 would increase the public's access to healthcare. Healthcare is already very expensive, as we all know. And this bill can save time, inconvenience, and cost of duplicate appointments, especially for people in rural areas, while still assuring quality care from trained professionals. I urge your favorable vote on LB391, and I can try to answer any questions, if you want. But I will tell you there's going to be much more better-suited professionals behind me. And I do have another commitment right after this. I will not be able to close, but I will try to lead you in the right direction with the people behind me. So thank you, Mr. Chairman. [LB391]

SENATOR RIEPE: Thank you, Senator Watermeier. Questions? Senator Howard. [LB391]

SENATOR HOWARD: Thank you, Senator Riepe. Senator Watermeier... [LB391]

SENATOR WATERMEIER: Is this a softball? [LB391]

SENATOR HOWARD: This is a softball. I was asked what kind of balls I was going to throw today. Can you walk us through the 407 for this? [LB391]

SENATOR WATERMEIER: Oh, my gosh. I'll bet you could, but I can tell you there's three steps to it. I mean you have the... [LB391]

SENATOR HOWARD: The one for this one, though. [LB391]

SENATOR WATERMEIER: Oh. I cannot; I cannot by this...by spot. I cannot; I am sorry. [LB391]

SENATOR HOWARD: I am certain someone behind you can. [LB391]

SENATOR WATERMEIER: I remember very well the 407 process and the three stages that is had, but I can't tell you that on this one. [LB391]

SENATOR HOWARD: Okay. We'll save that for the next person. [LB391]

SENATOR WATERMEIER: Okay. I should have put it in my testimony. I apologize because I know how important it is. [LB391]

SENATOR RIEPE: Are there any other questions? We know you do have another hearing. [LB391]

SENATOR WATERMEIER: I do. [LB391]

SENATOR RIEPE: We appreciate your being here, and I thank you very much. [LB391]

SENATOR WATERMEIER: All right; thank you, Chairman. [LB391]

SENATOR RIEPE: We would like to move to proponents, those supporting this piece of legislation. Sir, if you would state your name and spell it; and then the microphone is yours. [LB391]

CRESTON MYERS: (Exhibits 1-3) Good afternoon. My name is Dr. Creston Myers. First name is spelled C-r-e-s-t-o-n, last name M-y-e-r-s. I have a solo practice in Alliance. I am also the current president of the Nebraska Optometric Association, which represents approximately 80 percent of the licensed optometrists practicing throughout our state. I am here today to speak in favor of LB391, on behalf of our association. Before I get started, I want to thank each of you for the work you do for our state and our local communities. Optometrists in Nebraska can only do, in our practices, what the Legislature allows us to do. As a result, as healthcare advances and as our profession advances, we need to come to you in order to provide the very best care for the citizens of Nebraska. We're here today because many other states around the country have updated their laws in order to allow optometrists to better utilize current knowledge, education, and training, and to keep up with the current standards of care for the eyes and the visual system. We want to be able to provide better access to quality, high care for Nebraskans, and we believe Nebraskans should be entitled to the same benefit, of the same level of care, from optometrists as patients in these other states are receiving. There are nearly 400 licensed doctors of optometry in Nebraska, with 348 actively practicing in the state. These optometrists have primary clinics located in 48 counties, not counting their additional satellite practices. I provided you with a map that illustrates the distribution of the optometrists across the state. As you can see from the map, doctors of optometry are the primary providers of eye care for the citizens of Nebraska, especially in the more rural areas of our state. Doctors of optometry see patients with all kinds of conditions and problems of the eye and of general health. Because the visual system is integrated with so many other systems of the human body, we have to understand and monitor the overall patient health concerns that can be impacted, or impact, other eye diseases and visual disorders. We review the overall health history of each patient. We are also part of an integrated team of

healthcare professionals for each of these patients. We regularly refer to other optometrists with specific expertise, to ophthalmologists, to other medical doctors, such as when we diagnose or suspect a systemic disease like diabetes or hypertension. We also communicate closely in the management of these conditions with internists, general physicians, rheumatologists, neurologists, dermatologists, just to name a few. And there's also many optometrists in the state that are on staff and take call for the hospitals and emergency rooms in their local communities. So you may hear from opponents of this bill that access to care is not a valid issue. Let me remind you that I practice in Alliance, which has a population of about 9,000 people. There are no ophthalmology practices or satellite clinics in my city. The closest ophthalmology practice is in Scottsbluff, which is 50 miles and an hour's drive away. Sometimes I may even end up referring my patients to Rapid City, South Dakota or even Cheyenne, Wyoming, which requires a drive time of even two to three hours for additional care. I would like to share one of my recent patient encounters. This patient was a young woman who called my office midmorning because she was having eye pain in her eyelid. I was able to add her to my schedule that afternoon and, when I examined her, I discovered that her pain was coming from an eyelash that had grown into the skin of her lower eyelid, forming a cyst. The eyelash was just below the surface of the skin, and I could see it clearly, through the tissue, with the magnification of my biomicroscope. So the treatment needed to provide her relief from this pain would've been to remove the eyelash, which we are currently authorized to do as optometrists. But since this eyelash was below the skin, and the law clearly states that optometrists cannot make an injection or make an incision in the eyelid, which in this case probably would have only been like one millimeter in size, I had no way to reach the problematic eyelash. so instead I had to refer the patient to an ophthalmologist for the treatment. She had to wait five days for that appointment and then drive 100 miles, round trip, to have the procedure done. So instead of being able to provide simple, timely treatment that would've provided for relief from her discomfort, she had to suffer for days before she could get the needed treatment. I can assure you this case is not an isolated case. Since I am one of only three eye doctors in Alliance, I provide a significant amount of primary eye care for injuries and acute problems. The local medical doctors in Alliance, one of them who is my wife, they are not comfortable treating these things, so they refer to me pretty much daily. I take out foreign bodies and do a lot of acute care. Often I can provide treatment with medications, but occasionally the treatment is simple, yet outside what the law currently allows in optometrists. Therefore, my patients cannot receive the timely care, have extra costs from travel, another doctor's visit, inconvenience, and lost time from work. There's three doctors that are coming up, following me, that will discuss more about the education and training of optometrists, the provision involving injections, and the proposed authority for additional procedures. Their presentations may address many of the questions you will have. But I am pleased to take questions on anything I've covered, as well. Thank you for your time today, and I would appreciate your support. [LB391]

SENATOR RIEPE: Thank you very much. Are there questions? Senator Williams. [LB391]

SENATOR WILLIAMS: Thank you, Chairman Riepe. And thank you, Doctor, for being here. Just a couple of questions that I have as concerns, that other people may want to address, also, when they come up and talk. The procedures that would be allowed under LB391, would you characterize them as emergency procedures? [LB391]

CRESTON MYERS: In most cases, no; they're not emergency procedures. Minor discomfort issues...a lot of times it doesn't have to even revolve (sic: involve) these procedures. We can treat it with medical means like warm compresses. It's going to be discussed a little more by the two doctors following me, as kind of where we're going with that. But yeah, in most cases these are not emergency procedures. They're just convenience; they're better access to care for the citizens of Nebraska. [LB391]

SENATOR WILLIAMS: Okay. And then, just so I understand your map better, and I am looking, in particular, at my legislative district, which is primarily Dawson and Custer County...your listing, the number four there, is that the number of optometrists that you have in there? [LB391]

CRESTON MYERS: The blue counties are optometrists, and then the yellow counties are where optometrists and ophthalmologists are both. The first number is the number of optometrists; the second number on the yellow is the number of ophthalmologists. That data comes from April 2013, so it could have changed just a little bit over the last three or four years. But it's relatively close. [LB391]

SENATOR WILLIAMS: Okay. How do you, on this map, take into consideration the fact that in Dawson County, the Lexington hospital, the Cozad hospital and the Gothenburg hospital are all served by ophthalmologists? [LB391]

CRESTON MYERS: That was a satellite clinic, correct? [LB391]

SENATOR WILLIAMS: Yes. [LB391]

CRESTON MYERS: Yeah. And that is a...that's a valid argument that people are going to make if they're... [LB391]

SENATOR WILLIAMS: I am not making an argument. [LB391]

CRESTON MYERS: Yeah, but... [LB391]

SENATOR WILLIAMS: But I am asking how your map takes into consideration... [LB391]

CRESTON MYERS: It doesn't take into account...the map doesn't show any satellite clinics. There's also satellite clinics for optometry spread throughout the state, too, that the map doesn't show. The problem with satellite clinics is it's hard to really know how many days they're open, how many patients they can actually serve. There's access in Alliance, Nebraska, just for a case. We had a satellite clinic that come over two days a month until about six months ago, and now they no longer serve us. So I mean, two days a month is better than no access, but it's still far and few between. [LB391]

SENATOR WILLIAMS: Thank you. [LB391]

SENATOR RIEPE: I had a question. I think you said...is your wife a general practitioner, a family physician? [LB391]

CRESTON MYERS: She's in family practice with women's care specifically. [LB391]

SENATOR RIEPE: So would she...in her scope of practice, is she able to make the nick to be able to, for the eyelash? [LB391]

CRESTON MYERS: She could, I think, as a medical doctor. Is she going to? No, because she's not comfortable around the eyes at all. I mean she's going to refer to me, because that's what I do. Just like I wouldn't want to deliver a baby, which is what she does, so (laughter). [LB391]

SENATOR RIEPE: Preserve a good marriage, too (laughter). [LB391]

CRESTON MYERS: That's right; that's right. [LB391]

SENATOR RIEPE: Okay, okay. [LB391]

CRESTON MYERS: I think there is... [LB391]

SENATOR RIEPE: I was just curious because family medicine docs used to do more. [LB391]

CRESTON MYERS: And I think there is a little bit of...they have to be credentialed through the hospital, so they have to have certain requirements that they have to meet to be able to provide some of that care. [LB391]

SENATOR RIEPE: But this wouldn't be a hospital, per se. [LB391]

CRESTON MYERS: Yeah, in a clinic. She could probably do it in her own clinic just fine, if she was comfortable with it. [LB391]

SENATOR RIEPE: Okay. She just wasn't comfortable with it. [LB391]

CRESTON MYERS: No. And in fact, in general, there's five-six doctors in Alliance that, kind of...it changes daily as they come and go. And most of them are not comfortable, you know, doing stuff with eyelids. They're going to refer either to me or refer out to ophthalmology because they have a lot of other stuff that they treat, and that's not something they're comfortable doing every day. [LB391]

SENATOR RIEPE: Okay, fair enough. Just a curiosity question. Are there any questions? Senator Williams, please. [LB391]

SENATOR WILLIAMS: One more question, and Senator Howard asked this of Senator Watermeier, and that's the 407 process. Has that been gone through on this scope change? [LB391]

CRESTON MYERS: Yes, it...we had a 407 review clear back like six-seven years ago, before we had the last bill that we passed parts of it. So this has been covered. It's going to be discussed a lot more. In fact, Chris Wolfe, that's coming up next, is probably going to cover some of it. And Dr. Vandervort will also cover some of that. [LB391]

SENATOR WILLIAMS: We'll wait and ask. [LB391]

CRESTON MYERS: Yeah, you'll...you'll get a lot... [LB391]

SENATOR WILLIAMS: Or I will. [LB391]

CRESTON MYERS: You'll get lots more details there. [LB391]

SENATOR WILLIAMS: Thank you. [LB391]

SENATOR RIEPE: Were you...were you...oh, I am sorry. [LB391]

SENATOR ERDMAN: Go ahead. Go ahead, Senator. [LB391]

SENATOR RIEPE: Senator Erdman. No, go ahead. I'll... [LB391]

SENATOR ERDMAN: Thank you, Chairman Riepe. Thank you, Dr. Myers, for coming. So you had made a comment other states are doing similar type things. Can you tell me what states those are? [LB391]

CRESTON MYERS: Yeah. That's also a good question that's coming up in another presentation. But just to give you...there's going to a handout coming up, too, that will show you those states highlighted. [LB391]

SENATOR ERDMAN: Okay. [LB391]

CRESTON MYERS: Just to give you a little brief overview, and then you'll get more of that, there's actually 14 states that can actually perform the same injection as what we're requesting to do right now. There's 18 states that have surgical procedures greater than what Nebraska has. And the big ones that we always talk about are Louisiana, Tennessee, Oklahoma, Kentucky. [LB391]

SENATOR ERDMAN: Okay. [LB391]

CRESTON MYERS: But there's a map that we will get in about two presentations. [LB391]

SENATOR ERDMAN: And so in those states, the scope of practice is similar to what you're asking for here? [LB391]

CRESTON MYERS: Or...or even more, in some cases. [LB391]

SENATOR ERDMAN: Even more? Okay. All right. Thank you; thank you for coming all the way from Alliance. I appreciate it. [LB391]

CRESTON MYERS: It was a nice drive. [LB391]

SENATOR RIEPE: Has your...has the optometrist group or association been an endorser of LB402, which we're talking about, which is scope of practice? Or is that something you're familiar with? [LB391]

CRESTON MYERS: Not 100 percent sure. [LB391]

SENATOR RIEPE: Okay. [LB391]

CRESTON MYERS: Like, you know, that's probably a... [LB391]

SENATOR RIEPE: It's a replacement for... [LB391]

CRESTON MYERS: 407, right? [LB391]

SENATOR RIEPE: 407. [LB391]

CRESTON MYERS: Yeah. I mean we're a...we're in favor of that. It's not specifically through our...we said we would support it because it will probably make the process better. But it wasn't really specifically requested by us. [LB391]

SENATOR RIEPE: Fair enough. Are there other questions? Seeing none, we appreciate your coming in and testifying. [LB391]

CRESTON MYERS: Thank you. [LB391]

SENATOR RIEPE: You came some distance. [LB391]

CRESTON MYERS: A little. [LB391]

SENATOR RIEPE: Additional proponents, please. [LB391]

CHRISTOPHER WOLFE: (Exhibits 4 and 5) Good afternoon. My name is Dr. Christopher Wolfe, spelled C-h-r-i-s-t-o-p-h-e-r W-o-l-f-e, and I want to start by saying thanks for everything you all do here. I know that it's oftentimes thankless. And we really do appreciate it, as citizens. I am an optometrist, and I practice in Omaha, Nebraska. And I practiced with my father for the last nine years. And we're at a...we're really grateful for the opportunity we've had, being able to serve our community. What I'd like to do today is just discuss the conditions that lead up to the procedures that we're discussing, and also how we treat them currently, as well as I can address 407 issues, if you'd like that, so those again, as well...as well as the evidence of this scope of practice being safe to the public. So what happens...in every one of our eyelids we have about 25-30 oil glands that line the inner surface of our eyelids. They kind of look like tubes. If you

flip the eyelid up or down, either the upper or the lower eyelid, and those tubes can become obstructed. So what's common to have happen is...the pathophysiology, the underlying cause of that is that we get skin cells, epithelial cells that will grow over the orifice of those glands. And bacteria, or other microorganisms that live along the eyelids, can kind of munch on those skin cells and the oils that are produced within the oil glands. And that can harden those oils and become...kind of block them up. And they can almost get as hard as kind of our like keratin plaques that are like the surface of our fingernails. And what normally expels those oils from the eyelid is the normal blinking mechanism. So as we blink our eyelids, there's a squeezing; there's a muscle reel, and it squeezes those oil glands out so that those oils coat the surface of our tear film. And the reason that's important is that, if we don't have a nice, smooth, oily layer of our tear film, then the tears we have will evaporate off the surface of our eyes and that will cause an ocular surface dysfunction that commonly leads to inflammation and irritation. And we treat these--this--all the time in our practice. But what can happen is, if that lasts for too long, then you get an obstruction there, and then the gland will pump more and more oil into the central duct, which causes the oil to get...the gland to get fatter. And it can go one of two ways. It can dilate and then atrophy, or die off, over time, slowly and gradually. That's not really what we're...we can address that already with our current scope of practice. But the other way it could go is it can actually become inflamed and infected. That's typically called a sty, when that happens. So when somebody comes and: I have a sty in my eye, that's what they're...that's what they're talking about. It's kind of tender to the touch. We aren't talking...about once the sty is occurring, we're not typically going to be poking around in the sty. We would treat that with warm compresses, we'd treat it with oral medications, we'd treat it with topical medications. And...but over time, in some patients, it can go another way. It can become this kind of encapsuled, kind of pussy tissue that becomes hard in the eyelid. And it's no longer tender at that point; it's just...it's just this firm mass. And so that's what we're discussing right now. That's what we're talking about. And so the...once that kind of firm ball occurs, then the way that you remove them is you flip the eyelid open and you make a small incision into that gland. And then you go in and you remove all that pussy material and take it out, and it kind of heals up. You use topical medications and oral medications. And then, typically, they're not requiring sutures. And you flip the eyelid back over. They've got some crusty tears for a few days, and we use those medications for prophylaxis. I can tell you, just as Senator Watermeier and Dr. Myers said before me, all the things, preoperatively and postoperatively, that we're talking about are already things that we're doing in our practice to care for these conditions. The techniques involved in creating those small incisions are very similar to the ones that we're using to remove things like corneal foreign bodies. The instrumentation, the sterilization techniques are similar to what we already use in our practices. That being said though, LB391 does outline a very specific education and training regimen for all optometrists, even ones in the state who have...who are trained in these procedures, like myself. And so the last thing I'll say is that, in Nebraska, we really want to be able to make sure that patients have access, and that they have access to primary care optometrists that are trained to the fullest scope of practice, and that they can benefit from the

training and the education and the knowledge that those providers have. And if we don't continue to move our profession forward in being able to take care of these conditions, then we lose the best and brightest in our profession and those patients aren't...those doctors aren't going to be as willing to want to come back and practice in Nebraska, especially for our rural areas. So with that, I would encourage you to support LB391. I'd be happy to take any questions on 407 or any other questions you may have. But thanks again for everything you do, and I really appreciate it. [LB391]

SENATOR RIEPE: Okay; thank you very much. If I recall, that you have seven children. [LB391]

CHRISTOPHER WOLFE: Yes, thanks. And hopefully one of them will be...we'll have one of them that's an optometrist behind me so I'll have three generations in our practice (laughter), God willing. [LB391]

SENATOR RIEPE: Congratulations on seven. [LB391]

CHRISTOPHER WOLFE: Thanks. [LB391]

SENATOR RIEPE: That's an example for others. [LB391]

CHRISTOPHER WOLFE: Thanks. My hairline is receding a little bit slowly, but that's okay (laughter). [LB391]

SENATOR RIEPE: You look like you're doing quite well. [LB391]

CHRISTOPHER WOLFE: Thanks. [LB391]

SENATOR RIEPE: We'd ask for any questions. Senator Howard. [LB391]

SENATOR HOWARD: Thank you, Senator Riepe. Thank you for visiting with us today. Can you walk us through your 407? [LB391]

CHRISTOPHER WOLFE: Yeah, absolutely. So about four or five years ago, we went through a 407 review on this particular piece of legislation. And in the technical review committee...we had a failing outcome on the technical review committee. We had a favorable outcome on the Board of Health, and the medical director...his opinion was unfavorable for it. We took all of that

information that the 407 process gathered, and we eliminated some of the things that were in that 407 review. And what you're seeing before you is a scaled-down version of what was in the 407, so that we could address some of the concerns that the technical review committee had. I would also encourage you to read, to actually read the 407 technical review committee and the medical director's opinions. Unfortunately, there was a lot of...there wasn't a lot of evidence as to why they didn't support it. It was more a feeling, like we feel like this isn't rigorous enough. But all the evidence that we've shown, the education and training in other states that authorized this scope of practice, hasn't actually borne out in patient harm. And so it was sort of like well, we would like the education to be more, but we don't really know what it should be. But what we've outlined in LB391 is what is currently used in our profession to train doctors of optometry to perform these procedures in a safe way and has been implemented across the country. As far as the medical director's opinion, it's unfortunate; there was quite a few errors in it. He cited, specifically he cited college of optometry that don't exist or didn't exist at the time as factors of things that he looked at to make his opinion. And so we could provide you with the outline of those, as well. But the bottom line is that we took that 407 review, which was much broader than what you're seeing today, and we scaled it back, based on some of the concerns that the technical review committee had. And that's what has landed at LB391. [LB391]

SENATOR HOWARD: Thank you. [LB391]

SENATOR RIEPE: Do we have other questions? Senator Erdman. [LB391]

SENATOR ERDMAN: Thank you, Senator Riepe. Thank you for coming, Doctor. So did you, after that 4017 (sic: 407) review, did you then try to implement legislation at that time? [LB391]

CHRISTOPHER WOLFE: Yeah, correct. We did, yeah. So we had this...basically this piece of legislation that you see here, which was introduced in...well, it passed in 2014, but it was a scaled-back version of it. So it included the cleanup of some of the oral medications to...for the treatment of glaucoma and oral steroids. And then it, in a...in a compromise in order to get something done that year, we...the senators decided to eliminate the minor procedure component of that. [LB391]

SENATOR ERDMAN: Do (inaudible)... [LB391]

CHRISTOPHER WOLFE: But we got...we got to...past General File. And so all of this was already at second reading a few years ago. [LB391]

SENATOR ERDMAN: Can you tell me the number? Do you remember? [LB391]

CHRISTOPHER WOLFE: What number? [LB391]

SENATOR ERDMAN: What the LB...the LB number was? [LB391]

CHRISTOPHER WOLFE: Oh, I can't off the top of my head. [LB391]

SENATOR ERDMAN: Okay; I'll (inaudible). [LB391]

CHRISTOPHER WOLFE: I want to say it's 4-something or LB526 or LB527. [LB391]

SENATOR HOWARD: LB471? [LB391]

SENATOR ERDMAN: Okay. [LB391]

CHRISTOPHER WOLFE: Okay. Could be. [LB391]

SENATOR HOWARD: (Inaudible). [LB391]

SENATOR ERDMAN: It was LB471? [LB391]

CHRISTOPHER WOLFE: You know, I...I can't tell you off the top of my head. [LB391]

SENATOR ERDMAN: Someone else, then; thank you. [LB391]

SENATOR HOWARD: I'll go with that. [LB391]

CHRISTOPHER WOLFE: Yeah; thanks. Sorry. Thanks. [LB391]

SENATOR RIEPE: You know, probably make up a number, and we all wouldn't know (inaudible). Senator Kolterman. [LB391]

SENATOR KOLTERMAN: Thank you, Senator Riepe. So two of the three legs of the stool are gone, and it didn't advance. That was four years ago. Is there any reason you didn't go back again this year and ask for a new updated 407? [LB391]

CHRISTOPHER WOLFE: Well, the main reason is that when...one is that there are...the time commitment involved in taking a scaled-back version of what had already passed on one of the levels of the technical review committee, the time commitment of going through that, especially when there hasn't been definitive rules and regulations implemented by the 407 review, is why we mainly didn't go forward with that. [LB391]

SENATOR KOLTERMAN: Okay. [LB391]

SENATOR RIEPE: Senator Williams, please. [LB391]

SENATOR WILLIAMS: Thank you, Chairman Riepe. And thank you, Dr. Wolfe. First of all, the same question I asked Dr. Myers. Are these procedures that are allowed in LB397 (sic: LB391) emergency procedures? [LB391]

CHRISTOPHER WOLFE: No, most of them aren't emergent. The issue again, with access to care, isn't always about emergencies, although sometimes it is. It's mainly access. We see LB391 as access to the right treatment by the right practitioner at the right time. And so if a patient can...is in our chair, and I tell him: look, I've got to send you to somebody else to take care of that, I'll tell you that the frustration on their face is real. I mean, when they think this is just something that's a minor issue, that I want to be able to have taken care of, and they want...they have to go see somebody else and build the level of trust that has come within the generations in our practice; and that can't be duplicated in one visit. And so...so that is real. They do get frustrated when they have to go. So no, it's not emergent, but access to care isn't always about emergency. [LB391]

SENATOR WILLIAMS: Because you have access to care from your practice, correct, in Omaha? [LB391]

CHRISTOPHER WOLFE: Say that...so I can...I can get... [LB391]

SENATOR WILLIAMS: You have more access to ophthalmologists. [LB391]

CHRISTOPHER WOLFE: Oh, yeah, yep. Sure. [LB391]

SENATOR WILLIAMS: In the...I want to talk about the example that you gave of using a sty. [LB391]

CHRISTOPHER WOLFE: Um-hum. [LB391]

SENATOR WILLIAMS: And help me with definitions. On page 2, line 15, of the bill, where it talks about injections, it talks...doesn't use the term "cyst." Or, excuse me, "sty." It uses the term "cyst." [LB391]

CHRISTOPHER WOLFE: Yeah. [LB391]

SENATOR WILLIAMS: An agent injected into the eyelid for treatment of cysts. [LB391]

CHRISTOPHER WOLFE: Correct. [LB391]

SENATOR WILLIAMS: What is a cyst, compared with sty? [LB391]

CHRISTOPHER WOLFE: A sty is sort of a layman's term of, in general, of a cyst. Specifically, when somebody tells me a sty, I think of what's clinically called an internal hordeolum, or and external hordeolum. And that's the...that's the gland that I was talking about. So it can...it can develop into kind of this hard...this hard cyst that it's kind of just pussy material. Other cysts would include like sweat gland cysts, so on our eyelids. So they're just sort of this encapsulated dome. Oftentimes they're see-through, just like Dr. Myers was talking about, that there's kind of fluid-filled pockets that really, all you have to do is lance them, and they'll express and they're gone. [LB391]

SENATOR WILLIAMS: So there's more than one kind of cyst. [LB391]

CHRISTOPHER WOLFE: Yeah, correct. Yeah, because there's different eyelid glands. So depending on, like so the technicality of depending on where the gland is, right in the eyelid. If it's a sweat gland cyst associated with the actual follicle of a hair, that's a slightly different cyst than an oil gland cyst, which is called a meibomian gland. [LB391]

SENATOR WILLIAMS: Okay. [LB391]

CHRISTOPHER WOLFE: But the techniques involved... [LB391]

SENATOR WILLIAMS: When do you drop into the area that the cyst could be cancerous? [LB391]

CHRISTOPHER WOLFE: Yeah, that's a great question. So...so right now we're currently...we're treating those patients who have eyelid cysts, and we're already responsible for making the determination on whether or not this is risky for cancer or not cancer. But I can tell you, in terms of lesions that appear suspicious, I wouldn't...I wouldn't want to mess with those. I would send them to somebody else that has a higher level of expertise. The other thing that... [LB391]

SENATOR WILLIAMS: My...my question, then, is you might be making that subjective judgment, but does LB391 preclude an optometrist from making a decision that I am going to mess with this lesion? [LB391]

CHRISTOPHER WOLFE: Yeah. Well, by definition, our scope of practice would...LB391 would only allow us the authority to remove those that are not suspected to be...to be a cancer, cysts or infected or inflamed glands of the eyelid. And so... [LB391]

SENATOR WILLIAMS: When do you...when do you know that? [LB391]

CHRISTOPHER WOLFE: Yeah, so if there's suspicion, what typically happens...I can tell you, that is, if they're recurrent, so if it happens once and happens again and it happens again, that is suspicious; clinically it's suspicious. Most ophthalmologists that we send these to are never going to culture them. Or excuse me, never going to send them to the laboratory unless it's a recurrence, once or twice or more than that. [LB391]

SENATOR WILLIAMS: On page 3, line 13, I was looking here. The first part that we were talking about was injections. This part is about the surgery procedures...same thing though. Your answer, I think, would be the same. It talks about cysts here... [LB391]

CHRISTOPHER WOLFE: Correct, yeah. [LB391]

SENATOR WILLIAMS: ...instead of... [LB391]

CHRISTOPHER WOLFE: Correct, yeah. [LB391]

SENATOR WILLIAMS: So we have this... [LB391]

CHRISTOPHER WOLFE: Correct. [LB391]

SENATOR WILLIAMS: ...same explanation, correct? [LB391]

CHRISTOPHER WOLFE: Yes. There's nothing...there's nothing different that we're talking about with the injections than what we were talking about with the minor procedures. [LB391]

SENATOR WILLIAMS: Thank you. [LB391]

CHRISTOPHER WOLFE: Yes, sir; thanks. [LB391]

SENATOR RIEPE: Thank you, Senator Williams. Senator Kolterman. [LB391]

SENATOR KOLTERMAN: Thank you, Senator Riepe. I want to walk you through a live example of how this has worked in my life. I had a cyst on my eyelid, went to my local doctor, my family practice doctor. He said: I don't want to mess with that; it's too touchy...just like the other optometrist said. Sent me to a surgeon, a plastic surgeon to have it removed. The plastic surgeon removed it. He did a biopsy of it. He sent me the results. Are you telling me most people wouldn't do a biopsy? [LB391]

CHRISTOPHER WOLFE: It depends on the...it depends on the reason for it. So if we're talking about...I mean there's obviously a lot of other lesions on the eyelids that we're not even talking about here, so I can't necessarily comment on your case, that would be absolutely be biopsied. In the sense of chalazions, or incision and curettage, which is the procedure that we do to remove the chalazion, I can tell you that very few that I've ever sent, if any that I've ever sent, have been biopsied. [LB391]

SENATOR KOLTERMAN: Okay. Thank you. [LB391]

CHRISTOPHER WOLFE: You're welcome. [LB391]

SENATOR RIEPE: One of the questions I had, and I think there's a concern with the, quote end quote, procedural creep, and that would be as in LB391. Is this...is this a single procedure, or is this a family of procedures? [LB391]

CHRISTOPHER WOLFE: Well, it's a...it's mainly the same procedure that's being...that would be done in multiple...on multiple cysts or glands. So like, depending on where it is, it's the same...it's the same basic technique. Yeah. [LB391]

SENATOR RIEPE: Meaning that cyst family, if you will. [LB391]

CHRISTOPHER WOLFE: Yeah, correct. [LB391]

SENATOR RIEPE: Okay. Are there additional questions? Thank you very much. [LB391]

CHRISTOPHER WOLFE: You're welcome. [LB391]

SENATOR RIEPE: You were very helpful. [LB391]

CHRISTOPHER WOLFE: Thanks a lot; appreciate it. Have a great day. [LB391]

SENATOR RIEPE: Welcome. And if you would state your name and spell it, please. [LB391]

FAITH SCHNEIDER: (Exhibits 6 and 7) Yep. Faith Schneider, S-c-h-n-e-i-d-e-r. And I'd like to start off with good afternoon, and thank you all for being here today. My name is Dr. Faith Schneider, and I am here to express my support for LB391, specifically relating for optometrists in Nebraska utilizing the therapeutic benefits for injectable medications. I am a Nebraska optometrist, currently practicing in York and Central City, Nebraska. And growing up on a farm in south central Nebraska, I knew that once I completed my optometry degree, I wanted to return to rural Nebraska and give back to the surrounding communities where I grew up in, by providing them with exceptional primary eye care. Practicing in a rural setting has been very rewarding, for I love the fact that the people that I serve there are more than just my patients. They have become a part of my rural Nebraska family. And these people...they include my relatives, my friends, my high school classmates, the medical doctor that reset my son's broken arm, my church choir members. And although being a primary care provider in rural Nebraska is gratifying, it can also be challenging, for many of my patients have to travel 30-60 minutes for their primary healthcare needs. And for these patients, having local, timely access to care is needed. So today I would like to review the situation in which optometrists in Nebraska are requesting the privilege to use injections to treat patients. LB391 would allow injections into the eyelid for the treatment of cysts or infected or inflamed glands of the eyelids. One thing that I would like to emphasize at this time is that there is nothing in this bill that would allow injections into the eyeball itself. Now in one of the many, tiny glands that line the eyelid become infected or inflamed, the standard of care for treatment is to first prescribe warm compresses, maybe an eye drop or ointment, or sometimes oral medications. If these lines of treatment do not work, injecting a small amount of steroid medication into the inflamed gland can improve this problem. This is the procedure that is being requested. Please note that the improved timely access to care for patients for this injection procedure may reduce the need for a surgical procedure. This is also important to my practice, as patients from the area that I serve may have to travel up to two hours to see a general ophthalmologist to receive these procedures. It is notable that optometrists in Nebraska are currently authorized to manage these cases, using

medications involved in the procedures mentioned, just not by injections. Optometrists in 14 other states can perform the injections we are discussing for patient care. And some other states in the Midwest that can already perform these injections are Wisconsin, North Dakota, Oklahoma, and Tennessee. Besides medical doctors and doctors of osteopathic medicine in Nebraska, the professions that are currently allowed to perform injections include physician's assistants, podiatrists, dentists, dental hygienists, pharmacists, paramedics, nurse anesthetists, registered nurses, and emergency medical technicians. Even nonmedical, licensed professions are currently authorized to perform injections in the state of Nebraska, and these professions include tattoo artists and permanent makeup artists. And many of these professions have far less medical training than optometrists do. I am confident that the Nebraska optometrists will be prepared to join the many other licensed professions in the state and across the country that have authorized these similar injections. This will be a benefit to our patients. We would appreciate your support on this bill, LB391, and I'd like to thank you all for listening today and thank you all for everything that you do for healthcare in Nebraska. [LB391]

SENATOR RIEPE: Thank you very much. I wanted a point of...so if you can clarify for me, are we, in talking about injections or incisions, because I thought earlier we were talking about a slight incision to remove an eyelash? So...and you were talking mostly about, not incisions, but injections. [LB391]

FAITH SCHNEIDER: Yes. [LB391]

SENATOR RIEPE: Is it either/or, or is it both? [LB391]

FAITH SCHNEIDER: It could be either/or. [LB391]

SENATOR RIEPE: Oh. [LB391]

FAITH SCHNEIDER: And the doctor behind me will talk about that more, too. [LB391]

SENATOR RIEPE: Okay. Are there other questions from the committee members? Senator Kolterman. [LB391]

SENATOR KOLTERMAN: Yeah; I have a question. You indicated that your patients in York and Central City have to travel up to, possibly, two hours. That's what your testimony said. [LB391]

FAITH SCHNEIDER: Yes. My practice also receives some people from more than just York and Central City. So we also pull people from Thayer County, and Thayer County would have to

travel an hour to come see us at York. And then they would be about two hours from the ophthalmologist that we would work with. [LB391]

SENATOR KOLTERMAN: Can you tell me, does York have an outpatient service of ophthalmologists in their specialty clinic? [LB391]

FAITH SCHNEIDER: York does. The ophthalmologist that comes in only performs cataract surgery at that outpatient. So if we needed to send our patients for too risky of these procedures, they'd be happy to go to his office in Lincoln. [LB391]

SENATOR KOLTERMAN: Okay; thank you. [LB391]

FAITH SCHNEIDER: Yep; thank you. [LB391]

SENATOR RIEPE: Okay. Any other? Senator Williams. [LB391]

SENATOR WILLIAMS: Thank you, Chairman Riepe. And thank you, Doctor, for being here. In your testimony, you talked about...and another new term jumped up here: the injection of a small amount of steroid medicine into the eye. To the best of your knowledge, is the most recent treatment...does the most recent treatment for treating a cyst include the injection of a steroid? [LB391]

FAITH SCHNEIDER: The first line of treatment would be a digital warm compress and then, possibly some eye drops or eye ointments and possibly oral medicine. It's if these first line of treatments do not work, that's when the injection would be warranted. [LB391]

SENATOR WILLIAMS: So following those...well, I'll use the term noninvasive procedures. [LB391]

FAITH SCHNEIDER: Um-hum; yes. Correct. [LB391]

SENATOR WILLIAMS: The most currently acceptable treatment, as far as you're concerned, would be the injection of a steroid at that point. [LB391]

FAITH SCHNEIDER: After those procedures have been performed. [LB391]

SENATOR WILLIAMS: After those procedures. Okay. [LB391]

SENATOR RIEPE: Okay. [LB391]

SENATOR WILLIAMS: I am going to leave it there. [LB391]

SENATOR RIEPE: Okay. I see no other questions, so thank you very much for being with us. [LB391]

FAITH SCHNEIDER: Thank you for having me. [LB391]

SENATOR RIEPE: Additional proponents, please. [LB391]

ROBERT VANDERVORT: (Exhibits 8 and 9) Good afternoon. My name is Dr. Robert Vandervort, spelled V-a-n-d-e-r-v-o-r-t, and I am testifying in support of LB391, specifically addressing academic and certification requirements of the bill. I am an optometrist in Omaha since 1985. Prior to that I was a full-time assistant professor at Southern California College of Optometry. Since moving to Omaha, our office has served as one of many clinical externship sites across the country for optometry students in their fourth year of training. In addition, I have served as chair of the continuing education committee for the Nebraska Optometric Association, for 30 years, and I have helped coordinate and implement continuing education in the last four changes in our scope of practice since 1985. And I will be happy to elaborate on the 407 processes in that regard. Today you will likely hear from our opponents of this bill, comparisons between the doctor of optometry degree and the doctor of medicine degree that question our education, training, and experience. The doctor of optometry degree is comparable to doctoral degrees in medicine, dentistry, and podiatry. It is important to understand that optometric education is not a subset of ophthalmology. They are two different professions. And optometrists are uniquely trained to provide primary eye care to our patients, including the care that we utilize by this bill. I've distributed to you a handout summarizing optometric education for further elaboration. In order to be certified to perform the procedures described in LB391, optometrists currently licensed in Nebraska will take additional classroom and clinical courses conducted by a fully accredited school or college of optometry, under the direction of the board of optometry and authorized by the Nebraska Department of Health and Human Services. New graduates or doctors seeking to become licensed in Nebraska will be required to meet the same requirements. It is important to understand the context of the certification process. Our opponents will try to characterize this education as if all the material and procedures we are learning are new to us. Nothing could be farther from the truth. Treatment and postoperative management of cysts, sties, and infected glands of the eyelid are very common occurrences in everyday practice, and have been part of our scope of practice for decades. Most of the infected glands respond medically. But many do not, and thus require an injection or a minor surgical procedure to get them to resolve. We have been safely performing other higher-risk procedures, such as corneal foreign

body removal, for over 25 years. You will hear opponents suggest that these procedures can't be adequately learned or safely performed without a medical school education and ophthalmology residency. However, there is no proven scientific basis for that opinion. On the contrary, physician's assistants, podiatrists, and dentists perform similar and even more complex procedures without a medical degree. No one, including ophthalmologists, claim that the public is at risk from those professions. It is also important to remember what Senator Watermeier said. The procedures in this bill are not complex eye surgeries, as our opponents will likely characterize them. This bill does not take optometrists in Nebraska into uncharted territory. Optometrists in at least 18 other states, educated in the same schools and trained to the same courses as our Nebraska optometrists, have broader scope-of-practice privileges for surgery than Nebraska. Optometrists in these states were trained in the same manner outlined in this bill. We are not guessing at what type of...what kind of education and training is enough to protect the public. We're not throwing some dart at the wall to pick a number of hours or courses. We are basing the education requirements on what we know has been successful in other states. Despite what MDs may think about optometric education and training, the track record of optometrists in other states proves that the education and training outlined in this bill are appropriate. Nebraska doctors of optometry are uniquely trained, and we have more than four decades of experience in properly and safely implementing the five previous enhancements to our scope of practice, authorized by past Legislatures. The implementation of LB391 will have the same success for the benefit of the citizens of Nebraska. I respectfully ask that you support this bill, and I'd be happy to answer any questions about optometric education in general and the education that will be provided in order to certify optometrists under provisions of this bill. Thank you, and thank you for your service to the citizens of Nebraska. [LB391]

SENATOR RIEPE: Thank you very much. Are there questions from the committee? Senator Williams. [LB391]

SENATOR WILLIAMS: Thank you, Chairman Riepe. One quick question. What percentage of optometrists do you believe would take the time and go to the effort of getting the additional training that's required by LB391, so they can perform these kind of procedures? [LB391]

ROBERT VANDERVORT: Essentially 100 percent by the year 2020. The bill requires that...we don't like to have different tiers of optometrists in Nebraska. And so in the bill, I think it's by the year 2020, anybody licensed in Nebraska would be required to meet the requirements. So in essence, anybody in current practice would be certified by 2020. [LB391]

SENATOR WILLIAMS: Would be certified. Is there any way of telling how many would, even with the training, feel comfortable doing these kind of procedures at that point? [LB391]

ROBERT VANDERVORT: It's going to vary. You'll find it probably more frequently in rural Nebraska than you would in an urban setting. But it's like any other change in scope of practice. I've been at this now for 30 years, and people become increasingly comfortable. I think one of the things, and this kind of goes back to a question you asked earlier, is professional judgment. And you're going to hear all kinds of horror stories or...not horror stories, but ominous predictions, most likely. And these are the same ominous predictions that have been said to the Legislature for 30 years, ever since I've been here. A good question to ask is: Why don't these predictions of problems with safety ever come true? Because they haven't. They haven't come true in Nebraska, they haven't come true in any other state in the country, where the same arguments against these bills have been presented. And the reason is professional judgment, at least one of the reasons. One of the reasons is we're well trained. We have a good education, we have good continuing education, we have a system that also has checks and balances. If you mess up, you have...first of all, you've got a very angry patient, which nobody wants. You have potential lawsuits, you have potential sanctions by the state board. So there are checks and balances in the system. So an optometrist, as they approach any patient, is going to look at this and say: Is this something I am comfortable doing? The kind of thing that Dr. Myers mentioned earlier with a little ingrown lash underneath the skin...my bet is 90-plus percent of the optometrists in the state would just take care of it. Doing a chalazion surgery, as Dr. Wolfe explained, you know, it's going to be less. But that's where their professional judgment comes in. And that's where...that's, in essence, how the public is protected from any profession. We all have professional judgment, and ophthalmology does not have the market cornered on professional judgment. Medicine does not have the market cornered on professional judgment. It's...we've seen in any profession out there, is we're out to care for the public, and we have an excellent track record for showing good judgment. [LB391]

SENATOR WILLIAMS: Thank you. [LB391]

SENATOR RIEPE: Thank you. Any additional? I don't see any additional questions. Thank you very much for your testimony. [LB391]

ROBERT VANDERVORT: Thank you very much. [LB391]

SENATOR RIEPE: Additional proponents, please. [LB391]

JUSTIN BRADY: (Exhibit 10) Senator Riepe and members of the committee, my name is Justin Brady, J-u-s-t-i-n B-r-a-d-y. I appear before you today as the registered lobbyist for the Nebraska Optometric Association, trying...going to give you a little bit of history and a little foreshadowing. Obviously I am...have no training in the medical field, as the previous testifiers, so hopefully your medical questions are out of the way with them. Looking back, 23 times the

Optometry Act (sic: Optometry Practice Act) has been changed. Seven of those times in the history, it's been to expand their scope. So this is nothing new to come to you; it's been laid out before. This is where they have to come to ask. All of those times, it was opposed by ophthalmology. All of those times eventually, sometimes first year, sometimes after many years, some part of that scope was passed. Looking at the arguments you're going to hear from the opponents: You're going to hear lack of education and training; you're going to hear the public will be put in danger; and you're going to hear there's not an access problem in rural Nebraska. And you'll ask yourself: How do I know that? Well, one thing I've done for the optometrists is I went through and read the hearings of all the bills that have ever been introduced on optometry, going back to 1979, all the transcripts. And the same three arguments are the same: they aren't trained: there's not an access problem; and the public will be harmed. And I'll tell you, you know, I think as when it comes to the training piece, I think some of the previous testifiers have talked about that. Might also ask yourself: The AG, in scope of practice issues, has said, if you want training, you have to be specific. You can't just say; Hey, go get more training. I mean you have to lay out, like LB391 does, specifically what is the training that's needed and required. And I would say if there's questions, to ask yourself or ask the optometrist or ophthalmology, what is the extra training or specific training they would like or be comfortable with. You know, on that, like I said, this training has gone back, starting in 1979, when it dealt with the issue of putting eye drops in the eyes. They said: Well, they don't have the training to do that. And so you'll hear that. The next thing you'll hear is that the public will be harmed. Giving examples, in 1986, in the scope of practice they said: When vision loss occurs as a result of an optometric screwup, this will be that the Legislature's fault. Or '93, they said: Next to death, the worst thing that can happen to a person is blindness. And they're going to come up here, and they're going to try to scare you to say: Hey, the public will be harmed. Access...they've said, in the past there's not an access issue because family physicians are capable. Well, the handout I gave you is from the University of Nebraska Medical Center, that talks about there is an access problem, especially in rural Nebraska. And it's going the wrong way. They are declining in the number of physicians available. And to go back through some of these points, like I said, the training you've heard about...if there's something specific, I would encourage you to ask them. Ask both the ophthalmologists and the optometrists to say: What about this and how can we address it?, if there's something specific. When looking at whether the public has been harmed, part of the research is I contacted the Department of HHS and looked at all the complaint data, going back for the past 35 years. At no time did complaints go up after any one of those seven expanded scope bills happened. No time did the public come to the department and say: Hey, this is wrong, any more at the rate that they were. To give you an example, when the rate is 4.6 complaints a year, so you aren't talking about a profession that receives a lot of complaints, but to give a specific example, when the expanded scope on glaucoma bill was passed, looking at the four or five years before the scope bill was passed, there was an average complaint of 4.7 complaints a year. Five years afterwards there were 4 complaints a year. And that was a major fight; that took years, where these same arguments of they aren't trained, there's not access, and the public will

be harmed came. Again, as far as the access issue, I think all of you have heard from this committee multiple times that there's an access issue, and those of you who live outside of Lincoln and Omaha, I have no doubt you know that. So in conclusion, you know, history has shown that, when expand in scope bills are done in a responsible manner, which I would say LB391 does, the public receives a benefit, not harmed from it. And access across the state is enhanced. With that, I'd try to answer any questions, as far as history. The one thing I'd add, Senator Erdman, I believe it was LB526...was the bill in...okay, you've got it. And...all right. [LB391]

SENATOR RIEPE: Problem solved. Do we have questions from the committee members? Seeing none, thank you very much. [LB391]

JUSTIN BRADY: Thank you. [LB391]

SENATOR RIEPE: More proponents. Do I have any more wanting to speak in favor? I have not. Do we have opponents? Welcome. If you'd state your name and spell it, that would be helpful. And then we'd just invite you to go forward. [LB391]

MATTHEW APPENZELLER: (Exhibits 11-14) Absolutely. I am Dr. Matthew Appenzeller, M-a-t-t-h-e-w, last name spelled A-p-p-e-n-z-e-l-l-e-r. First off, I'd like to say good afternoon and thank you for allowing me to come and speak. I greatly appreciate the time that you're offering us to talk. I am an ophthalmologist in Omaha, Nebraska, and I am the current president of the Nebraska Academy of Eye Physicians and Surgeons. I speak to you today in opposition to LB391. I come to you with a background of extensive training and experience that began as a young adult, teaching the neediest Americans as a volunteer for Teach for America in rural Louisiana, and progressing then through ten years of graduate education and intensive one-on-one training by experienced surgeons. I am currently certified to practice vitreoretinal surgery and general ophthalmology. As eye surgeons and medical doctors, we take an oath to protect patient safety through promoting and providing the highest quality medical and surgical eye care for the citizens of Nebraska. In my practice, I work with 11 ophthalmologists and 7 optometrists, and I have the great privilege of observing how our work together can compliment and enhance one another to provide safe and efficient care for our patients. Therefore, I do truly say I have tremendous respect for my optometric friends and the contributions that they make every day. However, the bill before you today, LB391, goes against this model of safe and efficient patient care. The truth is is that LB391 is an attempt to reintroduce a bill that was rejected in 2014, in hopes of expanding optometry's scope of practice to include injections and surgical procedures. This idea already was evaluated by the 407 technical review committee, the Board of Health, and the chief medical officer of the state of Nebraska. In two of the three cases, these entities decided that the bill was not in the best interest of Nebraskans. In 2014 the Legislature passed a bill to

allow optometrists to prescribe pharmaceutical agents, but it rejected the idea of expanding optometry's scope of practice to include injections and surgical procedures. LB391 requests, amongst other things, that optometrists be permitted to inject medication into the eyelids, to perform surgery on the eyelid, and to authorize suturing of the eyelid, and additional surgical treatments to treat infected and inflamed glands of the eyelid. In light of these requests, some clinical information is important to understand. It is important for you to know that most eyelid cysts do not require or respond to an injection. The vast majority of these are small, benign, and are simply observed. For the small number of cases in which intervention is required, complete surgical excision is the typical mode of treatment, necessitating proper techniques and knowledge to avoid incomplete excision, recurrences, complications and, all too commonly, misdiagnosis by inexperienced providers. The majority of chalazia, which are blocked oil glands below the skin of the eyelid margins--I think my proponent explained it extremely well--respond to simple, no-cost, hot compresses, as been described here, usually for a couple of weeks before deciding if surgical drainage is even necessary. This almost universal initial intervention is already within the optometric scope of practice. It is only occasionally that these lesions need surgical attention. When optometry sends patients for needed secondary intervention, they can do so relatively easily. These lesions are not urgent or emergent. And access to care is a relative issue, but in Nebraska approximately 99 percent of Nebraskans are within 30-minute's drive of any ophthalmologist or satellite clinic. Moreover, optometrists need to refer a patient to ophthalmologists who have learned appropriate surgical techniques during their on-on-one surgical training with experienced, skilled surgeons and with an appropriate volume of cases over time. We also learn the pitfalls, variations, and how to avoid and treat complications, become proficient in providing the standard of care our patients expect and deserve. In addition, it must be stressed that the training required to safely perform surgical treatments is determined and verified by a national, independent body, the Accreditation Council for Graduate Medical Education, rather than a board of ophthalmologists. This is in direct comparison to LB391, where the responsibility is with the Board of Optometry, a self-regulatory body. It must also be noted that there is no difference in cost, from claim code to claim code, between our optometric friends and ophthalmology. Thus, cost savings are not possible. This legislation simply shifts healthcare dollars around, rather than save them. What we are experiencing in Nebraska is simply part of a national campaign by optometry to gain expanded scope of practice, including surgical privileges without the education, training, and experience commensurate with well-established medical standards that have served our citizens for decades. It is currently six states that provide for these eyelid procedures, nine that allow for injections. The rest that have been mentioned have no statute governing whether they specifically will inject. I urge the committee to reject this bill and, instead, encourage both sides to continue working in a collaborative fashion, as we do. It is a team effort rather than one of ineffective and wasteful conflict and, above all, it prioritizes patient care. Our patients expect and deserve it. And with that, I would be happy to answer any questions the committee may have. [LB391]

SENATOR RIEPE: Thank you. [LB391]

MATTHEW APPENZELLER: Thank you. [LB391]

SENATOR RIEPE: Senator Kolterman. [LB391]

SENATOR KOLTERMAN: Thank you, Senator Riepe. Mr. Appenzeller, you indicated, or you heard the testimony before about the satellite offices, like in Seward and York, people in my district that have specialty clinics. And I believe the optometrist indicated that, perhaps, those were just for cataract surgeries. Is there willingness, on the part of ophthalmologists, to staff these satellite clinics in a more robust way, so that some of these issues can be taken care of? Or do they already do that, in your opinion? [LB391]

MATTHEW APPENZELLER: In my opinion, in terms of staffing in a robust way, if the question is whether the ophthalmologist would be seeing patients who are noncataract patients, I would hope that the answer is yes, because that is the oath that we take. That is the promise that we make to people. If someone is in need of my services, I am never going to turn them away. But I hope that that would answer the question. [LB391]

SENATOR KOLTERMAN: Well, the other side of that is this could be done in a clinic setting, in most cases, couldn't it, what they're asking to be? [LB391]

MATTHEW APPENZELLER: It depends on the actual condition itself. [LB391]

SENATOR KOLTERMAN: Okay. [LB391]

MATTHEW APPENZELLER: The majority of these that are discussed will be handled in a clinic situation. [LB391]

SENATOR KOLTERMAN: Okay; thank you. [LB391]

MATTHEW APPENZELLER: You're welcome. [LB391]

SENATOR RIEPE: Are there additional...Senator Williams. [LB391]

SENATOR WILLIAMS: Thank you, Chairman Riepe. And thank you, doctor, for being here. And you've covered much of what have been my questions, in your testimony. I want to delve

into, a little bit, a comment that was made earlier that I would like you to respond to. Is a cyst a cyst? [LB391]

MATTHEW APPENZELLER: A cyst is defined as a lesion that is filled with some material that it shouldn't be, whether it be fluid or epithelial cells or any number of different lesions. It is up to the professional at this bedside to make a decision as to what they believe that cyst is. That is derived from experience, it's derived from training, it's derived from many, many, many hours of study and one-on-one help from our mentors in the beginning of our three years of training in ophthalmology, the three plus one of internal medicine. A cyst is never just a cyst. It can be. As a medical doctor, I am trained and am required to consider the worst-case scenario. And I have to, based on that experience and training, make the decision there as to whether I believe this is something that should be observed or something that should be drained or something that needs to be surgically excised and sent for pathology. So I would say no. [LB391]

SENATOR WILLIAMS: Okay. I want to pursue a question that I was asking Dr. Schneider. And in her testimony, which I have here in front of me, she was talking about the treatment of a problematic gland, I think was the term used to here, that after the hot compress, after the drops, if the inflammation is longer lasting, injecting a small amount of steroid medicine into the eyelid could improve the situation. And in your testimony, you talked about going through some of these things and then leading to intervention, which is required, which would be complete surgical excision. Which is the current method of handling method of handling that situation? [LB391]

MATTHEW APPENZELLER: I had the wonderful opportunity, in my training, to learn at the hands of Dr. Robert Kersten, who is currently a professor of oculoplastics at UCSF in San Francisco. He routinely gives lectures across the world and also participates in Orbits (sic: Orbis), which is the Flying Eye Hospital, going to southeast Asia, Africa, etcetera, so truly considered probably one of the world's experts in this very issue. I have actually had this conversation with him when I was a resident, because I felt that I wanted to know: What should I be doing? He will tell you that injection of steroid into an inflamed gland, etcetera, is a controversial topic. Many ophthalmologists will not do it. There are a few that will, but even those that will, will do it in conjunction with surgical excision. They would almost never do it by itself. And that is Dr. Kersten's opinion, and I carry the same opinion. [LB391]

SENATOR WILLIAMS: But also under LB391, if it were passed, the optometrist could do both. [LB391]

MATTHEW APPENZELLER: LB391, as written here, does provide that authority. [LB391]

SENATOR WILLIAMS: And my last question is the question that was provided by Dr. Vandervort, which is: Your concerns that you have testified to, why don't they seem to come true in other states that have passed such legislation? [LB391]

MATTHEW APPENZELLER: That's a very complicated topic. There are...most of what we would say were problems that have occurred, keeping in mind that most problems that would occur would be small in number, that is true...and the reason being that not all lesions will be cancer; not all lesions will lead to significant destruction of tissue. What I can say is that, on anecdotal evidence, I personally, as a physician, have seen when a single patient has been harmed when inappropriate or inexperienced hands have been at work. There have been cases in other states where we do not know the specifics because the cases have been sealed in court. So will there be some massive torrent of problems, complaints, etcetera? Only the future could tell. Will there be a single patient that comes to my patient that comes to my practice with a problem? That is a distinct possibility, because I have already seen it. [LB391]

SENATOR WILLIAMS: Thank you. [LB391]

SENATOR RIEPE: Okay. Thank you very much. Senator Howard. [LB391]

SENATOR HOWARD: Thank you, Senator Riepe. Thank you for visiting with us, Dr. Appenzeller. It's nice to see you again. [LB391]

MATTHEW APPENZELLER: Thank you, Senator. [LB391]

SENATOR HOWARD: I wanted to just clarify a portion of your testimony. You said that this bill is an attempt to reintroduce a bill that was rejected in 2014. LB526 was not rejected, and these portions were not rejected by the Legislature. What we decided was that we were in a short session; we had a very short amount of time to complete the work on LB526. Senator Chambers had promised, as he does, to filibuster the bill if we couldn't come to a compromise; and so we made a compromise. But the Legislature didn't reject these offerings; they never said these are not safe, or terrible ideas. What we said was that we're in a short session and we don't have the time. And so I just wanted to make sure that that was clarified, for the record, because there's been no rejection. This is an ongoing conversation, and I think...I welcome the opportunity to continue it. Thank you. [LB391]

MATTHEW APPENZELLER: Thank you. [LB391]

SENATOR RIEPE: Okay. Thank you very much. I have a couple questions. [LB391]

MATTHEW APPENZELLER: Yes, sir. [LB391]

SENATOR RIEPE: First of all, under practice models, are there...everything is moving more towards team models. Are there practices where, in a partner relationship, where ophthalmologists and optometrists have found peace, if you will, that...a division of labor and work together in partnership? Are you familiar with any of those? [LB391]

MATTHEW APPENZELLER: Absolutely I am. One of them I practice in. [LB391]

SENATOR RIEPE: Oh. [LB391]

MATTHEW APPENZELLER: As I had noted, I work with 11 other ophthalmologists and 7 optometrists in my practice. [LB391]

SENATOR RIEPE: Oh, okay. [LB391]

MATTHEW APPENZELLER: One of them is a partner...is a partner in my practice, and we constantly work in a collaborative effort, working within the confines of what we all mutually agree would be best for the patient, given our experiences and education and training. Also, there is a model that has been forwarded by the American Academy (sic: Society) for Cataract and Refractive Surgery, where they have begun moving this direction, where they would like optometry to begin to fulfill that cooperative, collaborative mode with ophthalmology, to continue to provide as efficient as care as possible. As we all know, healthcare dollars continue to become stretched, and we need to find all the ways that we can to work in a team effort, in general medicine and in eye care, in order to make those healthcare dollars move as far as they can. [LB391]

SENATOR RIEPE: Thank you. That feeds in a little bit to my next question, which has to do with access. And do we have a...is there an excess number of ophthalmologists in the state of Nebraska? [LB391]

MATTHEW APPENZELLER: An excess number of ophthalmologists... [LB391]

SENATOR RIEPE: Yes. [LB391]

MATTHEW APPENZELLER: ...in the state of Nebraska? I would say no. [LB391]

SENATOR RIEPE: Okay. [LB391]

MATTHEW APPENZELLER: There does not appear to be one in Nebraska. There does not appear to be one in the United States. [LB391]

SENATOR RIEPE: It's more distribution, probably. [LB391]

MATTHEW APPENZELLER: There is a certain element of distribution, yes, since the creation of most of our satellite clinics to try and reach our patients. [LB391]

SENATOR RIEPE: I know in some of these she comes down with a...both the growing population and the aging population, in terms of how many hands on deck do we need and who do those hands on deck need to be. And I know in our group we talk a lot about highest and best, having people practice at the top of their...the scope of their practice. So nurse practitioners and everyone else and so it's just a curiosity question on my part, so. [LB391]

MATTHEW APPENZELLER: May I comment briefly on that? [LB391]

SENATOR RIEPE: Absolutely. [LB391]

MATTHEW APPENZELLER: I think that for our allied health professionals thinking of those very things...when I lived in North Carolina and practiced in North Carolina for a little while and I had the privilege of teaching physician assistants. And the physician assistants in allied health professionals, many of them do function well as physician extenders. But it is interesting to note, because thinking of prior testimony, many of these professionals, many professionals are under physician supervision or training, such as physician assistants. So I think that as we continue to expand and provide access, the team related model that you have just described is key. [LB391]

SENATOR RIEPE: Okay. Senator Kolterman. [LB391]

SENATOR KOLTERMAN: Thank you, Senator Riepe. Do you see any potential for telehealth in the application of expanding your services? [LB391]

MATTHEW APPENZELLER: I do. Specifically, I am a vitreoretinal surgeon. That is my subspeciality. One of the things that we are seeing starting to expand even here in Nebraska, is the use of telemedicine for the monitoring of diabetic retinopathy where primary care physicians can take photographs of retinas of their diabetic patients, send those pictures to be scored and/or

evaluated by eye care professionals such as myself, and they receive feedback to let them know whether we see anything of concern, when, how soon should this patient be evaluated if necessary by an eye care professional. So I do see a continued role for telemedicine and continued growing for telemedicine. [LB391]

SENATOR KOLTERMAN: Thank you. [LB391]

SENATOR RIEPE: Okay. Any other questions? Seeing none, thank you very much. [LB391]

MATTHEW APPENZELLER: Thank you. [LB391]

SENATOR RIEPE: Helpful information. Additional opponents. Welcome. If you would say your name and spell it and... [LB391]

ROB RHODES: (Exhibit 15) Good afternoon. Thank you, Chairman Riepe, my name is Dr. Rob Rhodes, R-o-b, my last name is Rhodes, R-h-o-d-e-s, I'm a board certified family physician practicing here in Lincoln. I'm the president-elect of the Nebraska Medical Association and I'm here to testify on behalf of the Nebraska Medical Association in opposition to LB391. I'd like to thank all of the committee members here and I'd also like to thank all the optometrists that are here. They do, as well as you, serve our state and I'm very appreciative of their work. I do want to stress to you though the importance of this bill. These are major issues with complex diagnoses and more importantly complex surgical techniques involving the face and eye and sometimes fatal issues. I was trained to do these procedures, as outlined in LB391, and my license in Nebraska is for medicine and surgery. But I choose not to do that because of nerve, vascular, and cosmetic concerns potentially. And as one of my faculty once said to me, "Stay away from the eye lid. Think to not affect the blink." And by that, there's a lot of mechanism in the eye that even as a practicing physician I'm very, very cautious with. Optometrists are already credentialed to treat lumps and bumps with baseline treatment, which is often a hot compress, which is what I do. Medical doctors, such as family practitioners and emergency medicine physicians are also trained to treat such eye issues. But more serious emergencies or injuries require the advanced training of experienced ophthalmologists and sometimes plastic surgeons, dermatologists, and even general surgeons in Nebraska. Nonemergent problems can be seen in scheduled clinics. Minor emergencies are being covered by optometrists, family practice, and emergency medical physicians. Anything more serious needs to see an ophthalmologist or one of the specialized surgeons I listed previously. The bill before you specifies hours of training beyond basic optometry to support the request for expanded scope. The total number of hours mentioned in the bill is 24.8 hours for injections and 16 hours for surgery. That is less than a week of training compared to the four to eight years beyond medical school for an ophthalmologist. The NMA recognizes the intricate and delicate nature of the eye and its

functional relationship with the rest of the body. The eye does not exist in isolation and this must be recognized and appreciated. Nebraska Medical Association asks that you oppose this dangerous scope of practice expansion for optometrists. Thank you again for the opportunity to share these concerns with you. I also submitted a letter from Dr. Madara from the American Medical Association for the record. [LB391]

SENATOR RIEPE: Okay. Thank you. Are there questions from the committee members? I see none. Thank you very much for being here. [LB391]

ROB RHODES: Thank you for your time. [LB391]

SENATOR RIEPE: Additional opponents. Thank you for being here. If you'd share your name and spell it, we'd appreciate it. [LB391]

KEEGAN HARKINS: (Exhibits 16-18) Hello, my name is Keegan Harkins, spelled K-e-e-g-a-n H-a-r-k-i-n-s. I am the chief resident of ophthalmology at the University of Nebraska Medical Center. My comments today are made as a licensed medical doctor and a private citizen of the state of Nebraska. Nearing the end of my training and growing up in western Nebraska, I feel I am uniquely qualified to share my experience and its value to the current discussion. I appreciate this opportunity and your time. As a physician-in-training, future ophthalmologists spend four years going through medical school. We spend time studying the anatomy, physiology, and cellular biology of the human body. Next, time is spent learning the disease processes and the best evidence-based methods to treat them. During the second two years of training, we spend our time rotating through hospitals in all areas of medicine. This experience provides a robust foundation for the understanding of the human body and the body's reaction to disease and their respective treatments under the direct supervision of experienced physicians. During this time medical students must pass a series of three national standardized examinations to ensure competency before licensing and moving on to residency training. Ophthalmologists next undergo four years of residency training. The first year is spent in a medical or surgical internship. This is an extremely challenging year were I would work seven days a week and at least 80 hours a week. During my personal time on the hospital wards I ran codes, diagnosed cancers, and treated many life-threatening diseases. Without this time in the hospital I do not believe that I would be able to understand my patients as a whole and understand both the preoperative safety considerations as well as the potential post-treatment complications and how they affect the body as a whole. The next three years of residency consist of extensive training in the field of ophthalmology. This includes both didactic and clinical training in the anatomy, physiology, and pathology of the eye and the human body as well as medical and surgical treatments. We see thousands of patients in the outpatient clinic. In addition to our clinic time we spend a quarter to a half of our time seeing patients on call in the hospitals for emergencies for

ocular and facial trauma in the emergency room or ICU setting. These experiences are invaluable to one's training and cannot be attained in other training settings. Surgery of the eye is a very tedious and delicate procedure. Training starts with surgical practice on animal eyes, computer simulations and observations of skilled physicians before we are even able to attempt portions of the procedures under careful supervision. The extensive length of the training allows us to see a myriad of potential complications that may occur and how to deal with them. National guidelines are in place to set rigorous standards that ensure the quality of surgical residents that come out of ophthalmology training and to protect the safety of our patients who put their trust in our care. Nationally, ophthalmologists must perform 364 surgeries, while residents at UNMC average between 700 and 1,000 surgeries during their training. Without this large volume and extended period of training we could not hope to achieve the efficacy nor experience the possible complications. In addition to hands-on training, we are also exposed to intensive written and oral examinations for a knowledge base. Residents take yearly in-service exams and at the conclusion of our training we must pass a national standardized written exam followed by an oral examination, which is proctored by experts in the field of ophthalmology in order to become licensed. This immense knowledge base and extensive training is in direct contrast to the 8 hours of injection training and 16 hours of surgical training suggested in LB391. On a more personal note, I have a deep concern for the healthcare of rural Nebraska. I grew up in the Panhandle of Nebraska and have an understanding of the large expanses of distance that give healthcare in that setting unique problems. However, convenience cannot be a substitute for quality of care. A complication from a poorly performed procedure can create an emergency that would create a need for even more specialized care that the patient would likely have to travel even farther away to obtain. I have a passion for rural eye care. Soon I will be moving to North Carolina to take part in a two-year vitreoretinal surgery fellowship to obtain more specialized care, after which I plan to return to western Nebraska and continue to practice there for the rest of my career. I hope my statements have given some insight into the unique training ophthalmologists receive. And I welcome any questions you have. [LB391]

SENATOR RIEPE: Thank you very much. You certainly know how to play to our Panhandle senator over here. So are there questions from the committee? Senator Williams. [LB391]

SENATOR WILLIAMS: I do have one. And thank you for being here and thank you for your commitment to healthcare in Nebraska, especially your thoughts about coming back to the rural area. And you have done an excellent job, as have others, of talking about the educational requirements and what you have to go through. I don't know if you can respond to this or not, but does anyone else besides me see the irony that you professionals that are highly trained in doing these things are asking seven senators who have no clue about this to make a decision that your two organizations should solve? And then when we make our decision, then we take it to 42 other senators and in that room none of you get to participate in the discussion. This has been great testimony, thus far, and I'm sure the rest of it will be, too. But you know the position that all

of you are putting us in when you can't figure this out yourself. I don't think there was a question in there. Thank you. [LB391]

SENATOR RIEPE: Thank you, Senator Williams. He was right on the tip of coming out with a question. Are there any other questions or comments that...to be said? Thank you so very much for your time and being here. [LB391]

KEEGAN HARKINS: Thank you for your time. [LB391]

SENATOR RIEPE: Additional opponents. We have one coming up here. It's always good to see a Navy Corpsman, so welcome, Doctor. [LB391]

DAVID WATTS: Thank you, Senator. [LB391]

SENATOR RIEPE: If you'll give us your name and spell it, please? [LB391]

DAVID WATTS: (Exhibits 19-22) My Name is Dr. David, D-a-v-i-d, Watts, W-a-t-t-s. Good afternoon, Chairman Riepe and distinguished members of the Health Committee. I am a board-certified dermatologist and I specialize in high-risk skin cancer surgery in Omaha, Nebraska. I'm representing the Nebraska Dermatology Society, the Metro Omaha Medical Society, and the Nebraska Medical Association in opposing LB391. I'm the current president of the Metro Omaha Medical Society. I hope today's testimony on medical and surgical eye care for Nebraskans will help you to determine who can safely provide that care to your constituents. On one hand is the question of access, certainly. On the other hand, you're asked as the Health Committee to be responsible for patient safety, to decide how much experience and training is adequate to safely diagnose and treat lumps and bumps on the eyelids of people in our communities. Those folks will simply assume their eye doctor's license means they're qualified. We have three comments today about eyelid surgery as proposed in LB391. Our first concern is that the language in the bill is ambiguous. It says: the performance of minor surgical procedures for the treatment of cysts or infected or inflamed glands. Minor surgical procedures is not defined in this bill and we think that's important. This nonspecific language could mean cutting out, cutting into, biopsy sampling of, or draining of either benign or malignant cysts or glands on the eyelid. The language could also allow destruction of eyelid lesions by freezing--called cryosurgery--or burning--electrosurgery--which are also considered minor surgery. And by the way, even minor surgery carries risks and complications. Our second concern is a missed cancer. Many lumps or bumps that appear to be cysts or inflamed glands turn out after biopsy to be something very different. Even for experienced surgical doctors it can be quite challenging to tell cancer from noncancer by outward appearance alone. And getting the correct diagnosis can also depend greatly on how the lump or bump is biopsied. A delayed or missed diagnosis of cancer may lead

to unnecessary additional surgery and cost, impaired eyelid function, permanent eyelid disfigurement, or even in some cases, death. Skin cancers like basal cell and squamous cell carcinoma, sebaceous carcinoma, and malignant melanoma can all grow on or inside the eyelids. It's estimated currently that 1 in 28 Americans will develop some form of melanoma in their lifetime, and 1 in 5 will develop one or more of the extremely common nonmelanoma skin cancers. We've provided some pictures of what appear to be cysts or inflamed glands on the eyelids, to show the complexity of diagnosing bumps on the eyelid. I will warn you ahead of time that a couple of those photos are graphic and I'll be happy to discuss these with you at a break or after testimony. Our third and most important concern: How much training and experience is enough to safely perform surgery on people's eyelids? The 24-hour training requirement in this bill does introduce the student to injection technique and elements of eyelid surgery. However, the 407 Technical Review Committee, the Board of Health, and the Chief Medical Officer all expressed safety concerns about this minimal level of training. All three emphasized the need for a standardized surgical training program with hands-on training on actual patients and ongoing competence assessment. However, to our knowledge, no such standardized program for Nebraska optometrists exists as of 2017. A fundamental rule of medicine is: First, do no harm. We respectfully ask that you recognize the extensive medical and surgical education, the thousands of hours of supervised surgical residency training, and the broad experience of specialty eye physicians and surgeons. We hope you will oppose LB391, a potentially dangerous move to allow optometrists without adequate surgical training to perform eyelid surgeries that could harm patients. For the record, I've also submitted letters from the Nebraska Dermatology Society, American Academy of Dermatology Association, and the Nebraska Oncology Society. Thank you all so much for your time and your service, and for the opportunity to share these concerns with you today. I'd welcome any questions. [LB391]

SENATOR RIEPE: Thank you, Dr. Watts. Are there any questions from the committee? Dr. Williams. Senator Williams. [LB391]

SENATOR WILLIAMS: See, I sat here long enough. Thank you, Senator Riepe. And thank you, Dr. Watts, for being here. And irregardless of the slip of the tongue by Senator Riepe, I know nothing about that end. But one end that I do know something about that I would like to ask you about is capitalism. We've heard all the conversation thus far about patient safety, patient access, and all of that. And nobody has been willing at least to talk about protecting their turf from an economic standpoint. Would you, who are not one of these, who is a dermatologist involved in this thing, share any thoughts you might have about, if we pass LB391, are the ophthalmologists going to suffer financially? If we don't pass it, are we passing up a financial gain to the optometrists? [LB391]

DAVID WATTS: Thank you, Senator. I hope this isn't about a turf battle and I honestly don't think it is. I think both the optometrists and the ophthalmologists have patient care at their root.

As far as the money is concerned, there are the same codes whether the ophthalmologists bill for those or optometrists bill for those and I don't think it's a large part of the earnings of either specialty. I think, personally, that this is about public safety or patient safety, public health. [LB391]

SENATOR WILLIAMS: Thank you. [LB391]

DAVID WATTS: Yes, sir. [LB391]

SENATOR RIEPE: Good question. Any other questions? Okay. Seeing none, Dr. Watts, thank you. Other opponents. No more opponents? Anyone testifying in a neutral capacity. Come forward. If you will state your name, sir, and spell it. [LB391]

JEFF PAPE: (Exhibit 23) Yeah. My name is Jeff Pape, J-e-f-f, last name Pape, P-a-p-e. I am an optometrist practicing in Norfolk for the last 20 years. I was appointed to the Nebraska Board of Optometry by the Board of Health in 2011 and I currently serve as their chairman. As directed by my board, I will be testifying in a neutral capacity today. At our last meeting we had a chance to review LB391 and found no concerns regarding public welfare and safety. After the meeting I contacted the state boards of Oregon, Tennessee, Louisiana, Kentucky, and Oklahoma. These states were chosen because they have a similar if not greater scope of practice of that being sought in LB391. None of the boards responding reported having had any issues regulating these procedures and none had registered any complaints. In general, there are two key points I wanted to emphasis today about optometry and the Board of Optometry in specific. Number one, optometrists are held to the same standard of care as an MD or ophthalmologist doing a similar procedure. There are not two sets of standards, one for optometrists and one for ophthalmologists. Number two, optometry has a longstanding track record of providing safe, effective care. Of the regulatory boards, the Board of Optometry is historically among those with the fewest complaints and investigations. On average, there are 800 cases per year reviewed by the Nebraska state boards. In 2015, the Board of Optometry reviewed six and last year we reviewed two. None involved privileges granted by scope expansion. The bottom line is it's up to the Legislature to pass or not pass the bill. But if it does pass, the Nebraska Board of Optometry is confident in our ability to implement it and ensure public safety. I tried to hit kind of the high points contained in my letter. You should have a copy of that. But I would be happy to answer any questions. I know you guys have been here a long time already. I appreciate your time. [LB391]

SENATOR RIEPE: Thank you. Are there questions from the committee? Senator Erdman, please. [LB391]

SENATOR ERDMAN: Thank you, Senator Riepe. Thank you for coming. I've asked several other people who have come in that position called neutral, it appears from what you've testified here that you...your group may not be neutral. You may be in support of the bill. I would question people...I question people who come in the neutral position. I've not understood that position. From your testimony, I don't understand that position. I believe you're a proponent. It's the way it appears to me, which is fine. I don't really care, but I just show it out that for other people who want to come neutral, neutral is not what you said. It appeared to me that you're a proponent and I agree that's fine. You may be in the wrong category. You maybe should have been on the proponent side. But I appreciate the information you have. It's very vital that we know how these other states are handling that. I'm not downplaying the information you shared with us. That's important. It makes sense. But the point I'm trying to make is, it doesn't seem to be neutral. [LB391]

JEFF PAPE: Can I comment on that? [LB391]

SENATOR ERDMAN: Yeah, you bet. [LB391]

JEFF PAPE: I tried to stick to the facts as much as I could on that. When we meet, we have a limited amount of time to kind of discuss these issues. [LB391]

SENATOR ERDMAN: I agree. [LB391]

JEFF PAPE: More than anything, I wanted to kind of tell people what the Board of Optometry did. And that's what I was trying to do more than anything with this thing. It's kind of one of those things where if nobody knows who you are, then you're probably doing a good job. And I think that's kind of where the Board of Optometry is, more than anything else. But like I said, I wanted to explain kind of what we did a little bit. And I tried to stick to the facts as much as I could. [LB391]

SENATOR ERDMAN: And I have no problem with you stuck to the facts. I understand that. And I'm not saying...I'm not trying to discount your testimony. I appreciate it. I'm just saying it appears that going forward it would be better if you were in one position or the other, because of the way your testimony was. [LB391]

JEFF PAPE: Okay. [LB391]

SENATOR ERDMAN: Thank you. [LB391]

SENATOR RIEPE: Thank you very much. Are there any other questions? Senator Williams. [LB391]

SENATOR WILLIAMS: Thank you, Chairman Riepe. It wouldn't be fair if I didn't ask Jeff Pape a question or two. How long have I known you? [LB391]

JEFF PAPE: My whole life. [LB391]

SENATOR WILLIAMS: Are you a graduate of Gothenburg High School? [LB391]

JEFF PAPE: I am not, actually. I moved halfway through my junior year of high school to Grand Island, but I'm a lifelong Swede anyway. My grandparents grew up there and my parents grew up there. [LB391]

SENATOR WILLIAMS: Are your parents both graduates of Gothenburg High School? [LB391]

JEFF PAPE: Yeah. My sister, also. Yeah. I'm the lone wolf in that group. [LB391]

SENATOR WILLIAMS: Let's end this hearing. [LB391]

JEFF PAPE: Go Swedes. They're in the state playoffs next week, too. So there you go. [LB391]

SENATOR RIEPE: So you were a Gothenburg young man? [LB391]

JEFF PAPE: Yeah, I grew up in Gothenburg until about halfway through my junior year. [LB391]

SENATOR RIEPE: And you didn't return to Gothenburg, you went to Norfolk? [LB391]

JEFF PAPE: Yeah. [LB391]

SENATOR RIEPE: Was there a story there? [LB391]

JEFF PAPE: Just opportunity, more than anything else. [LB391]

SENATOR RIEPE: Okay. Okay. We'll assume...I'll let that go. [LB391]

JEFF PAPE: Great. [LB391]

SENATOR RIEPE: Thank you very much for being here. [LB391]

JEFF PAPE: Thank you. [LB391]

SENATOR RIEPE: We appreciate it. [LB391]

JEFF PAPE: Thank you. [LB391]

SENATOR RIEPE: Are there others testifying in a neutral, quote unquote, neutral capacity? Seeing none, Tyler, do we have any letters in proponents or opponents? [LB391]

TYLER MAHOOD: (Exhibit 24) I have one letter of opposition, signed by Dr. Debra Johnson of the American Society of Plastic Surgeons. [LB391]

SENATOR RIEPE: Okay. And I'm looking around for Senator Watermeier... [LB391]

SENATOR ERDMAN: He said he wouldn't be here. [LB391]

SENATOR RIEPE: He's not going to be back to close. Okay. This concludes the HHS hearing for LB391. Thank you very much. We are now going to finish up on our appointments and reappointments. And we have two individuals that are here with us at this time. The first appointment would be Dr. Benjamin Iske. If you would, kind sir, if you'd state your name, spell it for us for the record, and tell us a little bit about your background and why you have been intrigued about serving on this particular board. [LB391 CONFIRMATION]

BEN ISKE: My name is Ben Iske, B-e-n I-s-k-e. I practice dentistry in Bridgeport, Nebraska, in the Panhandle. I grew up south of Gretna in Springfield, but I grew up in a small town between Lincoln and Omaha, which is a different aspect from living in the Panhandle where a small town is a small town and it's not as easy to get back and forth for anything from groceries to whatever else you're looking for. I was approached by some other dentists from the Panhandle to apply for this position for Rural Health. And I have been in practice in the Panhandle for about two years and I do see a need for more education and for treatment and access to care. It's different for, like I said, for people to travel to get groceries, to go school shopping, to do things like that. They're not adverse to traveling, but it is harder for a lot of people to get to medical care, dental care, so that's something that has intrigued me, and more so the education part. There's a lot of ranch and

farm families that home school their kids, where they don't get some of the other education that can be presented at schools and education for prevention of...a lot of people don't come to see the dentist until they have problems or don't go to the doctor until something is wrong. So the education side of public health and rural health is something that I look forward to helping to solve or at least better in some way. [CONFIRMATION]

SENATOR RIEPE: Okay, thank you. Do you have one particular thing that just sets your hair on fire that you want to accomplish as a member of the board, obviously? [CONFIRMATION]

BEN ISKE: I can't really predict. This is my first meeting. I don't...the Department of Health and Human Services in the Panhandle has, from what I've seen in my less than two years, has made an effort to start with the younger kids for doing screenings, providing fluoride treatments, trying to start the education process earlier. And a lot of the times you get into the schools and you talk to kids and you indirectly educate parents from what kids go home and tell their parents and what you can give them in handouts, any information. I don't know if I have any goals or anything in specific at this point. [CONFIRMATION]

SENATOR RIEPE: That's fair, you're coming in new. Are there...your fellow Panhandler, Senator Erdman, has a question right here. [CONFIRMATION]

SENATOR ERDMAN: Thank you, Senator Riepe. Fellow Panhandler, that's pretty good, huh? Thank you for coming. Dr. Iske came nearly 400 miles to visit with us, that's probably why you were a little late. It takes a while to get here. I appreciate it. [CONFIRMATION]

BEN ISKE: I'm a little tired. Yeah, I woke up pretty early this morning. [CONFIRMATION]

SENATOR ERDMAN: I appreciate that. I appreciate your willingness to step up and do this, because as you well know, in western Nebraska there are not a lot of people. So when we have people like yourself that are willing to do this, I really do appreciate it. And consequently we, as those kind of people who do that, feel like we should give back to our communities. Dr. Iske is a great addition to our community and I appreciate him coming there because if he hadn't come there, the other dentist had retired and we wouldn't have anyone at all. So I appreciate your service there as well as doing this. [CONFIRMATION]

BEN ISKE: Thank you. [CONFIRMATION]

SENATOR ERDMAN: Thank you for coming. [CONFIRMATION]

BEN ISKE: To comment on Senator Erdman's, there are a lot of dentists in the Panhandle that will be retiring in the next five to ten years. And there's not...there's enough graduates, but not a whole lot of people that are going back to that area. So you're getting less dentists, same population, and that's another thing that concerns me, I guess. I can't see everybody, unfortunately. To recruit and to bring quality physicians, dentists, medical personnel to those areas is a concern. [CONFIRMATION]

SENATOR RIEPE: It sounds to me like you're on the edge of a monopoly. [CONFIRMATION]

BEN ISKE: I don't know. I don't know if I even want that, but. [CONFIRMATION]

SENATOR RIEPE: Well, thank you. And Senator Erdman has to be happy today, he has an ophthalmologist and he has a dentist. He's, as they say on the farm, walking in tall clover. [CONFIRMATION]

SENATOR ERDMAN: That's it. [CONFIRMATION]

SENATOR RIEPE: Are there other questions that the committee members might have? We very much appreciate your coming this far. We very much appreciate your willingness to serve. It's important and few people step forward to do it, but we are thrilled that you're willing to. [CONFIRMATION]

SENATOR ERDMAN: That's right. [CONFIRMATION]

BEN ISKE: Thank you. I apologize for being late. [CONFIRMATION]

SENATOR RIEPE: No apologies needed. [CONFIRMATION]

SENATOR ERDMAN: Thank you. [CONFIRMATION]

SENATOR RIEPE: Thank you very much. [CONFIRMATION]

BEN ISKE: Thank you. [CONFIRMATION]

SENATOR RIEPE: Okay. I would like to go to...we're going to go to the next reappointment, which is Dr. Brian Buhlke. Welcome, sir. If you'd just give us your name, spell it, tell us a little

bit about yourself so we can get to know you. And this is a reappointment (inaudible). [CONFIRMATION]

BRIAN BUHLKE: Reappointment, yeah, several times. My name is Dr. Brian Buhlke, B-r-i-a-n, Buhlke, B-u-h-l-k-e. I'm a family practice doctor from Central City, Nebraska, and from Genoa, Nebraska. I work for Bryan Health in a critical access hospital and a rural health clinic in Central City and I actually own my own practice in Genoa. So Central City is about 2,800 people, Genoa is about 900 people. And so that's why I represent a physician for the Rural Health Advisory Commission. I've been on the commission for quite some time. I had the good fortune of sending a letter in 2005 to Senator Nelson and Senator Johanns about loan repayment. And the question was, why I had to pay income tax on loan repayment. And as you guys probably know, Nebraska led the charge after that letter was sent and we got loan repayment to be tax free and so that benefited a lot of people. After that letter I became interested in policy. I became interested in what else I could do serving on the board and so I was asked to serve on the Rural Health Advisory Commission. So this will be my third reappointment. I'm passionate about rural medicine, specifically right now about mental health. Central City does a great job, I think probably better than anybody else in mental health. We have mental health practitioners. We have mental health providers, psychiatrists that come via telemedicine. Genoa, Nebraska, was the first place in the state of Nebraska that had telepsych and Dr. Magnuson from UNMC provided that service and we were extremely excited to have him there. One of my passions right now is to try to figure out why we overlooked family medicine. Everybody is talking about mental health, but we're not talking about how do we help family medicine physicians provide better mental health. And so that's something that I'm going to try to champion in my next appointment. We need to get those people who are already out there the opportunity. So we're very interested in trying to get new people into rural Nebraska. We're trying to figure out how we can get people to move out to rural Nebraska. But we're forgetting that there's already people there that could get the training and who have already established those communities being home. And so that's something I'm very interested in, so. [CONFIRMATION]

SENATOR RIEPE: Very good. Are there questions? Senator Linehan. [CONFIRMATION]

SENATOR LINEHAN: So maybe you've answered a question because a couple...in the last week we've heard that there are 91 counties that don't have sufficient mental health services or 93, and maybe you're the one county that does have sufficient health services. Do you feel like you do? [CONFIRMATION]

BRIAN BUHLKE: I agree. I agree. Our hospital-clinic, we have psychologists, we have psychiatrists, we have nurse practitioners that practice mental health. We have coordinated with Boys Town and they're providing us that counseling. We have telepsych and that service is

always available. Younger people tend to like telepsych and the older individuals don't like that as much, but I don't see it. At least in our community, we don't see it. We have a lot of opportunities for those people. What we haven't done--again, in my opinion--is we haven't done a very good job of potentially reeducation primary care to take care of some of these issues. These are my patients anyway, and so I know them best. And so if I felt more comfortable with those treatment options, perhaps that would be the best place to go. These are the people who are my neighbors anyway. And so that's something I really want to look into. And I've sat on the Board of Family Medicine at Nebraska and I think that's something we could look into. [CONFIRMATION]

SENATOR LINEHAN: How did...you've been there for a while, right? [CONFIRMATION]

BRIAN BUHLKE: Yeah, 15 years. [CONFIRMATION]

SENATOR LINEHAN: So over the last 15...what occurred that you, as a community, felt that was important to provide mental health services? And you answered, filled that need. What... [CONFIRMATION]

BRIAN BUHLKE: That's a great question. Maybe Central City and Genoa are a little bit more unique. We have four assisted livings that are dedicated to individuals with mental health needs. They're basically community-dwelling mental health centers that are run like assisted living would be. They assist with food and medications, things like that, so we have a large population already. And so because of that population, we are easily able to find people to provide that service to them. [CONFIRMATION]

SENATOR LINEHAN: Okay. Thank you very much. [CONFIRMATION]

SENATOR RIEPE: Okay, thank you. Are there any questions? If not, thank you for being here. [CONFIRMATION]

BRIAN BUHLKE: I appreciate it. I apologize for my tardiness. [CONFIRMATION]

SENATOR RIEPE: And I think one of the real important things, at least from our perspective, is the continuity of having served multiple terms. [CONFIRMATION]

BRIAN BUHLKE: Sure. [CONFIRMATION]

SENATOR RIEPE: It gives us continuity and a history, if you will, as we look at this advisory information that's so important to us. [CONFIRMATION]

BRIAN BUHLKE: Absolutely. [CONFIRMATION]

SENATOR RIEPE: So thank you, thank you. [CONFIRMATION]

BRIAN BUHLKE: Thank you, Senator. [CONFIRMATION]

SENATOR RIEPE: Okay. That concludes our hearings. We're going to take a little brief break here. And we'll be in about...can we do it in three minutes? How fast can (inaudible)? Thank you.

BREAK

SENATOR RIEPE: On to part two, if you will, of Health and Human Services. Our presenter at this time is Senator Brasch, who is going to present on LB466. If you'd just simply give us your spelling on your name and it's yours. [LB466]

SENATOR BRASCH: (Exhibit 1) Thank you, Chairman Riepe and members of the Health and Human Services Committee. My name is Lydia Brasch, spelled L-y-d-i-a B-r-a-s-c-h, and I represent the 16th District in the Nebraska Legislature. I will be very brief in my introduction and I will introduce very quickly. I have some testifiers behind me that one needs to leave by 4:00 and the others also need to leave because they have practices, they're on call, so please bear with me. I will stay for closing. I'm here to introduce LB466. In 2015, the Legislature passed LB107, a bill that helped improve access to the medical care all across the state of Nebraska by eliminating the integrated practice agreement between certified nurse practitioners and physicians. This bill will do the same thing, but for certified nurse midwives. By eliminating this requirement, certified nurse midwives will have greater geographical freedom in where they practice. They will not be required to be tethered to a location where they can be overseen by a physician. This will bring Nebraska in agreement with 28 other states who also do not have integrated practice agreements. I see it's five minutes before 4:00, so I will have my testifiers come forward. They will be explaining the intent of this bill and the important information. And then I will close with what needs to remain...be said. So thank you and if you can hold your questions till later or to those introducing, I would be grateful. [LB466]

SENATOR RIEPE: Okay, thank you very much, Senator Brasch. We will take the first proponent. [LB466]

SENATOR BRASCH: Oh, and excuse me. I have it ordered here, I'd like to tell you. Jearlyn Schumacher would be first, Jenda Stauffer next, and then Dr. Kirsch, and then Dr. Whitcomb. [LB466]

SENATOR RIEPE: Okay. We would ask for the first testifier. Is it proponent? Thank you very much for being here. We want to be respectful of your time, so if you would simply state your name and spell it for the record, and then proceed. [LB466]

JEARLYN SCHUMACHER: Okay. My name is Jearlyn Schumacher, it's J-e-a-r-l-y-n, Schumacher, S-c-h-u-m-a-c-h-e-r. And I have been asked to tell my story through my midwifery career. And I've been a CNM for 22 years. I began my career at Mutual of Omaha Health Plans in Lincoln. Our clinic was sold to The Physician Network and that clinic had failed after a year. Another midwife and I had opened...decided that we were going to open a women's health clinic. And we named it Heart and Hands. We opened in July 1999 and closed in November 2013. We had recruited an OB-GYN who stayed with us for two years. We also paid his salary. When he joined another clinic, we struggled with physician backup. We enlisted family practice doctors for nonsurgical procedures. We were transferred to The Physician Network again, which was our last clinic. And we paid our collaborative physician $5,000 a month for her backup. Eventually, our money failed. So at that time then she said that if she wasn't going to get paid, that she would...she can't take time away from her family and her children if she's not going to get paid. So when that happened, then we were just forced to close. So we had to close our clinic and I'm now retired and I am no longer practicing as a CNM. And that is really the crux of this whole practice agreement thing, because people like our physician that we had recruited, our manager had made it very clear to him that we were looking for somebody who was going to stay with us and then he bailed on us. And we were paying him $240,000 a year. So I'm still paying on an SBA loan. So I think, in my opinion, we need to get rid of the practice agreement, because it will give more flexibility. You know, if something came up, at least someone could do something about it. And thank you for allowing me to testify. [LB466]

SENATOR RIEPE: Well, thank you for your patience and for your testimony. Are there committee members who have questions? Seeing none, thank you very much for being with us. [LB466]

JEARLYN SCHUMACHER: Thank you. [LB466]

SENATOR ERDMAN: Senator Riepe. [LB466]

SENATOR RIEPE: Oh, I'm sorry. Was it Senator Linehan? [LB466]

SENATOR ERDMAN: I have a question. [LB466]

SENATOR RIEPE: You have a question? Oh, I thought you were pointing over there. Senator Erdman. [LB466]

SENATOR ERDMAN: I'm sorry. So tell me what training you had to become a midwife. What does that involve? [LB466]

JEARLYN SCHUMACHER: I first was an RN and I've got a bachelor's degree. And then I knew that I wanted to be a midwife and so that was about a two and a half year program. So I have a certificate in midwifery. At the time that I was doing this, my daughter was getting ready to go to out-of-state college and so we were going to have to be paying out-of-state tuition so I did not do a master's. I just was satisfied with the certificate, so. [LB466]

SENATOR ERDMAN: Is it a requirement you be an RN before you can become a midwife? [LB466]

JEARLYN SCHUMACHER: Yes, in this state it certainly is. [LB466]

SENATOR ERDMAN: Okay. All right. Thank you very much. And how many children have you delivered? [LB466]

JEARLYN SCHUMACHER: Almost 4,000. [LB466]

SENATOR ERDMAN: Wow. Thank you. [LB466]

JEARLYN SCHUMACHER: Yeah. Thank you. [LB466]

SENATOR RIEPE: Just a second. Just a second, ma'am. We have another...Senator Howard has a question. [LB466]

JEARLYN SCHUMACHER: Oh, I'm sorry. [LB466]

SENATOR HOWARD: Thank you for visiting with us today. Can you remind me where your practice is located? [LB466]

JEARLYN SCHUMACHER: Yeah, it's here in Lincoln and it's called Integrated Women's Health. And my husband was having some health problems and so I'm now retired. [LB466]

SENATOR HOWARD: When you had the...and I'm sorry about your husband, that's really difficult. When you had the integrated practice agreement, tell me a little bit more about your interaction with your physician who you had the agreement with. Were they coming to your clinic every day? [LB466]

JEARLYN SCHUMACHER: The previous physician that we had recruited? [LB466]

SENATOR HOWARD: The previous physician, yeah. Were they really involved in your work or were they just sort of there on call? [LB466]

JEARLYN SCHUMACHER: Both, kind of, because if something was going on, then the physician that we had recruited would go ahead and do what he thought was best. And then like if we had to do a Cesarian, then one of the midwives would assist. But really I think he just got...I think he just kind of missed his buddies, because we had an all-female clinic and so I think he just missed his friends. [LB466]

SENATOR HOWARD: Okay, thank you. [LB466]

SENATOR RIEPE: Are there other questions? And thank you very much. [LB466]

JEARLYN SCHUMACHER: You're welcome. [LB466]

SENATOR RIEPE: Next proponent, please. Again, if you would be kind enough to state your name and spell it and then just proceed forward, please. [LB466]

JENDA STAUFFER: (Exhibits 2-6) Chairperson Riepe, committee members, thank you for hearing us today. My name is Jenda Stauffer, J-e-n-d-a S-t-a-u-f-f-e-r, and I currently serve as the president of the Nebraska Affiliate of the American College of Nurse-Midwives, ACNM, and I'm here today speaking on behalf of the affiliate. Our national organization is the American College of Nurse-Midwives, ACNM, and they have sent a letter of support that you are receiving now. Due to the over time, we have kind of changed around our presentation so I'm sorry for that. We have a little confusing start for our order. I've been a certified nurse-midwife for 18 years in Omaha, the first 14.5 years in a group practice at Methodist Physician's Clinic and the last few years in a small private practice. Like most midwives in Nebraska I started my nursing career in pediatrics and labor and delivery as a nurse and I did that for ten years before returning to

graduate school. To begin with, I've provided you with a chart about the types of midwives. I am a certified nurse-midwife or CNM and the only type of midwife licensed in Nebraska. CNMs are trained in nursing and midwifery. We maintain an RN license, go to graduate school, pass a national credentialing exam, and maintain certification with required continuing education cycles that are reviewed and renewed every five years. Entry to practice now in the state of Nebraska requires a masters degree and some certified nurse-midwives have doctorate degrees. CNMs are educated in maternal, newborn, primary and gyn care for women. We usually practice in clinics and attend births in hospitals here in Nebraska. Nebraska currently has about 44 CNMs with active licenses, though not all are currently practicing in Nebraska. There's one birth center in Bellevue and another planned to open in Lincoln this year. Most midwives in Nebraska practice in Omaha and Lincoln. Others are Beatrice, Norfolk, Hastings, Grand Island, and Scottsbluff. Not all are attending births, some work in clinics and others are in education. CNMs are one of four types of Advanced Practice Registered Nurses, APRNs, and this term is used nationally to describe CNMs: Nurse-Practitioners, NPs; Clinical Nurse Specialists, CNS; and Certified Registered Nurse Anesthetists, CRNA. We are all regulated by the Board of Nursing and have a subcommittee that is advisory to the board called the APRN Board. My license reads APRN-CNM. And I'm mentioning this about APRNs because it's relevant to this bill which is consistent to what is happening nationally in regards to nursing. Later testimony will speak to specific national initiatives to remove APRN practice restrictions, and I'll mention now that there are three main restrictions or barriers to CNM practice and consumer access to CNM care at this time in Nebraska. The first barrier is the requirement that certified nurse-midwives have to have a written practice agreement with a physician in order to hold a license and practice as a midwife. We have heard testimony from Jearlyn that she paid a large salary to a physician just for the privilege of being able to be licensed as a certified nurse-midwife. Later on in her practice, she was required to come up with $5,000 a month just to maintain that practice agreement and that physician would still continue to bill for the services that they did provide. So maintaining these practice agreements are very prohibitive. The other restrictions we have are attending home births, that we're only one of other two states that does not do this. And we also have problems within our system for liability coverage because nurse-midwives who have independent practice do not fall under the excess liability fund for insurance. And so we are looked at as employees of a hospital group or a physician practice. This bill addresses the written practice agreement matter only. To clarify, in drafting we did have to reorder the line that bans CNM-attended home births, so it is underlined in the bill but this is not new to our practice act and nothing about that is being proposed. Additionally, this bill adds a hyphen between nurse and midwife, which unfortunately made the bill long. This was added to match our national credential and punctuation used by the ACNM, our professional organization. As mentioned earlier, this bill removes the written practice agreement that we are currently required to have to maintain licensure. This is required to be with a physician who practices obstetrics and it replaces it with a transition to practice provision of 2,000 hours. This is consistent with what's now required of our NP peers. For example, you may have noticed in the news that South Dakota

just removed their written practice agreement. And the House and Senate bills addressed both CNMs and NPs and the governor signed this bill last week. I provided you a map regarding other states and practice agreements. And because my time is about up, you'll see that 28 states have full practice authority for certified nurse-midwives. Regarding the transition to practice provision, ACNM national is not supportive of them, but our state organization would prefer not to have it, but we included it to be consistent with our NP peers. And I think that a transition to practice provision for new nurse-midwives and APRNs will help to develop collaborative relationships and support within our communities that's necessary when we have these kind of referral networks. I appreciate your time and I am asking for your support of this bill, LB466. [LB466]

SENATOR RIEPE: Thank you very much. Are there questions from the committee? Senator Howard. [LB466]

SENATOR HOWARD: Thank you, Senator Riepe. Thank you for visiting with us today. I want to make sure that I understand, for collaborative agreements in Nebraska, does it require the physician to be on site? [LB466]

JENDA STAUFFER: No. [LB466]

SENATOR HOWARD: Okay, and so they can work elsewhere and then just be on call or be available for referrals? [LB466]

JENDA STAUFFER: Yes. [LB466]

SENATOR HOWARD: Okay, great. Thank you. [LB466]

JENDA STAUFFER: Yes. [LB466]

SENATOR RIEPE: Senator Erdman. [LB466]

SENATOR ERDMAN: Thank you, Senator Riepe. Thank you for coming today. Do you know, have you tried...have they tried to pass legislation like this before? [LB466]

JENDA STAUFFER: They had this type of legislation, but it was tied with home birth before. [LB466]

SENATOR ERDMAN: Okay, thank you. [LB466]

SENATOR RIEPE: Additional questions? Senator Linehan. [LB466]

SENATOR LINEHAN: Thank you very much, Mr. Chairman. And thank you for coming. So if we pass this--it's late in the day so maybe I'm not paying enough attention--and so you don't have a practicing agreement, I understand that. But what happens when you're at a birth and then you need a doctor. Then what would happen? [LB466]

JENDA STAUFFER: Understand that most of the time people are concerned about what happens in the hospital, because those seem to be more urgent safety things. It's important to understand that nurse-midwives do a lot more than just deliver babies. But in the hospital it is very important for us to have a collaboration...collaborative relationships with our physicians in our community. And so while I have a physician on my practice agreement currently, I have a whole pool, a network of physicians that are available to me just a phone call away should I need anything at all. And if those relationships would continue, no different than if a family practice doctor were in a hospital and had a baby that's not descending and knew that they needed a Cesarian they would call in their obstetric colleagues to assist them. [LB466]

SENATOR LINEHAN: Okay. So it's just a matter of doing...the doctors...there's always going to be a doctor nearby is what you're saying, it's just that you don't have to have these practice agreements with a particular doctor. [LB466]

JENDA STAUFFER: It's the limitation. A practice agreement is required for us just to maintain a license to be a certified nurse-midwife. And I have a clinic, so I see annuals and treat vaginal infections and prescribe birth control and insert IUDs and do a lot of other things that aren't just birth related. But typically the controversy is surrounding what's happening to us in the hospitals. But there are lots of nurse-midwives who...we don't necessarily all deliver babies; some don't deliver babies. [LB466]

SENATOR LINEHAN: Okay. Thank you very much for being here. [LB466]

SENATOR RIEPE: You mentioned...excuse me, okay? You mentioned Methodist Physicians. Are they still...midwives practice as part of the integrated practice at Methodist Physicians? [LB466]

JENDA STAUFFER: I worked for Methodist and left them to start a practice in 2013 and the remaining midwives that were there maybe a year later resigned and joined a separate group. And so they still deliver babies at Methodist, but they work for a different entity. [LB466]

SENATOR RIEPE: Okay. One of the concerns I have is you talked about a physician nearby. Not so much when you get out to the Panhandle and so that's one of the challenges we have in Nebraska. [LB466]

JENDA STAUFFER: So for...yeah. And when you're in the Panhandle you have a labor and delivery nurse that's attending to your patient in the hospital, not a physician. So you have a nurse that is monitoring the patient and alerting the physician to any concerns. A physician is not sitting in-house (inaudible). [LB466]

SENATOR RIEPE: But it's not an OB-GYN. [LB466]

JENDA STAUFFER: So I'm explaining to you that in a Grand Island hospital labor and delivery unit if a woman is in labor an RN...a labor and delivery nurse is tending to that patient. And if there is complications or something that is concerning, she will call her obstetrician to come in and take care of her patient. [LB466]

SENATOR RIEPE: Do you pointedly avoid high-risk, diabetic moms? [LB466]

JENDA STAUFFER: We pointedly avoid high risk. And there's clear guidelines to who we manage independently and there are clear guidelines of patients who have risk factors that need to be comanaged and there are strict guidelines of who needs to be transferred. [LB466]

SENATOR RIEPE: Okay. Other questions? Senator Erdman. [LB466]

SENATOR ERDMAN: Thank you, Senator Riepe. You stirred a thought in my mind about western Nebraska and perhaps you think Grand Island is western Nebraska. I think Senator Riepe was referring to Scottsbluff. Are you familiar with Scottsbluff and what happens there? [LB466]

JENDA STAUFFER: I am not familiar with what happens in Scottsbluff, but typically our obstetricians do not stay in house throughout a woman's labor. [LB466]

SENATOR ERDMAN: But against popular belief, we do have electricity and (inaudible) (laughter). [LB466]

JENDA STAUFFER: And I know that there are lots of young women who are going to school and wanting to be nurses and wanting to be nurse-midwives and they decide not to become nurse-midwives because they don't think that they are going to be employed when they get out of school. [LB466]

SENATOR ERDMAN: Thank you so much. [LB466]

SENATOR RIEPE: Thank you. Our next proponent, please. Please, if you'd just state your name and then spell it and then please proceed. [LB466]

DANIEL KIRSCH: (Exhibits 7-9) My name is Dr. Daniel Kirsch, it's D-a-n-i-e-l, last name, K-i-r-s-c-h. I'm really here on behalf of myself as a private practice obstetrician-gynecologist who works with nurse-midwives and have them in my practice and advanced practice RNs as well. I've been in practice, board certified in Omaha for the last 15 years in private practice after completing med school and residency at Creighton University. I've been working with certified nurse-midwives in my practice since August of 2013. I have also been working in the hospital as an OB hospitalist, not only in Omaha but also in Lincoln and in the state of Maryland. All of these places utilize midwives and I have come to learn that midwives see a different and unique patient set. I have also learned that midwives and physicians are not competitors for obstetric patients but work in collaboration to care for all subsets of female patients who are looking for different but equal philosophies in treatment and management of women's issues. There are many patients who want to see a midwife who won't consider seeing an obstetrician. And there are, likewise, patients who are uncomfortable seeing midwives who see OBs. So there are the thought I think that obstetricians and midwives compete for patients. And it's not a competitive market, because we see very different patients who are looking for different types of care from their provider. In real life practice, I believe that certified nurse-midwives and the community would benefit from the passage of this bill, particularly in rural regions of the state where the work force shortages limit access to care for pregnant women. I am a supervisory physician for two outstanding midwives in our community and their practice continues to grow as does their reputation for exceptional care in both areas of obstetrics and routine gynecology. We work in the same office and most of the time they do not need me to see their patients. Certified nurse-midwives know of the medical obstetrical conditions that fall out of their scope of practice and refer patients accordingly, similar to myself or family practice doctors who see patients that are outside our scope, we will refer to our colleagues. A practice agreement does not change collaboration with a physicians, consults, or referrals. Certified nurse-midwives, like advanced practice nurses and physicians consult and refer patients to other colleagues when patients

present with or develop conditions outside our respective specialties that require attention. A practice agreement is not required for this and should not inhibit a certified nurse-midwife from maintaining a license to practice within their training and scope of practice. Nurse-midwives, like family practice physicians that practice obstetrics, need to have a referral system in the hospital for complications that may arise during labor, delivery, and the postpartum period. This is to ensure that patients receive the optimum care required and expected in our hospitals. A formal agreement with the state is not needed to ensure that this occurs. ACOG, and the ACNM and the hospital as well are aware of midwives' limitations in their areas of obstetrics and measures are in place in the hospital to assure patient safety. Mandatory physician consultations or a patient transfer is required with specific patient conditions that may occur. Several articles that we've provided you today demonstrate that practice agreements can be a barrier to patient care by willing trained midwives who wish to care for patients in a rural and remote area. States that promote autonomous midwifery practice demonstrate a large midwife presence in the community without a decrease in quality of patient care or adverse outcomes in births managed by midwives. Midwives also provide much needed basic gynecologic care to women of all ages that may not seek care elsewhere. I have seen firsthand the benefit of midwives in my practice and have learned from them and their midwifery methodology. More patients are seeking a more natural, holistic approach to healthcare that midwives provide. I feel removing the restrictions on midwives' licensure by elimination of written practice agreements for licensure will promote Nebraska's willingness to accept all methods of medical practice and help us reach out to patients and areas of the state that lack the medical staffing that we need. I have thoroughly enjoyed working with the midwives in my practice. They have never paid me a cent. We have a practice agreement that has worked well. They know their scope of practice. Again, most of the time they see patients in the office that I never see and those patients that need tubals or hysterectomies or those type of things obviously are referred or OBs that develop complications are beyond their scope are transferred. The nice thing at least here in Omaha is we have hospitalists, which is now becoming the community standard, where there are doctors in the hospital all the time. So if there's even an emergent thing, there's somebody there to take care of that. But there are always physicians in the hospital that are willing to help, even outside of their written practice agreement. [LB466]

SENATOR RIEPE: Okay. Thank you very much. Senator Kolterman. [LB466]

SENATOR KOLTERMAN: Yeah, I just want to clarify something. You passed out this state designated shortage area of OB-GYN. [LB466]

DANIEL KIRSCH: This is just a map just showing the shortage areas in the state of Nebraska for OBs. That doesn't even... [LB466]

SENATOR KOLTERMAN: That's strictly OB-GYN? [LB466]

DANIEL KIRSCH: Right. So imagine the state...we have very few spots in the state that are covered with OB-GYNs. So if we can even get maybe nurse-practitioners in those areas without a license agreement, we can see a lot of these patients who would like to see a women's healthcare provider that are not being able to do it today. [LB466]

SENATOR KOLTERMAN: But would it be accurate to say that there's no...I mean, I know there's a shortage of MDs, but don't a lot of the MDs...if this were people delivery babies, which is really what we're talking about today, wouldn't this be much different? [LB466]

DANIEL KIRSCH: What do you mean? [LB466]

SENATOR KOLTERMAN: Well, would there be that kind of a shortage that this... [LB466]

DANIEL KIRSCH: Well, this is just applying obstetrics. [LB466]

SENATOR KOLTERMAN: OB-GYNs, is all. [LB466]

DANIEL KIRSCH: Right, not family practice physicians that are there. [LB466]

SENATOR KOLTERMAN: Okay. Thank you. [LB466]

SENATOR RIEPE: Senator Williams. [LB466]

SENATOR WILLIAMS: Thank you, Chairman Riepe. Thank you, Dr. Kirsch. If I am reading this map correctly, Maryland is a state that does not require...has no legal requirement for a collaborative agreement. And you practiced in Maryland? [LB466]

DANIEL KIRSCH: I currently practice out there as a locums hospitalist with midwives. [LB466]

SENATOR WILLIAMS: My question with that is comparing that to the situation in Nebraska, have you experienced or seen any issues there where they do not have a requirement of the agreement? [LB466]

DANIEL KIRSCH: No, the hospital that we have, the hospital-based practice has five midwives employed in that facility, so they have a large midwife presence and those midwives help staff the labor and delivery to accommodate patient care there. [LB466]

SENATOR WILLIAMS: I'm going to ask you a question, something I don't know anything about, but help me with this. I'm assuming each medical facility, hospital--let me use that term--allows different doctors, different nurses to practice there with privileges of some kind. [LB466]

DANIEL KIRSCH: Correct. [LB466]

SENATOR WILLIAMS: If a particular hospital or hospital board...if we passed this legislation, if a particular hospital or whatever didn't want to have this, they could deny privileges, couldn't they? [LB466]

DANIEL KIRSCH: I suppose they can deny privileges. [LB466]

SENATOR WILLIAMS: I'm not saying they would, but if they had some hang-up on this whole thing. [LB466]

DANIEL KIRSCH: They can. I was the first physician to have midwives at Bergan Mercy Medical Center and that caused a lot of stir and angst among physicians because they thought that was competition and who was going to cover them and how are we going to take care of this. And actually, it's worked out well. And the physician who is the chairman of the department now has his own midwife. So clearly it's swung around and they see the benefit of that. [LB466]

SENATOR WILLIAMS: I guess I'm just pointing out that there could still be a level of local control, if that would be the way to turn it. [LB466]

DANIEL KIRSCH: I suppose there could be. [LB466]

SENATOR WILLIAMS: Thank you. [LB466]

SENATOR RIEPE: Question that I have, you were serving as a hospitalist with locum? [LB466]

DANIEL KIRSCH: Yes. [LB466]

SENATOR RIEPE: Are you serving in that role as an OB-GYN or are you serving in it in some other medical... [LB466]

DANIEL KIRSCH: It's not as a general hospitalist, it is a OB hospitalist or a laborist in labor and delivery, so, yes, it's... [LB466]

SENATOR RIEPE: So you're not serving...sometimes in trauma centers you have psychiatrists serving in these urgent care centers and that's a problem. [LB466]

DANIEL KIRSCH: No, this is strictly labor and delivery, OB emergency department labor and delivery facility. [LB466]

SENATOR RIEPE: Okay, very good. Thank you. Are there other questions? Seeing none, we appreciate your time and we appreciate your coming. [LB466]

DANIEL KIRSCH: Thank you. [LB466]

SENATOR RIEPE: Additional proponents, please. [LB466]

LISA WHITCOMB: I'm Lisa Whitcomb, L-i-s-a W-h-i-t-c-o-m-b. [LB466]

SENATOR RIEPE: Thank you. [LB466]

LISA WHITCOMB: (Exhibit 10) Okay. Good afternoon, Senator and members of the committee. Again, my name is Lisa Whitcomb, I'm a board certified pediatrician. I've been practicing in Omaha for 19 years. I'm a member of the Academy of Pediatrics. I own my own practice called Family First Pediatrics. I did my medical school at UNMC and completed my residency at Tulane in New Orleans. I'm speaking here today on my own behalf. Over the years I've seen more and more families choosing midwives for their OB-GYN care. What I've seen through my years of practice is babies that are born to moms that have "seeked" out midwife care tend to have higher breastfeeding rates, they have lower C-section rates, low induction, and generally my patients are pretty happy when they see midwives. My observation from my patients that go to midwives is that they have that care from beginning to finish...beginning to start...beginning to end, sorry. And so the midwives are with them through the whole labor and delivery process, which often they don't get from an OB-GYN. And there are...just as Dr. Kirsch mentioned, there are a lot of patients who seek out that care. Some don't. Some want to go to an OB-GYN. And I think it's just important for patients to have that option in care. I believe a few more studies are going to be presented to you, but in studies where they've looked at states where

they have practice agreements and nonpractice agreements, there doesn't seem to be any difference in outcomes for babies. They do see fewer low birth weight babies, fewer preterm births, and again no increased risk to newborns that are born to moms that are delivered by midwives. So, again, as a pediatrician, my concern is the care of these babies and the health of these babies. I have lots of patients who ask me for referrals for who to go to. I have patients that become pregnant and midwives are often my first choice because I know they're going to get good care. And again, OB-GYNs are awesome, too, it's just it's a good option. I also refer a lot of teenagers for gynecological care to midwives and their care there is very good there as well. The midwives tend to spend a little more time with them and they're very thorough. If they're going in for just a general gynecologic problem I know that they're going to discuss birth control, they're going to discuss date rape and other big concerns for these children. My concern with midwives not having access to practice is that there will be less access for patients to see midwives. I've seen firsthand the difficulties that midwives have had maintaining these written practice agreements. If an OB leaves the state or retires, their license is in jeopardy and they have to find another OB to cover them. So again, my opinion, my recommendation is to loosen these regulations so that the midwives can practice so patients have access to this care. And again, I practice in Omaha, not in a rural setting. And I understand the issues in rural settings are even greater, where patients may not have access to OB-GYNs. And again, it's important to my patients and my patient population to have this as an option. So thank you for your time. I'm open to any questions. [LB466]

SENATOR RIEPE: Okay. Thank you. Thank you very much. Are there questions? Just sit and let's see if we have some. Senator Williams does. [LB466]

SENATOR WILLIAMS: Thank you. And I should have asked this question of one of the practicing midwives, so if one of them can listen to this question and be sure that I get it answered. Are there any insurance concerns with you being paid and the mom, dad, and all of those off the hook? Do insurance companies recognize paying midwives for their services the same way as they would anybody else? And it's coded the same and all of that? Could you say, yes for me? Could you say? [LB466]

LISA WHITCOMB: Oh, yes, yes. I'm sorry. Yes. [LB466]

SENATOR WILLIAMS: Thank you. Thank you. I wanted that in the testimony. [LB466]

LISA WHITCOMB: Yes, there's no concerns. [LB466]

SENATOR WILLIAMS: I'm sorry. [LB466]

LISA WHITCOMB: That's okay. [LB466]

SENATOR RIEPE: Okay. Are there additional questions? Senator Williams, do you have any more questions? [LB466]

SENATOR WILLIAMS: No. [LB466]

SENATOR RIEPE: Okay. [LB466]

SENATOR WILLIAMS: I promised them I wouldn't. [LB466]

LISA WHITCOMB: Okay, thank you. [LB466]

SENATOR RIEPE: Okay, thank you very much. Additional proponents. [LB466]

ANN SEACREST: Well, you've had a fun afternoon, going from eyeballs to babies, right? [LB466]

SENATOR RIEPE: And we're not done. [LB466]

ANN SEACREST: (Exhibit 11) And you're not done. Okay. My name is Ann Seacrest, A-n-n S-e-a-c-r-e-s-t. Chairman Riepe and members of the Health and Human Services Committee, I want to thank you for taking time this afternoon, although I was a little concerned about those of you that didn't stand up during break. Remember, moving around is good for your health. Okay? We've got a lot of healthcare practitioners in the room. I'm a graduate of UNMC College of Nursing. I'm a registered nurse, I'm the mother of four children, the grandmother of two. I've worked in maternal child health for the past 36 years and currently serve as executive director of a nonprofit organization that provides care to new families. In 1981, a long time ago, I moved to Nebraska seven months pregnant with my first child. I'd received prenatal care from a nurse-midwife during my pregnancy in another state and I was incredibly dismayed when I moved to Nebraska and could not continue this care. So three years later in 1984, pregnant with my second child, I worked with several senators to craft legislation which legalized CNMs in the state of Nebraska. We were the 49th state in the country to legalize certified nurse-midwives. Okay? At the time, all advanced practice nurses were under practice agreements in Nebraska, although the nurse-anesthetists even at that time were already in the process of moving from practice agreements to collaborative agreements. Nebraska is often very cautious about embracing new ways of doing things and this is good. However, all of us who work in healthcare and are healthcare consumers know that the changing landscape of healthcare has required us to embrace

concepts that focus on prevention, access, and affordable healthcare. This bill is really long overdue. It restricts access to care that is safe, undeniably safe, and needed as part of the healthcare team. CNMs are focused on patient-centered care. They work as part of a healthcare team that aims to make a difference in outcomes. They use professional judgment like all of us do who have licenses, depend upon our livelihood to take care of people in a wise way and not move outside of our scope. I'm very pleased to say that my fourth child who is now 21-years old was born with the assistance of a certified nurse midwife in a hospital here in Lincoln. Our nurse-midwife provided our family with excellent care. Unnecessary restrictions really do not serve any of us well. And I encourage you to support this bill and Nebraska families and move this bill out of committee. Thank you very much. [LB466]

SENATOR RIEPE: Thank you. Are there any questions? We appreciate your being here, we appreciate your time. Thank you. [LB466]

ANN SEACREST: Thank you so much. [LB466]

SENATOR RIEPE: Other proponents. You've been here long enough you've probably seen the drill, so. [LB466]

NIKI EISENMANN: (Exhibit 12) Yes, I'm refreshed on my physiology of eyeballs there, so. Yes. Good afternoon, Senator Riepe and members of the committee. My name is Niki Eisenmann, N-i-k-i E-i-s-e-n-m-a-n-n. I am here today on behalf of the Nebraska Nurses Association testifying in support of LB466, to change credentialing and regulation of nurse-midwives. Nurses are an important part of the healthcare delivery in the state of Nebraska. Advanced practice nurses, including CNMs, are an integral part of the healthcare team, providing affordable, safe, and accessible healthcare to the citizens of Nebraska. In the landmark report, "The Future of Nursing: Leading Change, Advancing Health", 2010, the Institute of Medicine endorsed higher levels of nursing education and the importance of allowing all nurses to practice to the full extent of their education and training. Removal of the practice agreement for CNMs is an important step to allow nurses to care for patients without cumbersome regulatory barriers. In recent years, great strides have been made in the consensus of APRN practice across the country. Nurses and stakeholders are working diligently to ensure that education, accreditation, certification, and licensure of APRNs is consistent from jurisdiction to jurisdiction in order to assure patient safety while expanding access to affordable healthcare. Nebraska has removed the integrated practice agreement for nurse practitioners and now we ask the same for our certified nurse-midwives, getting us closer to APRN consensus in Nebraska. The current practice agreement presents a barrier to practice and the Nebraska Nurses Association is supportive of policy changes and legislation that eliminate these barriers to APRN practice. CNMs in Nebraska require a graduate education from an accredited institution, ongoing

certification from their certifying body with rigorous exams and recertification. CNMs are highly regulated by our dedicated Advanced Practice (Registered) Nurse Board in the interest of consumer protection. The removal of the practice agreement is simply removing a barrier to licensure and practice. Nurses of all types, registered nurses, midwives, CNRAs, and our nurse-practitioners work in collaborative networks assessing each specific patient's needs and identifying the appropriate providers to consult and provide expertise to that patient's care. This includes midwives. The midwives fill a crucial role in providing care to the childbearing women of Nebraska and other women's healthcare needs. This work is always carried out as part of a high-functioning healthcare team. CNMs collaborate with medical specialists and refer as needed to provide the best possible care to their patients. Passing LB466 simply allows the patients better access to the high quality, affordable care these advanced practice nurses can provide. It is important to note LB466 contains a transition to practice provision which is not a recommendation of the "Future of Nursing" or the APRN Consensus Model. The transition to practice is a compromise with those in opposition of the bill. Even with this provision we are in support of LB466 as this bill brings Nebraska one step closer to meeting national nursing goals in the interest of providing safe, quality, affordable healthcare to our patients. NNA respectfully asks for your vote in support of LB466. [LB466]

SENATOR RIEPE: Thank you very much. Are there questions from the committee members? Seeing none, thank you very much. [LB466]

NIKI EISENMANN: Okay, thank you. [LB466]

SENATOR RIEPE: Additional proponents. If you'd be kind enough to state your name and spell it and then please proceed. [LB466]

BECKY SHERMAN: (Exhibits 13-17) Yes. Thank you so much, Senator and committee members. My name is Becky Sherman, B-e-c-k-y S-h-e-r-m-a-n, and I am the educational chair for Nebraska Friends of Midwives. I'm a consumer. NFoM is a consumer-driven, grassroots organization and has been involved with supporting full practice authority for CNMs since 2002; before I knew what a midwife was. In the last 15 years, NFoM has been around the Capitol many times weekly with our babies and our M&Ms lobbying for bills that would have removed various restrictions on CNM practice. Most of you have not met us because in recent years we have not been as active. We've grown increasingly frustrated with not being able to be heard. It's frustrating to know that we can have the care that we desire in other states, namely our neighboring states, Iowa, Wyoming, Colorado, Kansas, and now South Dakota, but not here in Nebraska. Geography has never meant so much. Our members are interested in greater access to CNMs in all settings, clinical, hospital, birth center, and in their homes, similar to what families in other states have. NFoM members would also like to see greater access to midwifery care

across the state. The vast majority in our state do not have reasonable access to midwifery in their own areas. It has been proven that written practice agreements reduce the number of CNMs practicing, including in rural areas. Another area of concern for Nebraska Friends of Midwives that we have addressed in the past is safety. It's a very popular question. If you're concerned with the safety of myself and my baby, I am very thankful. I know that you guys put in a lot of hours and you sift through a lot of issues for my own safety and I'm very thankful for that. However, I do want to humbly remind you that there's no one or no group more interested in safety for myself and my baby than me. I am more concerned about my children than I ever thought possible. I was not going to be a worrying mother and I am. I don't just pick doctors, dentists, midwives, or I guess now optometrists on a whim. I research what I need. I research their ideals. I research their practice. I research their reputation and more. And as the saying goes, a worried mother does better research than the FBI. So with that in mind, I would like to present some research for you concerning this topic. And I understand that you may have some of this already, so please bear with me. I think they've all been passed out. There was a study published in 2016 with the lead author Yang, and it compared states with and without written practice agreements. And it showed that states without the agreements have more than doubled the number of CNMs attending their births. They have lower odds of C-section, preterm birth, and low weight in babies. The next one would be, "The Practice of Midwifery in Rural US Hospitals" published in 2016 showed that states that didn't require practice agreements had more CNMs practicing in their rural hospitals as well. The National Bureau of Economic Research states, and I quote: Our findings indicate that scope of practice laws are neither helpful nor harmful in regards to maternal behaviors and health outcomes in infants, but states that allow CNMs to practice with no SOP-based barriers to care have lower rates of induced labor and Cesarean section births. And also: Our results point to the conclusion that removing barriers on the CNM practice will not harm mothers and infants and that the restrictive laws primarily serve as artificial barriers to care. We have shown no evidence or deleterious health effects and in fact show very small improvements in gestational age at birth. Nine years ago in 2008, there was a meta analysis of 11 research trials with more than 12,000 women and their babies. And that review actually was reviewed again in 2014. And it showed lower rates of preterm birth, lower rates of episiotomies, vacuums, forceps. It showed more vaginal births, more breastfeeding, and more women felt in control of their labor. So we're concerned about safety. And because of that, we want greater access to midwifery care. NFoM members across the state would like more access for midwifery care for themselves and their communities. We understand that if this bill passes, it might be a significant amount of time before we see change, but it's a start. And that's where we would like to start. Thank you so much. [LB466]

SENATOR RIEPE: Okay. Thank you very much. Are there questions? Apparently not. Thank you. [LB466]

BECKY SHERMAN: Thank you. [LB466]

SENATOR RIEPE: Are there more proponents? [LB466]

HEATHER SWANSON: (Exhibits 18-22) My name is Heather Swanson, H-e-a-t-h-e-r S-w-a-n-s-o-n, I'm a certified nurse-midwife, family nurse-practitioner, and lactation consultant, originally from central Nebraska. I currently live in the Sandhills north of Newport in Keya Paha County. I'm a member of the Nebraska ACNM affiliate, on their legislative committee, and am an uncompensated lobbyist for them, and have served a term on the ACNM national board of directors. I've worked in a variety of settings in the neighboring states. I won't mention all of them, you can read that yourself. As most of you know, 407...well, I'll visit about the 407 review because I know that's a significant concern and people are wondering why we didn't proceed with that, so I'll speak to that. As most of you know, 407 is a three-step process where the Department of Health and Human Services examines a topic--in particular, new licensing or scope of practice changes--and reports back to this committee with recommendations. The steps include a review by the Technical Review Committee, then a subcommittee to the Board of Health, the full Board of Health, and then the State Medical Director. 407 reviews are not mandatory, but an available tool. On the topic of CNMs in Nebraska getting closer to full practice authority, the Nebraska ACNM affiliate decided to have a bill introduced rather than immediately requesting a 407 for a few reasons. We've already gone through 407 twice. Recent data in support and national nursing agencies and organizational support for the matter in the bill is significant. We don't feel like this is a scope of practice change. And, frankly, there wasn't enough time to do a 407 review before the session started. In previous attempts to remove the written practice agreement, some of the questions asked that we didn't have data on at the time were related to outcome data on states with and without practice agreements. We now have recent data that Mrs. Sherman spoke to today, most of which I presented to you if I met with you earlier in the session. I've provided a report from each of the two 407s that have been completed. Both reviews looked at direct-entry midwives and certified nurse-midwives, including the topic of home birth. The first was in '93-94. Recommendations regarding CNMs were to allow us to attend home births and to remove barriers to that practice, which could imply practice agreements as they have been demonstrated as a barrier to such practice in other states. That review was requested by this committee and no action was taken on the recommendations. And there were legislative efforts afterwards and they were unsuccessful. With that favorable 407 in hand, in 2005 this committee heard bills again and there were multiple bills prior to that. There was a question about that. There have been multiple attempts to remove the home birth restriction and to remove the written practice agreement. Despite having three cosponsors on the committee, the Chairperson insisted it go back to 407. I ended up being the applicant and sat on the Technical Review Committee. Two applications were accepted, one regarding direct-entry midwives and the other, CNMs. Included in the one for CNMs was the specific topic of practice agreements, which the Technical Review Committee recommended removing, though the Board of Health and the State Medical Director did not support any measures requested in the application. 407 recommendations are not binding, they are simply recommendations. And as

well-intentioned as the review process is and with recent revisions, there was a fair bit of room for bias yet. So for a number of reasons, we didn't start with another 407 review at this time. We're coming directly to you after having reviewed the bill with the Department of Health and Human Services' nursing licensure units and having their support. We also have supported the Nebraska Nurses Association, the Nebraska Action Coalition, which you have a letter of support from, and on the heels of South Dakota granting full practice authority to NPs and CNMs last week. If what has been presented thus far isn't compelling, let me add to it a 2014 report from the Federal Trade Commission. Unfortunately, I requested a letter from them only recently, so you might be getting one forwarded to you down the road. But the FTC Web site has multiple letters to states supporting legislation that removes APRN practice restrictions, including written practice agreements, and recognizes this as an antitrust matter. I agree. I currently practice in a setting where I am recognized as an independent practitioner in a fairly rural and high-risk population. What I didn't mention before is I live in Keya Paha County, I work across the border for the Indian Health Service--and, again, I'm speaking in my own behalf--and a fairly high-risk population. I don't always have an OB-GYN around during my two-week rotation, so I consult with physicians via phone as needed, collaborate regarding established plans of care for high-risk women, and I transfer care out as indicated. Not all CNMs would want to practice how I do, but there are some of us that want to live in rural areas and provide care to women there. I mentioned in my intro--or I have noted there--that I was the clinical director of a birth center practice in Texas. We also attended home births. In Texas, I didn't have to have a written practice agreement to be licensed and practice, but for prescriptive authority there I did. And as it was a birth center, I did review 10 percent of our caseload with a physician monthly, but he rarely was ever on site; actually only for board meetings did he come. We consulted, collaborated, transferred care with and to a number of other physicians in the area, not necessarily the physician I did chart review with. With the client we provided fairly detailed education and informed consent about risks and benefits of that care model and location and what would happen if there was... [LB466]

SENATOR RIEPE: We do have the red light on. Can you kind of pull it together? [LB466]

HEATHER SWANSON: Yeah. So, essentially, when people talk about rural areas and care outcomes and what do we do, I feel like I can speak to that. Patients, I feel, should have the right to access to other areas and in some of these rural areas women may choose to stay there and deliver. And as a healthcare practitioner, I want to be certain they have informed consent and that we're making appropriate healthcare decisions. If people have more questions about that, I'm happy to meet with people later on and speak to that. FTC-wise, I do think this is pretty compelling it's considered an antitrust matter and nationally ACNM feels pretty firmly about this. And I do want to comment a couple of things. There was a question about hospital privileges. A few years ago, LB68 was passed, that added nurse-midwives to the list of healthcare professionals that cannot be denied hospital privileges just because of their license type. Now, places can come up with any other reason they want to, to restrict a practitioner from

getting privileges there. And there were some other questions about distance, but I'll leave the questions if you guys have them. [LB466]

SENATOR RIEPE: Okay, thank you. Maybe we'll get to those in the questions from the committee. Any questions from the committee? Okay, seeing none, thank you very much for being here. [LB466]

HEATHER SWANSON: Oh, the last point I think is really important. We did meet with the...sorry to add this, but we did meet with the State Medical Director, Dr. Williams, yesterday, Jenda Stauffer and I did, and asked him to make an opinion on this bill and whether or not he would...whether or not he thinks it needs to go back to 407. He did say he didn't feel like he would have a response back by today, so that will probably be coming to you guys. But we thought that was important to have. [LB466]

SENATOR RIEPE: Okay, we have that on our record. Thank you. [LB466]

HEATHER SWANSON: Okay. [LB466]

SENATOR RIEPE: Are there additional proponents? Thank you very much. Okay, are there any opponents? Thank you. Please come forward. If you would be kind enough to give us your name and spell your name and proceed. [LB466]

JENNA FIALA: Yes. I'm Dr. Jenna Fiala, J-e-n-n-a, last name, F-i-a-l-a. I'm here to...as a part of the Nebraska Medical Association to talk about this bill. For the record, I am an OB-GYN in Lincoln, Nebraska, since 2009. I'm a graduate of Creighton University School of Medicine in 2000. I did my residency in Hartford, Connecticut. I was a nurse-midwife supervisor of Heart and Hands from 2011 until they merged with Integrated Women's Health in 2013. I am the medical director of the birth center that will be opening here in Lincoln, Nebraska. I am a board member of the Advanced Practicing Nursing Board here in Lincoln, as of last year. I was the department chair at St. Elizabeth for four years. I am an OB hospitalist serving in Lincoln, Nebraska. And I am centering certified, which is a way of providing medical care that a lot of CNMs also provide. I have always enjoyed my work with certified nurse-midwives. I do think they do an amazing job. I wish they'd continue to do all the excellent work they do, but I have a few points that I would like to clarify. In regards to the first speaker, not being tethered to a location when delivering, there are places in this state where you can deliver babies. There are places that you cannot. They have to go to one of those places. They have to have somebody who can help them when there's problems. How they arrange that is up to them. But if you do not have a relationship with your physician in some kind of formal manner, you might be denied privileges at the hospital that you want to deliver at and you might not have somebody who can

back you up when there's a problem. As she stated, I was one of the people who covered her. I was paid. It was my second job. I think anybody who takes a second job should also be paid. I was not paid $5,000 a month, I was paid $3,000 a month. I did that for one year until she and her partner told me they could no longer afford to pay me, at which point I said, why don't you join our practice and now we are all employed. In regards to the second one, like I said, I will be the medical director of the Lincoln birth center, so I do support nurse-midwives. But all my midwives there know that they have a limited number of people that can be seen in that place. They have to be low risk. This is another big statement. A lot of low-risk patients have great outcomes and that's what a lot of nurse-midwives take care of, low-risk patients. But it's very hard to say when a low-risk patient might turn a corner and become a high-risk patient. And that is why you have to have an agreement with a physician in place, so that it is not somebody's surprise when they are called to the hospital. Some places have a lot of collaborative physicians that will help them. Some places do not. In this city there are two groups of midwives that are practicing here. There are two groups of physicians that will support them. The majority of the physicians that practice in this city will not. I can't speak to the rural setting, but I would say that if I was a physician in the rural setting and I did not have a relationship with a midwife and then something shows up on my doorstep that's a major problem, I will not be very happy and I will be the one who has to take care of it. And it will be my responsibility, not the midwife's at that point. I agree completely with Dr. Kirsch in what he said, but remember I did get paid when I oversaw those midwives because it was my second job. As to the pediatric concerns, I agree with the pediatrician completely. I think that they do a fabulous job...midwives do a fabulous job taking care of their low-risk patients. And that is why most of their outcomes are so phenomenal. But you don't hear about their problems because their problems get passed on to their collaborative physician or their practice agreement physician and they're the ones who are dealing with all of the outcomes they don't have to list, the Cesarian sections, the vacuum deliveries, the forceps, the lacerations, all those things that happen at birth. I also think that when you asked about the insurance concerns, labor and delivery midwife care versus my care, all paid about the same. The malpractice is incredibly different. And in this state if you aren't under a collaborative physician they might have problems getting malpractice insurance. My biggest point to you is this: If you don't have a collaborating physician who's going to help you in these important aspects of what most midwives do that is crucial, and that is the birth for the mother and the baby, you might run into problems. And then somebody is going to have to take care of those problems. It is frustrating to be the physician called in when a home birth--and they do happen here--has gone awry and I'm the one who's on call for the city and I have to take care of it. It is much better to be called early from my midwives when they tell me they are concerned about their patient who was low-risk at one point who is now having problems and I can come in and help them facilitate their delivery. [LB466]

SENATOR RIEPE: Okay. Senator Erdman, please. [LB466]

SENATOR ERDMAN: Thank you, Senator Riepe. Thank you, Doctor, for coming. As I listen to the testimony this afternoon, I believe it comes obvious to me that these ladies or these families have made a choice. And I believe they should have the privilege to make that choice. And so are you saying that they shouldn't have that opportunity to make that choice? [LB466]

JENNA FIALA: I think you can seek your care with whomever you wish. Some people really like the midwife in the way that they do their care. Some people would rather go to a physician. Some people want a family doc. I'm not saying that you shouldn't get care with whom you want. I'm saying that if they don't have support that can take care of their problems when they arise--and in the world of obstetrics, they can arise very quickly--you might run into a lot more problems than you wish. [LB466]

SENATOR ERDMAN: Okay. In your testimony several times you alluded to the financial consequences. How much of your desire for this to continue is based on the financial aspect of it? [LB466]

JENNA FIALA: I want midwives to continue practicing in the state of Nebraska. I work with them. I have two under my supervision currently. I'm helping them open a birth center. I am employed by a network of physicians. I don't get any financial gain from that. I'm doing that because I think it is the right thing to do, but I'm also doing that because they practice with me and I supervise them and it's not just a random phone call. They run things through and by me and I review a lot of their work. [LB466]

SENATOR ERDMAN: Thank you. [LB466]

SENATOR RIEPE: Senator Linehan. [LB466]

SENATOR LINEHAN: So would you be happy with a collaborative agreement? [LB466]

JENNA FIALA: I feel like my agreement with them is collaborative. The way that this is set up though is that if you just have a collaborative agreement, it doesn't necessarily guarantee them to have hospital privileges. It doesn't necessarily agree that the person who they have collaborated with will come and help them in a setting where they might desperately need assistance. Being that I am responsible, I am in a practice agreement with them, I can't refuse to come and help them. I have seen people refuse to come and help others in this time. [LB466]

SENATOR LINEHAN: It doesn't seem like that would be the spirit of a collaborative agreement. [LB466]

JENNA FIALA: Heck no, but it does happen. [LB466]

SENATOR LINEHAN: Thank you. [LB466]

SENATOR RIEPE: Well, it doesn't apply necessarily to OB-GYN. I know Medicaid has...requires for hospitals to have transfer agreements with extended care facilities for continuity of care. There's some similarity there that the patients will be (inaudible). I don't know if you want to respond to that or not. [LB466]

JENNA FIALA: I don't know that I have enough information to respond. [LB466]

SENATOR RIEPE: Are there other questions of the doctor? Hearing none, thank you very much. [LB466]

JENNA FIALA: Thank you. [LB466]

SENATOR RIEPE: Are there other opponents? Yes, we do. Welcome. [LB466]

KIM ROBAK: (Exhibits 23-25) Thank you. Senator Riepe and members of the committee, my name is Kim Robak, K-i-m R-o-b-a-k. I'm here on behalf of the Nebraska Medical Association in opposition to LB466. I have three letters for you, one is from Dr. Rob Rhodes who was here earlier. He had to leave, he was unable to stay. I do have his letter in opposition to the bill that I will pass out. I also have a letter from Dr. Todd Pankratz who is a physician in Hastings who is the president of the NMA this year. He also was unable to be here today, but he did send his letter. And I also have a letter on behalf of the American Medical Association in opposition to the bill. But I wanted to say a few words, if I could. First of all, I think that...I hope that it's evident that nurse-midwives play an important role in the healthcare continuum, but I would be remiss if I didn't say that we were a little taken back by, first of all, the bill coming this year. I think Dr. Pankratz was notified some time in late November that there was the potential of a bill and then a bill was introduced. The concerns and the complaints that we're hearing are new to us, as the medical association. We have not heard that there have been issues getting collaborative agreements. We have not heard that there are problems with these collaborative agreements. We have heard that today, but this is the first time we've heard it. We do believe that a 407 process is the appropriate process to go through. The last 407, there were two 407s together, one was a 407 for home births, the other was a 407 to create a type of licensed care. One was accepted by the Technical Review Committee, the other was not, and both of them were not approved by the other two sections of the 407 process. But what the 407 process does, and I believe the nurse-practitioners could tell you this, it helps you to hone your argument. You get the facts out. It is

amazing to me that there are statistics that show that births are safer without an agreement than with an agreement. I would venture to guess that there are other factors, because I can't imagine that a piece of paper alone would create a safer birth. So there have to be other factors involved in that process. And they may be related to the fact that it's a nurse-midwife, but I think that's something that needs to be ferreted out and I don't think that this committee either has the time or perhaps you have the inclination to do that. But that's what the 407 process I think does well. I will also say that nobody expects to have a bad birth or a bad outcome. I know that I didn't. With my first child I was preeclampsic and I had to go to the hospital and be induced. When my baby arrived it was about the color of Senator Brasch's jacket, a bright blue. And luckily I was in the hospital where a physician was able to give her a shot and she immediately revived. Her first Apgar, if anyone knows about the...her Apgar score was a four; a little scary. Her later Apgar was an eight and now she is a wonderful grownup adult living on her own in New York City, so things do work out. But they're scary and they happen quickly and luckily it worked out well for us. Finally, I will just say that somebody reminded me of the movie Sully. I don't know if any of you have had the opportunity to see it, it's a wonderful movie. But no one expects to be in a plane crash. And when you're in that instance, when you're in that situation where you need that care, then you hope that you have someone with that expertise for that one moment. And what I think this committee needs to do--and I hope the 407 helps in that process--is to ferret out what the real issues are and make sure that the public safety outweighs the concern of the inconvenience. And with that, I'd be happy to answer any questions. [LB466]

SENATOR RIEPE: Thank you very much. Are there questions? Senator Linehan. [LB466]

SENATOR LINEHAN: Thank you, Mr. Chairman. So do I understand this map right, is this the way you understand...have you seen this? [LB466]

KIM ROBAK: Is that a map of... [LB466]

SENATOR LINEHAN: It's a map of where there's full practice authority, collaborative agreement required, or supervision required. [LB466]

KIM ROBAK: I have not seen that. And Senator, nor have we been asked about any of those other issues. [LB466]

SENATOR LINEHAN: Okay. So according to this, if this is correct--and it seems like I guess we need to check this out--but only Nebraska, California, Virginia, North Carolina, South Carolina, and Florida require supervised...supervision required. Many, many states require collaborative agreement, which seems to make sense. And then I also think...I didn't understand this. This isn't about home birth, these births would happen in hospitals? [LB466]

KIM ROBAK: These births would happen anyplace away from a home. So it could be a birthing center, it could be someplace other than a home. It doesn't have to be a hospital. [LB466]

SENATOR LINEHAN: But it wouldn't be home, correct? [LB466]

KIM ROBAK: That's correct. There is no allowance in this bill for home birth. [LB466]

SENATOR LINEHAN: Right. And so you talked about remembering way back when we had children, because we're about the same age, right? [LB466]

KIM ROBAK: It's been a few years ago. I wasn't going there, Senator. [LB466]

SENATOR LINEHAN: Yes, way back then. I remember very distinctly that the doctor showed up very much at the end. [LB466]

KIM ROBAK: Surprisingly, not in my instance. Surprisingly, my doctor was there through the evening and early in the morning and at 4:00 a.m., and maybe because I was preeclampsic, I don't know. [LB466]

SENATOR LINEHAN: Well, you were lucky, because I just had a daughter that had a baby and I don't think things have changed very much. It's an RN that's there and knows when you've dilated and knows when the doctor comes and the old joke comes, he comes in to catch the baby. So anyway, thank you for testifying today. [LB466]

SENATOR RIEPE: Are there other questions? Seeing none, thank you very much. Other opponents. No other in opposition? Any testifying in the neutral capacity? Seeing none, Tyler would you tell us if we have any letters? [LB466]

TYLER MAHOOD: (Exhibits 26-35) Yes. I have a letter signed by Victoria Vinton of the...all of these letters are in support: Victoria Vinton of the Nebraska Action Coalition; Alanna Reeves, representing herself; Amy Cherko, representing herself; Jessica Freeman, representing herself; Karen McGivney-Liechti, representing herself; Kelsy Harris, representing herself, Latrice Martin, representing herself; Lydia Rhodes, representing herself, Rebecca Wells, representing herself; and the Nebraska Nurse Practitioners. [LB466]

SENATOR RIEPE: Okay, thank you very much. Hearing nothing else, this concludes the HHS...oh, I'm sorry, the closing. Now the closing. Hey, the time clock is off but, please. I'm sorry. [LB466]

SENATOR BRASCH: I know it's late and I do want to be brief. [LB466]

SENATOR RIEPE: That's okay, we want to take the time. [LB466]

SENATOR BRASCH: But there are some things that I would like to clarify here. Of the concern of the doctor who had come just before you, the first one in opposition that if you read the bill--I don't know if she's seen the bill or not--on page 17 it is very clear in the language in the bill that there is a transition to practice agreement. That means a collaborative agreement between a certified nurse-midwife and a supervising provider, which provides for delivery of healthcare through a collaborative practice which meets the requirements of Section 38-613. So look at page 17. Also look at page 16, it defines what a supervisor provider means, and that is a physician, an osteopathic physician, or a certified nurse-midwife licensed and practicing in Nebraska and practicing in the same practice specialty, related specialty, or field of practice as certified. I'd be happy to visit with you. We were specific on having to make sure that the physicians are not being moved out of their need or their importance. We are simply looking at the same practice as all of our surrounding states, as 28 other states. I do believe that the question was asked by Chairman Riepe about if there's no physicians nearby in the Panhandle, surely if there's no physician, surely we'd welcome a nurse-midwife in the Panhandle when that is your closest recourse. I don't know, in our rural community when there's something that can't be handled, typically you hear the helicopter coming in. The sound of a helicopter happens too often, but at least we can get a helicopter. And the further west you go after Grand Island, I believe that the helicopter does take them to Denver. And so...and we did, as far as the 407, we did work very closely with Health and Human Services, the agency. It is not needed on this bill. You can call and verify with them. We worked with the licensing unit, also. That's why there is an amendment that we did pass out to you to look at. I don't want to...because of the hour, I won't read through. But the amendment we made was an agreement with the unit of public health in Nebraska, Becky Wisell, the head of licensing, Kathy Hoebelheinrich, and Ann Oertwich. They all carefully reviewed this...the bill and helped us with the amendment that you have before you. We would welcome any other amendments that we need. We believe that Nebraska should at least meet the states surrounding us and not drive our nurse-midwives out of the state, make more nurse-midwives available, especially in our rural areas. Is there any other question from the committee? [LB466]

SENATOR RIEPE: Are there other questions? Senator Howard, please. [LB466]

SENATOR HOWARD: Oh, thank you. Thank you, Senator Riepe. Thank you for bringing this bill. This is more of a point of clarification in regards to your intention for the transition to practice act. Is your expectation that somebody would have that collaborating agreement in place before they started practicing and building those hours? [LB466]

SENATOR BRASCH: And that's what the amendment addresses, a grandfathering of those who...grandfathering for those already licensed and have their 2,000 hours, that it would be also workable so no one will have to start all over. [LB466]

SENATOR HOWARD: So the question was actually not about grandfathering. It's actually, we're starting to have some conversations about whether or not somebody needs to have their collaborating agreement or their supervisory position or supervisor in place before they start practicing. It's more of a point of clarification in regards to your intention. [LB466]

SENATOR BRASCH: The intention. [LB466]

SENATOR HOWARD: So do you intend for them to have the collaborating agreement in place before they start practices... [LB466]

SENATOR BRASCH: Yes. [LB466]

SENATOR HOWARD: ...or do they have a period of time where they can start to build those hours before they have that supervisory collaborating agreement in place? [LB466]

SENATOR BRASCH: They'd have it in place. [LB466]

SENATOR HOWARD: Okay. Great. Thank you. [LB466]

SENATOR BRASCH: They'd have it in place. And then our apologies, my apology to the hospital association. As you know, I came here when the power went out on my Down syndrome bill last year. [LB466]

SENATOR HOWARD: And we kept going. [LB466]

SENATOR BRASCH: Yes. I did have a conversation with Kim Robak in the hallway. She had said she was meeting with them. We had an informal conversation. I did not hear back from Mrs. Robak following their meeting of any concerns or the...she mentioned the 407, we clarified with

Health and Human Services. So we are perhaps remiss, that we should have called them into...in a formal way into our office to sit down and go over this bill with us. It was done conversationally in the hallway and I had not heard back. [LB466]

SENATOR HOWARD: Okay, thank you. [LB466]

SENATOR RIEPE: Okay. Senator Erdman. [LB466]

SENATOR ERDMAN: Senator Williams had his hand up. [LB466]

SENATOR RIEPE: What's that? [LB466]

SENATOR ERDMAN: Senator Williams had his hand up. [LB466]

SENATOR RIEPE: Oh. [LB466]

SENATOR WILLIAMS: I'll pass. [LB466]

SENATOR RIEPE: Do you have one, Senator? Senator Erdman. [LB466]

SENATOR ERDMAN: Yeah. Thank you, Chairman Riepe. Thank you, Senator Brasch. Is the amendment going to be the bill? [LB466]

SENATOR BRASCH: No. Or it replaces the entire bill? Okay, well, I don't have the amendment in front of me. It is. Yes, it is. Okay. I apologize. [LB466]

SENATOR ERDMAN: Okay. That's what I thought when I read it. Thank you. [LB466]

SENATOR RIEPE: Okay. Are there additional questions? Thank you very much. [LB466]

SENATOR BRASCH: Thank you. Thank you, happy weekend. [LB466]

SENATOR RIEPE: This now concludes the Health and Human Services hearing on LB466. We are adjourned. Thank you. [LB466]