HOWARD: [RECORDER MALFUNCTION]-- and Human Services Committee of your Nebraska Legislature. This is not an official hearing. We'll be doing a series of briefings at 1:00 before our official hearings start at 1:30. And today we are joined by Darrell Klein from the Nebraska Department of Health and Human Services, Division of Public Health and the Licensure Unit, and he's going to give us an overview of the Credentialing Review Program, also known as the 407 process. Before we get started, I will invite my colleagues to introduce themselves. I'm Senator Sara Howard; I represent District 9 in midtown Omaha. And we will start with my right.

WALZ: Huh [LAUGHTER]. Senator Lynne Walz, and I represent District 15, which is all of Dodge County.

ARCH: Senator John Arch, Legislative District 14: Papillion-La Vista.

B. HANSEN: Senator Ben Hansen, the 16th District, which includes Washington, Burt, and Cuming County.

HOWARD: And we are joined by Sherry Shaffer, our committee clerk; Jennifer Carter, our legal counsel; and our two pages, Maddy and Erika. All right, excellent. All right. And we've just been joined by Senator Williams. Do you want to introduce yourself?

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

HOWARD: Fantastic. All right, Darrell, take it away.

DARRELL KLEIN: Well, thank you, Senator Howard and members of the committee. I am Darrell Klein and, just in case you're writing anything down, D-a-r-r-e-l-l K-l-e-i-n, and I am, I'm the new deputy director of Public Health for Licensure, and I have been in that position since the 2nd of January. But I have been an attorney with the Public Health and its predecessor, the Department of Health, for 29 years prior to that. And what I'm here to talk about is to give you an overview of what's called the 407 process. It's, it's a process that has three names. It's supported by statutes, regulations, and this PowerPoint. And of course, anything I say falls to anything above that, but the name of the Credentialing Review Program is technically the Nebraska Regulation of Health Professions Act, and it was introduced and passed in 1985 as LB407; so that's how the name stuck. And it was introduced by Senators [INAUDIBLE] and Wesely, and it was

essentially put together as a program, within the executive branch of government, that's designed to help the legislative branch in dealing with complexities of healthcare credentialing, both in terms of folks who wanted to come in and get a credential and already credentialed professions that wanted a change in the scope of their practice. And of course, the focus of it is the protection and advancement of the public health, and that is the whole objective of the review. And the idea behind it was to provide lawmakers with information on credentialing issues that was at least somewhat removed from, and independent of, interest groups. I mean you're never totally going to get away from that, but that was, that was the aim. And I had brief conversations with Senator Wesely on it and, in a nutshell, it was: How do you, as a legislator, weigh conflicting information you're getting? Some, somebody says there's an unmet need and we need to have this credential, and then some other profession may say no, we're already taking care of that, you don't need it. So it's a, it's an attempt to remove it from just that sort of conflicting information-- lobbying, if you will-- and to move it into some more evidentiary sort of based analysis. And as a former practicing lawyer, evidence is the way to go. So the idea is to formulate recommendations on policy direction, trying to look at what's best for Nebraskans as a whole. It's independent, using set statutory criteria. The, there are three parts of it. There's a technical review committee which we'll talk about it a little bit, which is an ad hoc committee that's created each time with three professional members, three consumers, and then a member of the Board of Health who is not a member of the profession at interest. And that technical committee, a new technical committee is created, basically for each 407 review, and they look through the statutory criteria and make their recommendation. Then it goes to the Board of Health, and the Board of Health looks through the same evidence presented and uses the same criteria to make its recommendation. And then, finally, it goes to the director of Public Health, again, who uses the same statutory criteria and then makes a recommendation. And all three recommendations are then presented to the Legislature. So you're not just, it's not filtered in that regard. And the philosophy is to regulate only when it's necessary to protect the public health or otherwise advance the public's interest, and with a focus on using the least amount of regulation as being the best regulator, increased regulation only when it's clearly necessary to protect the public or otherwise advance public interest. And the proposal must be both necessary and sufficient to address a credentialing-related issue or problem. And when we're using the term "credential" here, it's kind of an overarching concept that fits into

the concept of licensure. Sometimes folks get confused because healthcare facilities, particularly hospitals, can credential individuals. But we're talking about credential in terms of the state-recognized or issued authority or whatever other restrictions might be on the practice of a, of a certain health-related activity. There are three levels of credentialing that are talked about in the 407 process. And it's licensure, which is licensees have a scope of practice and they have the exclusive right to engage in that scope and to use the title that's issued to them as a licensee. Typically licensed individuals or licensure practice acts will carve out other exceptions, too, so it's kind of hierarchical. If you, if you create a new credential, there will typically be a statement of these, following prior people are not deemed to be invading in the province of that credential. The next-- and I think you could go, you could differ in terms of which of these are more restrictive-- but the next level of credential under the 407 process is a certification. And that's, that's voluntary. And once you meet the requirements for a certification, you can use that title and the title is protected. It's kind of like you're deemed as-- you've met requirements above and beyond what somebody else who would be able to exercise that profession. But it's not restricted, so if you're a certified whatever, another person could go ahead and practice that without using the title "certified." So it's kind of consumer driven, a consumer protection approach. If you know somebody's certified, then you're justified in assuming they've met some additional standards. And then there's another criteria which is called registration which, basically, the concept is you provide notice to the state that you've met the minimal requirements. There are fewer restrictions on it. Generally someone who is registered can be disciplined for transgressing to a lesser degree, generally, than somebody who's licensed. There are quite a few circumstances set out in statute that allow discipline of a license. The process-- applicants, an applicant group comes forward and they submit a letter of intent to the director of Public Health for consideration. And at that same time, they, they fork over a $500 non-refundable fee, and that fee can be waived under specified statutory circumstance, so it's not always applied. But my take on that is it, it's to ensure that folks have a serious proposal and they're not just going to try to walk through the process to see what happens from it. The director then makes a determination within 15 days and, if it's deemed that it is something that is subject to the 407, then they submit a formal application. And the proposals are ideas for change in the credentialing of health professions, and the applications are the documentation. And the application and the

information again is reviewed by all three review bodies, applying the same statutory criteria. And generally the types of reviews are for professions that are not currently regulated; a recent example would be dialysis technicians. And then, secondly, would be reviews for change in the scope of practice and again, recently, LPN/LPN-Cs would be an example of that. And then there is also something that's, that's called a directed review, and my notes tell me here to grab a different document which gives you a little more information. The-- under a directed review, this is something that can be initiated at any time by the director of Public Health with the Chair of the Health and Human Services Committee or by the Chair of the committee with consultation of the members. And a directed review is when there essentially isn't an interested applicant group that's been identified to come forward, yet the purpose of determining the advisability of credentialing a group or changing the scope of practice becomes apparent. And the technical review committee's duty in a directed review is to investigate the issues that they're, that they're charged with, as subject to the review, hold a public hearing to receive information from the public on the issue, and then develop a specific proposal to address the issues being investigated, taking into account the appropriate criteria in the 407 statutes. And then they provide a final report with their proposal, the other options considered, and other relevant information. A recent example is fluoroscopy by CRNAs in 2007, and then a second, licensed mental health practitioner review in 1993, and midwifery earlier than that. And any group can support a request for review. Now we're back to the group-driven ones. Whether or not they're members of the profession that would propose to be regulated, or whether or not they're members of the profession that's going to have a scope of practice, and then even folks who are opposed to the group under review would not be precluded. So back to the main text. Again, I mentioned the technical review committee: three professional members, three members from the public, and one from the Board of Health. And then the State Board of Health looks at it next and then the Director of Public Health. They're all independent but they would be using the same evidence, essentially evidence which can test, or which would consist of testimony at the various hearings and any technical or written documentation that they would also review. The regulations, which I will not get into depth and read, do provide for a kind of a ranking, a hierarchy of what's going to be given the most weight. So if you really want to dive into the weeds, you can look through the regulations here and/or ask me for more and I'll send it in a note or something. But the technical review committee, which is the first start, they generally have a meeting for orientation and

the applicant gives an overview, and then there will be discussions on the proposal, and this could be multiple meetings. There will be a public hearing on the proposal, subject to the Open Meetings Act, and formulation of final recommendations on the proposal. And then once those are formulated, which is generally put together by staff, there is a meeting to approve the recommendations, and that's frequently by teleconference. And there is typically about a month between those meetings, taking into account the folks' schedule who are involved. The Board of Health, when they get it, they have a credentialing review committee-- it's a subcommittee which looks at the proposal and looks at the-- well, looks at all of the information presented to the technical review committee. And then they propose something to the full Board of Health who then, again reviews the whole nine yards, and I assume they give some deference to the subcommittee for the credentialing review. But then the Board of Health makes a finding-- I may have skipped over this. On, on the criteria, which I'm going to get into in a minute, each of these three bodies makes a specific finding on each criteria that applies, and then they also make a final recommendation, a thumbs-up or thumbs-down on what the proposal is. And the statutory criteria-- there are six criteria for a change in scope of practice and there are four criteria for initial credentialing. And the purpose of the criteria, again, is to guide the analysis and the tools for making the recommendation. And then the final "recs," as I said, are made on a single up-and-down vote, but with findings on each of the specific criteria involved. And for folks who are not currently regulated, you look at the fact that there's not a separate regulated profession for the practice which creates a situation of harm or danger to the health, safety, or welfare of the public. And then you make a determination that creation of a new regulated profession would not create a significant new danger to health, safety, and the welfare of the public. I think that's probably always good policy. You don't want the licensed people to do something bad, but it is the statutory criteria. And then the creation of the separate regulated profession would, would need to have a benefit for the health, safety, and welfare-- and finally, that the public cannot be protected by a more effective alternative. So those are the criteria that are looked at for somebody who's currently not in the fold. For folks who want to change their scope of practice, again you look that there is some sort of inadequacy in the protection of the public that isn't addressed by the current scope of practice. And enactment of the change would benefit the same goals, the proposed change doesn't create a new, significant new danger, and then the current education and training for the, for the given health

profession is adequate to prepare practitioners to perform the new skill or service. And in my experience, that's something that's fairly common because what happens is the professions evolve, their education doesn't remain static, there are new opportunities to educate the profession to expand what they are competent to do, and so then the 407 can step in to then change what the statutory limitations might currently be, to address what these folks are now competent to do. And the competency, of course, goes to the protection of the public health and safety. And then, next, there need to be appropriate postprofessional programs and competency assessment measures to make sure that they are competent to perform the expanded scope. And there are adequate measures to address if they are not subsequently performing that expanded scope in a safe manner. Finally, or close to finally at least, the time for some recent 407 reviews shows-- as you can see, we've got a-- I think-- short period of 5.8 months and the long was 12.2. I believe the statute says it should be complete within a year. So as you can see, the program is doing a great job to comply with the time lines. And again, we're gathering a number of folks to serve on these three reviewing bodies, and we're listening from, to the perspective of proponents and opponents. So there's just inherently going to be some need for a little bit of time for people to be able to come together and put the, put their presentation together and have it be assessed. There is a pool of 60 volunteers that the program uses, folks who have expressed their willingness to serve on a technical review committee, and they're a mix of consumers and professionals. And when there's a new 407 proposal, call goes out, and generally about 25 to 30 people respond yes. And so then they're vetted and recommendations as to who should serve on the technical review committee are given to the director of Public Health. And then generally, or almost exclusively, there's a different Board of Health chair for every 407 review, very infrequent repeats. So you're not having the same people making the same decisions, even though there are different facts situations. And currently before us we've got two EMS-related 407s, we have a submission of a letter of intent for art therapy, and also, the physicians' assistants have submitted a letter of intent for a change in their scope of practice. And with that, if you have any questions, my contact information is here, and I'll respond now or you can get ahold of me later.

HOWARD: Thank you. Thank you, Mr. Klein. And you did very well with the time; I think you were only over by a minute, which is incredible.

DARRELL KLEIN: Thanks, okay. Well, for me, that's a record, I guess.

HOWARD: Are there questions? Senator Williams.

WILLIAMS: Thank you, Chairman Howard. And thank you, Mr. Klein, for being here. I think it was two years ago we had proposed legislation to make some changes to the 407 process, or do away with 407 process. And I think for most of us that are not medical professionals, we rely heavily on this process to try to make these decisions. Remembering back to that hearing-- and I know you just showed some information-- but if you would go into it in a little more depth. I'm remembering that we had testimony about the process was slow and cumbersome, that it didn't seem to lead to a result that was-- you might get through Step 1, but not get the full thing, that done. And the other thing-- and I think you just addressed this-- was it was becoming more difficult to get people to serve on the-- in particular, the technical review. Would you address those two things a little more in depth? And then also, are there changes that you would suggest that we could make to improve the process?

DARRELL KLEIN: I will start with the, maybe the easiest and the hardest question, first the last one. My experience with the 407 process dealt with some support of it in the past, as an attorney. And the-- currently I don't feel like I'm in a position to, to offer a critique of the, of the program, but clearly we will, we're open to discussing it internally and, if we come up with some ideas, we will, we will pass those on. I believe some of the statistics and the slides in here were intended to show that, although, you know, I guess, I guess if a year does sound like a long time, it is the statutorily-- it was the setup time that was originally intended by, by Senator Wesely. I suppose we could make every effort to tighten up that time line. I believe that in the instances where 407 was initiated, it went ahead and went to completion; I'm unaware of a circumstance where it didn't. I will also say that there is frequently-- I haven't looked at the actual statistics-- but frequently you get a consensus as to all three reviewers. That isn't necessarily going to be the case. And the value, I think, of the 407, even when the three bodies don't all agree, is it's then presented to the Legislature, and you can look at it and you can-- and evaluate what they heard, what the proponents and the opponents said, and instead of just dealing with, you know, a lot of, you know, impromptu or ad hoc information, you've got a little bit more to work with, whether, whether you follow all of the recommendations of the committees or not. I do know that the work that

the people put in on it is, is significant. They, they're all very dedicated to coming up with a good product. And that may, in some instances and accommodating folks' schedules, I think that contributes to it going about where the statutory time line is. But at the same time, Senator Wesely and the Legislature, in 1985, say, they, they set 12 months as the process. So I guess that's something that could be looked at, but I think you'll get a good product with the amount of time that, that is required for the technical committee and then the Board of Health. Part of it is just meeting schedules for busy people who are volunteering. Matt told me that they've got a pool of about 60 people right now which, which is pretty good. I mean, ideally, I guess, you could-- I suppose we could institute a draft process where we just pull people off the street, but there are people who are like, like you who are willing to dedicate their time to really take a look at things that do us all a lot of good. And so the people that we do have volunteering are high quality, and I think we have enough right now.

WILLIAMS: Thank you.

DARRELL KLEIN: You bet.

HOWARD: Other questions. Senator Arch.

ARCH: I've got a question. The slides aren't numbered, but it's this one-- time to complete review.

DARRELL KLEIN: Yes.

ARCH: It, is, is that the entire list of all the 407 reviews you've done over that period?

DARRELL KLEIN: Let me ask Matthew-- is, on the bars-- yes.

ARCH: Yes. So you're averaging about one and a half a year. Some, some years have two, some years have one, but-- so it's, it's not a high volume.

DARRELL KLEIN: No.

ARCH: But, but the process is lengthy.

DARRELL KLEIN: Yeah, yeah. It's labor intensive and it's fairly-- yes. That's the easiest answer, yes.

HOWARD: Senator Hansen.

B. HANSEN: Hi. Just a quick question about the first gatekeeper of the letter of intent that's sent-- the Public Health director. Do you ever foresee any issues with, maybe, a conflict of interest on why they may or may not approve something, because it seems like quite a powerful step, right off the bat, whether they can move it forward?

DARRELL KLEIN: I could see that, that if that was perceived. I, I'm not aware. Let me, let me ask. I'm going to put Matthew on the spot. Have we ever had a situation where the director of Public Health says something isn't right for the review? I think that the only-- my read, my advice, if I was back in the role as an attorney, would be if somebody came forward and it simply didn't fit within either asking-- a currently uncredentialed group asking for a credential-- or somebody asking for a change in scope of practice. For instance, if somebody confused it a little bit with a, with a motion for a declaratory order as to what is the scope of an existing profession, that's something that I could, could see being diverted from the 407, and we do have a, a process where that can be addressed, too. I--

B. HANSEN: So just, just like if, if, like, the Public Health director had to be like a, like a medical doctor--

DARRELL KLEIN: Yeah.

B. HANSEN: And then something else comes, a scope of practice where there might be a little bit of a conflict of interest with them or some other profession. And do you know if there's some other kind of step, and maybe what happens with that? Do they just move it on or if there's someone else who can [INAUDIBLE]? .

DARRELL KLEIN: My, my experience has been-- and I totally understand your question-- because frequently the director of Public Health is MD--

B. HANSEN: Sure.

DARRELL KLEIN: -- the CMO and the director are combined. My experience has been that if, if there were something that, that you would think that the medical profession might be opposed to that, that CMO/director would have it go forward to simply avoid that appearance. And I imagine there would be great howling and gnashing of teeth if we were perceived to have done it differently. So I do understand your

question, and I think that the folks at the department would see to it that, that we avoid that.

B. HANSEN: Thank you.

DARRELL KLEIN: You know, and that the conflict of interest-- I mean you'll see that in the technical review area, maybe, where folks are thinking-- for instance if it's a new profession wants to come in and somebody else that says they're currently doing it, it's, it's justifiable that the people who are currently doing it would assume that they are the most qualified. But you'll see that laid out right in the proponent/opponent testimony. And the other thing that guards against, I think, just a turf protection conflict of interest on behalf of anybody, is all of these groups are required to, and do, review the statutory criteria, and they also all know that they're not operating-- they're not hiding anywhere; they're all under a spotlight for it. So I think all of those things weigh in favor of seeing that are our best natures come forward.

B. HANSEN: Thank you.

HOWARD: Any other questions? Seeing none, I just have one.

DARRELL KLEIN: Yes.

HOWARD: Has the absence of a chief medical officer in the Department of Public Health delayed any 407s?

DARRELL KLEIN: I do not believe it has because, under these circumstances, it's actually a duty that devolves on the director. So we've had a director of health or an acting director of health and, for the duties of the chief medical officer, one has been appointed, as required, for each situation. So I don't think that has contributed to any delay.

HOWARD: Well, thank you so much, Mr. Klein, for visiting with us today.

DARRELL KLEIN: Thank you.

HOWARD: We appreciate all of your information.

DARRELL KLEIN: Thanks.

HOWARD: Wonderful. All right.

[BREAK]

HOWARD: Committee, my name is Senator Sara Howard. I represent District 9 in midtown Omaha. I'd like to invite the members of the committee-- and committee-- I'd like to invite the members of the committee to introduce themselves, starting with my right with Senator Murman.

MURMAN: I'm Senator Dave Murman from District 38; it's six whole counties and part of a seventh, Buffalo County, in south-central Nebraska.

WALZ: I'm Senator Lynne Walz. I represent District 15, which is all of Dodge County.

ARCH: Senator John Arch: Papillion-La Vista; it's District 14.

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

CAVANAUGH: Machaela Cavanaugh, District 6: west-central Omaha. And I have a special guest today-- Barrett.

B. HANSEN: Ben Hansen, District 16: Washington, Washington, Burt, and Cuming County.

HOWARD: And we are also joined by our legal counsel, Jennifer Carter; and our committee clerk, Sherry Shaffer; and we have two lovely pages, Erika and Maddy, with us today. So just a few notes about our policies and procedures. We ask that you silence your cell phones or turn them off. This afternoon we'll be hearing three bills, and we'll be taking them in the order listed on the agenda outside the room. On each of the tables near the doors to the hearing room you'll find green testifier sheets; we went with green-- lucky, bright. If you're planning to testify today, please fill one out and hand it to Sherry when you come to testify. This will help us keep an accurate record of the hearing. If you're not testing at the microphone but we'd like to still go on record as having a position on the bill today, there are white sign-in sheets at each entrance where you, where you may leave your name and other pertinent information. Also I would note, if you're not testifying but would like to submit written testimony for the record, the Legislature's policy is that all letters for the record have to be received by the committee by 5:00 p.m., the day

before the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. We would ask, if you do have any handouts, please bring ten copies and give them to our pages. We do use a light system in the Health and Human Services Committee. Each testifier has five minutes. So when you begin, the light will be green; when you have a minute left, the light will turn yellow; and when it's time for you to wrap up, I'll start waving my arms when the light turns red. When you come up to testify, please begin by stating your name clearly in the microphone, and please spell both your first and last name. If you do have a prepared statement or exhibit, give it to the page then. The hearing on each bill will begin with the introducer's opening statement. Then we will hear proponents, opponents, and neutral testifiers. And then the introducer of the bill will be given the opportunity to make closing statements, if they wish to do so. In this committee we have a policy of no props. And with that, we will begin today's hearing with LB74. Welcome, Senator Williams.

WILLIAMS: Thank you, Chairman Howard and members of the HHS Committee. My name is Matt Williams, M-a-t-t W-i-l-l-i-a-m-s, representing Legislative District 36, and I'm here today to introduce LB74. LB74 is being introduced at the request of the Nebraska Pharmacists Association to change pharmacy practice with regards to the allowable duties of certified pharmacy technicians. Currently most tasks completed by pharmacy technicians must be verified by a pharmacist. With the evolution of pharmacy practice and technology, changes are necessary to meet the ever increasing demands pharmacists experience when caring for patients. Four Nebraska hospitals, including Bryan, UMC, a hospital in Osceola and a hospital in Central City, were granted permission to do pilot projects that allowed certified pharmacy techs the ability to validate the tasks of other certified pharmacy techs for stocking Pyxis machines and medication carts, also frequently referred to as tech-check-tech. Representatives of those hospitals will follow me to further explain their projects. The result of those projects showed great success and equal or greater patient safety outcomes, with regards to medication accuracy, and provided the pharmacist with more time to care for their patients. Because of these positive results, the Nebraska Pharmacists Association gathered a working group consisting of hospitals, community and long-term care pharmacists, and pharmacy technicians to develop legislation to allow certified pharmacy techs to validate the work of other certified pharmacy technicians in the process of stocking medication systems and medication carts, specifically in hospitals and only with the

utilization of bar codes or RFID technology. This is also done with the goal of patient safety being the highest priority. It was important to the working group that this bill include the requirement of establishing policies and procedures to fit the practices of the hospital, since the practice varies across hospital settings. As healthcare continues to evolve, it is important that we allow our healthcare providers to practice to the best of their abilities, utilize technology when appropriate, and embrace efficiencies to improve patient care. The changes proposed in LB74 embrace this philosophy and allow Nebraska hospital pharmacists and pharmacy technicians to enhance medication safety for patients. I certainly urge the committee to advance LB74 to General File. And following me will be some expert testimony from Bryan and UNMC.

HOWARD: Thank you, Senator Williams.

WILLIAMS: Thank you, Madam Chairman.

HOWARD: Any questions? Fantastic. Seeing none, we'll-- and you're going to stay to close?

WILLIAMS: Yes.

HOWARD: Okay, thank you. Seeing none, we'll open up the hearing for proponent testifiers. Good afternoon.

LORI MURANTE: Good afternoon. Thank you for allowing me to testify. Senator Howard, members of the Health and Human Services Committee, my name is Lori Murante, L-o-r-i M-u-r-a-n-t-e. I hope I'm not waking Barrett up.

CAVANAUGH: Okay.

LORI MURANTE: I'm the director of pharmaceutical and nutrition care at Nebraska Medicine, which is a part of the Nebraska Medical Center. I'm here today to testify in support of LB74, and I'd like to thank Senator Williams for, for sponsoring this legislation. Senator, as LB, as Senator Williams has indicated, LB74 allows technology-assisted tech-check-tech in the hospital system. There's a reason we chose hospitals to ask for this. We are already rich in technology-assisted processes, and we are constantly searching for ways to make sure that our technicians and our pharmacists are practicing at the top of their license to ensure safety and zero harm within the hospitals. Our study was, I believe, the first pilot study that was conducted and it was

done in-- I believe you have the data in front of you and you have a summary-- but it was done from January of 2016 through June of 2017, I believe, and, and you can see by the data that we had a number of transactions and medications that were part of that study. We chose to do the pilot on our narcotic-- or controlled substances-- process, and that's a process that is already rich with technology assistance, all the way from when we bring it in to purchase and bring it into the hospital until the time it goes into an automated dispensing cabinet on the floor where only a thumb print or a badge swipe will allow a licensed practitioner, a nurse, to take it out of the ADC and administer it to a patient. That's important because there's always a licensed individual between hospital pharmacy processes and the patient. So we conducted this pilot for nearly 18 months in our controlled substances process. We, I would like to note that we didn't divorce a pharmacist from the process. By law pharmacists have to be involved in the validation of NDC and/or bar code numbers within the system to ensure accuracy at every step subsequent to that system. So that's important to note because then the bar code is also used prior to administering it directly to a patient. We were no, we were really surprised that the system, that the pilot revealed less than 1 percent, actually less than .03 percent error rate, and no errors reached the patient. The error rate was determined at every-- at every step of the process we asked the technicians and the pharmacists who did random checks to document whether they noted an issue. In the beginning it was .03 percent, and we found a couple places where we just needed to reinforce the process. And then you can see, subsequent to that, that it was really more like .016 percent; and I think that's probably more accurate than when you've had pharmacists checking without technology assistance. So it represents more than a million units of use that went through this pilot. So we're pretty confident that we had an end that would stand up statistically. Based on the data and the data of my colleagues that you'll hear more about later, I wanted to tell you that we fully support this LB74 and what it allows, and I do appreciate the opportunity today to testify. And I ask for your support of LB74. I'd be happy to answer any questions at this time. I tried to keep it short and sweet so you'd have time for questions. And I should mention that one of our colleagues, Reg Hain from Central City, was unable to make it today due to weather. I believe his testimony has been given to the clerk.

HOWARD: Any questions? Senator Arch.

ARCH: I've got a question. Just for, just for clarification, this is, this is only for the stocking of Pyxis, Omnicell dispensing. Is that correct?

LORI MURANTE: It could be used in the-- our pilot was only for-- what-- when product comes into the hospital, it's bar coded into the Omnicell system. We have a con, a controlled substance manager system. And If you could imagine a bank of six-foot tall machines that have clear cabinets in front of them that can only be accessed through secure technology, those live within the pharmacy and we call it our, our, our controlled substance safe, if you will. When we take items out of that, then we want to "barc," so we get a fill list for five west, and we bar code against the fill list and against what needs to go up on the unit's automated dispensing cabinet, which is a miniversion of what I just described. When the nurse takes it out of there, then they are, they are swiping who they are or using a thumb print; with the narcotics you can also use a thumb print in our system. And they also-- the, the Omnicells upstairs, the automated dispensing cabinets, regardless of the vendor, are most often interfaced with the med administration record so that you can't take out a medication for Lori Murante as a patient unless it's been ordered on my, on my medical record. So that's the interface there. Additionally, anybody taking anything out, we can see what they take. So again then, when they get to the bedside, they bar code my band and they bar code the medication, and we know we've got a match. So there's technology and steps all along the way. And most of our medications are handled in a similar fashion. The narcotics, or anything from Schedule II to V, which could include nonnarcotic medications, is controlled even more securely. So that's what I'm describing.

ARCH: So then where is the technician validating the technician?

LORI MURANTE: So where they're validating in it, is that there is a delivery methodology between the safe in my pharm, in my big pharmacy downstairs and those ADCs. So what we do is we, they are going against a fill list. They use technology to validate that fill list. Then a second check validates that fill list into the-- we purchased secure vinyl blue bags that have locks. So then you have a technician that takes it upstairs, and then they also bar code it into the system so the system knows what it's receiving. So it's really several steps along the way. But there used to be a pharmacist downstairs checking that content after a technician pulled it for the fill list. And quite

honestly, pharmacists have a hard time making that a priority when they've got IV medications coming out of a sterile processing area that they are also trying to keep track of. This is one of the things where we actually felt like, because of the attention to detail and the way they could prioritize it, the tech-check-tech I actually believe is, is more accurate. If I, as a pharmacist, go over there, I don't have to use the bar code system, so I might not be as careful. I hate to admit that but I don't, I don't want that to happen, don't want to set, to set anybody up for that. So the tech-check-tech is just a better-- it's a, it's a more solid process.

HOWARD: Thank you.

LORI MURANTE: Does that help answer your question?

ARCH: Yes, it does; thank you.

HOWARD: Other questions? Senator Hansen.

B. HANSEN: Lori, I applaud your effort to make things a little more--

LORI MURANTE: It's hard.

B. HANSEN: Yes it is. You know, when you've got all those medications and different people, and-- and so thank you for at least, for doing this. And so you mentioned before the error rate was .03 percent, and that's more down to .016 percent. Do you know what the error rate was before? I don't know for sure if I missed that.

LORI MURANTE: Prior to that?

B. HANSEN: Yeah.

LORI MURANTE: The--prior to that, so in our system incidents are voluntary, and so we would find them at different points in the system. But the biggest error rate would have been a delay in the delivery, a delay in getting the pharmacist. So if I'm filling it on ourselves, every time we don't meet a standard within our own processes, I would say the biggest error rate would have been the delay in getting a pharmacist over there to check those so that I could get him upstairs before that bin of whatever-- Drug A-- was empty.

B. HANSEN: OK.

LORI MURANTE: And realize that you can see there's-- I mean there's over a million unit abuse meds in this 18 months. This only represents about 5-7 percent of my overall dispenses a day--

B. HANSEN: Sure.

LORI MURANTE: -- or a month.

B. HANSEN: Which is why I think it is extra important we do the tech-check-techs.

LORI MURANTE: Yeah.

B. HANSEN: It's because all that stuff going out is-- I think that's-- I think that's awesome.

LORI MURANTE: Yeah, it's a, there's a lot. And so we do run into problems with the units on the floor being able to handle the capacity.

B. HANSEN: And so do you know-- and it's OK if you, if you don't know this off the top of your head-- mainly with the (INAUDIBLE)-- what were some implications of the errors of those delays?

LORI MURANTE: There's most of the most of the errors would have been-- so, so some of them come, and if you, if you want to recall cold medicine that comes out of a box, they're kind of in a card with several units of use inside each little punch area. So the cards might come with, say, ten on them. And so it's easier to do that if it's all attached. What's hard is when something comes back to the pharmacy or there's singles in there and that's, I think, when we might-- it might not be the wrong drug but it could be, or it might be an expired medication. And so, so those little things like that can cause us to-- we call it an error. It's not really the wrong drug to the wrong patient always.

B. HANSEN: OK.

LORI MURANTE: Sometimes a delay, to me, is an error if I'm slowing the process down anywhere. So none of them reached the patient, and that was the important piece. But I can't tell you that any of them were even the wrong drug. Some of them might have been.

B. HANSEN: OK. Here's-- I have one more question. Is that OK? And so you mentioned we're doing it by bar code, right?

LORI MURANTE: Uh-huh.

B. HANSEN: And, and I may have asked this question before, of someone else. But the bar code comes from the manufacturer--

LORI MURANTE: Um-hum.

B. HANSEN: -- and it's on the bottle. And so I think that's extra important so we're not bringing up bar codes ourselves so there could be another layer of error there.

LORI MURANTE: Um-hum.

B. HANSEN: So is, do we ever repackage medication?

LORI MURANTE: Um-hum.

B. HANSEN: And then where does the bar code come from? And then what's the process behind that?

LORI MURANTE: OK. So we rarely have to repackage any of the things that would come out of the safe for any of this process, but in the hospital it is possible that you can only purchase a bulk medication and, in our world, ideal in unit-dose medications. So usually at the unit-dose level it also has a bar code. But if you had to repackage it from a bulk bottle-- I'll just pick Vitamin C. I don't think that's really one of them, but let's just think Vitamin C. So you get a bottle of 1,000, and you repackage it. So we have automation that helps us repackage. We can create bar codes within our system. So within Epic, which is what Nebraska Medicine has, we would create a bar code for that entry. It would be linked to every-- every time it was ordered, it'd be linked to every time it was manufactured. We keep a log book and lots and bar codes and everything there, and then it all links back to-- so that it could still be scanned by the bracelet and the, and the bar code. The medication and the bracelet could be matched before it goes to a patient.

B. HANSEN: Oh, all right.

LORI MURANTE: So, so there is a methodology for it, but we do try to minimize that as much as possible.

B. HANSEN: OK.

LORI MURANTE: And my colleague, who is from Bryan, can probably speak to that, as well.

B. HANSEN: Oh. Yeah, great. Thank you; appreciate it.

LORI MURANTE: So any other questions?

HOWARD: Any other questions? Seeing none, thank you for your testimony.

LORI MURANTE: Thank you for your consideration.

B. HANSEN: Thank you.

HOWARD: Our next proponent?

TIFFANY GOELLER: Good afternoon. Chairman Howard, members of the Health and Human Services Committee, my name is Tiffany Goeller, T-i-f-f-a-n-y G-o-e-l-l-e-r, and I'm the pharmacy operations manager at Bryan Medical Center here in Lincoln. On behalf of Bryan Health and the Nebraska Pharmacists Association, I'm here to testify in support of LB74. I would like to thank Senator Williams for bringing this legislation forward for us. LB74 will allow for the advancement of both the clinical practice of pharmacists and certified pharmacy technicians in the state of Nebraska, in the hospital. Using tech-check-tech in the hospital setting can get our pharmacists out to the patient's bedside and, as an active member of the healthcare team, get them to go to rounds and work more closely with our physicians, nurse practitioners, physicians' assistants, and our nursing staff. This leads to us being able to devote more pharmacist resources to opioid stewardship, antimicrobial stewardship, and safe transitions of care to and from the hospital to other settings. Pharmacists also, through this process, have more time to devote to clinical activities such as: performing physician-requested consults for antibiotic dosing; anticoagulant dosing; and medication reconciliation. We've been conducting our pilot for tech-check-tech at Bryan since June of 2017. It was approved by the Board of Pharmacy after we presented how we were going to implement it and do our training in our phases. We have also been using our process to refill the automated dispensing cabinets at Bryan. We have Pyxis, and we chose the noncontrolled medications that go into Pyxis versus the controlled substances. And we really focused on-- I took three of my most senior-tenured

technicians with the most experience and chose them for this process, to give them a way to advance and to collect the data for us. So in our process they had to go through a pretty robust self-learning project that I had created for them, really focused on medication safety, medication errors, commonly confused medications, dosage forms, control mechanism releases, and then I did a practical checkoff and validation of that learning that they all had to go through with me personally. And then in Phase I they had to take the resource sheets, the fill list from the Pyxis machines-- and, for example, one fill list might be three or four pages long, but it might have 50 lines of different medications that need to be checked-- and so to get through the first phase they had to check successfully at least 500 lines of doses, with at least a 99.75 percent accuracy rate to move on to the second phase. And they all were able to complete that. And then, since that time, they've been in Phase II, which is where a pharmacist randomly checks 10 percent, or a minimum of 10 percent, of everything that they've checked. We've also used the bar code scanning very heavily so, in our process, the first certified technician pulls everything for that refill list, and then the second technician comes by. And right there on that refill list is the drug code number which is associated with every bar code for every medication. So after the first certified technician pulled the medications, the second one came along, checked to make sure the quantities were all right-- everything looked like it was the right dose, strength and everything-- and then scanned each item to make sure there was 100 percent match between those items. And then the pharmacist would check at least 10 percent of those transactions. And then the next step is that, that pharmacy technician takes it to the Pyxis machine and, as Lori has said, we also use bar coding there. So if I'm going to the Pyxis machine-- and the Omnicell is exactly the same, different vendor-- I log in, use my fingerprint, and then I choose "refill by bar code." I scan the bar code on the medication and then only the pocket that that medication has to go into will open. So all phases of this process, we used bar code scanning and we made sure that, just as UNMC also has done, there's also a provider, a nurse-- it could be a nurse practitioner, CRNA-- that's actually using bar code scanning or checking that product, after it's dispensed from the Pyxis machine, to give to the patient. So we felt like it was a very safe process that we had in place. Patient safety is our number one priority and allowing us to use this gave us more time to spend on clinical activities, gave us more time to really have the pharmacists being doing uninterrupted

work in other areas of the pharmacy. I appreciate your time today, and I would be happy to answer any questions that you might have.

HOWARD: Are there any questions from the committee? Seeing none, thank you for your testimony.

TIFFANY GOELLER: Thank you.

HOWARD: Our next proponent testifier? All right. We'll be moving on to opposition. We did receive two proponent letters for the record, one from Andy Hale and David Slattery from the Nebraska Hospital Association, and one from Julie Wollberg, representing herself. She is a pharmacy technician at Southeast Community College. Any opponents? Seeing none, anyone wishing to testify in a neutral capacity? Seeing none, Senator Williams?

WILLIAMS: Thank you, Chairman Howard. As you heard from both Lori and Tiffany from UMC and Bryan, patient safety is at the top of the list that we are attempting to accomplish with this. And again, I would stress that this is only in a hospital setting. And of course, we heard from two of our large hospitals, but the hospital in Central City and the hospital in Osceola were also involved with the test, with similar results. This is only after policies and procedures have been established by the pharmacist in charge at these hospitals. And it only applies to bar code or RFI [SIC] technology. So with that, I would encourage the committee to advance LB74 out of committee to the floor. Thank you.

HOWARD: .Any other questions for Senator Williams? Seeing none, this will close the hearing on LB74, and we will be moving on to LB22, Senator Kolterman, to change provisions relating to the Nursing Facility Penalty Cash Fund. Senator Kolterman, whenever you're ready.

KOLTERMAN: Thank you. Good afternoon, Chairperson Howard and members of the Health and Human Services Committee. My name is Mark Kolterman, M-a-r-k K-o-l-t-e-r-m-a-n, and I represent Legislative District 24. Today I'm introducing LB22 on behalf of the Nebraska Health Care Association. When a nursing facility is cited for noncompliance with a federal regulation, a civil money penalty, or a CMP, may be imposed. If imposed, a portion of those fines is deposited in the Nebraska Nursing Facility Penalty Cash Fund. Both federal and state regulations mandate that these funds be spent on projects that benefit residents in nursing facilities. How, however Nebraska's current state tax statute is more restrictive than the federal requirements. LB22 is a

technical change that would modify Nebraska state statute to mirror the federal regulations. This change would not prohibit the Department of Health and Human Services from awarding funds based on their current practice. It would merely provide more options for these funds to be used to improve the quality of care and life of nursing facility residents. I've also submitted AM18 for your consideration. AM18 is a technical amendment requested by the Department of Health and Human Services that will seek to avoid complications related to the interaction between state and federal law. Thank you for your time, and I'd be happy to answer any questions. But if you'd like deferred, but I would like to defer technical questions to the testifier that will follow. She's worked extensively in this arena.

HOWARD: All right. Any questions for Senator Kolterman? There are no easy questions for you.

KOLTERMAN: No?

HOWARD: We're going save the hard ones. All right. With that, are you going to stay to close?

KOLTERMAN: I, I have another bill right after this one.

HOWARD: Yeah, you do. With that, we would open up the testimony to proponents.

CINDY KADAVY: Good afternoon, Senator Howard and members of the Health and Human Services Committee. My name is Cindy Kadavy, C-i-n-d-y K-a-d-a-v-y. Excuse me. I'm here today to speak in support of LB22 and to express appreciation to Senator Kolterman for bringing this bill forward on behalf of Nebraskans receiving care in our skilled nursing facilities. Nebraska Health Care Association is a family of associations, including the Nebraska Nursing Facility Association, representing 184 nonprofit and proprietary nursing facilities across the state. So in front of you, you have a fact sheet that provides some background and history of the issues relevant to LB22. On the backside of that sheet are examples of how other states have used their nursing facility penalty funds on projects that benefit the residents of the nursing facilities. LB22, as Senator Kolterman mentioned, would just make a technical change to Nebraska statute by merely referencing the federal language. It would allow the funds that are collected from nursing facilities who've been found in violation of a federal regulation to be used for a wider variety of projects to benefit residents to improve their quality of care and their quality

of life. The Nebraska Department of Health and Human Services has, and would continue to have, the authority to determine how those funds are spent, with the approval of the Centers for Medicare and Medicaid Services, or CMS. This change would not prevent the department from spending the funds the way they do currently; it would just give them more options. To clarify, these funds cannot be used to benefit the facility, the nursing facility. They can only be directed towards projects that benefit the Nebraskans receiving care in the facility. So why this has been important to us is three years ago CMS approved Nebraska's plan to award a portion of those funds every year to projects that benefit residents. So Nebraska developed a plan, a program. They requested applications and they awarded contracts. However, before they could give the funds out, they had to pull those back and rescind those awards because, although their plan was approved by CMS, it actually was found to be not compliant with the state statute. So this LB22 would make a change to correct that issue. And just as some background, back in 2017 we met with the CEO of the department and, at that time, she agreed there needed to be a change, but it wasn't one of their top priorities. So before we talked to Senator Kolterman, we did check back in with the department to let them know that we had a plan to try to introduce this legislation. I do want to thank the department for their awesome $0 fiscal note; that's really appreciated. So you should also receive support letters from LeadingAge Nebraska and Nebraska Culture Change Coalition, which was one of the projects that was initially awarded funds. So I'm glad to answer any questions you might have.

HOWARD: Are there questions? Seeing none, thank you for your testimony today. Are there any other proponents? Seeing none, I'll read in the proponent letters sent to the record. We have one from Jennifer Acierno from LeadingAge Nebraska and one from Theresa Parker from the Nebraska Culture Change Coalition. Are there any opponents for LB22? Anyone wishing to testify in a neutral capacity? Seeing none, Senator Kolterman?

KOLTERMAN: Thank you again, Senator Howard. I would just ask that you advance this to the floor so that we can talk about it in General File. Thank you.

HOWARD: Thank you, Senator Kolterman. With that, that will close the hearing for LB22. And we will move on to LB205, Senator Kolterman's bill to adopt the Surgical Technologist Registration Act. You ready? All right.

KOLTERMAN: Good afternoon again, Senator Howard and members of the Health and Human Services Committee. I am Senator Mark Kolterman, M-a-r-k K-o-l-t-e-r-m-a-n, and I represent the 24th District in the Nebraska Legislature. I'm here today to, to introduce LB205, a bill that adopts the Surgical Technology Registry Act [SIC]. Similar legislation to LB205 was introduced two years ago and was supported unanimously at the committee level last year. I'm also introducing AM22 as a white copy amendment that addresses technical concerns from the Department of Health and Human Services. Many stakeholders have worked on, hard on this legislation over the past two years to reach an agreement on the language of this bill and to help ensure that it is passed in a timely manner this session. Many of those stakeholders are here to offer their support for both the bill and the amendment. There have been two 407 reviews which involve surgical technologists. Both reviews acknowledged a registry was appropriate to ensure public safety. Others here today will go into the details of those reviews. In addition to a first time registry for surgical technologists, the bill also updates in, language in statute clarifying delegation by physician, including surgeons. Surgical techs are a critical part of every surgical team directed by the surgeon in the operating room. There are about 800 surgical technologists in Nebraska. Currently in our state, the surgical technologist is the only member of the surgical team that does not have a minimum competency standard. This legislation allows for those who have a, on-the-job training to continue to work in their jobs, giving them 180 days to register and, if they have not been certified or have gone through an educational program, they can register after a competency assessment by a licensed professional in their place of employment. Surgical technologists are specifically trained in setting up sterile environment in these days of new and deadly infections. The surgical technologist readies equipment and surgical instruments which, even in the most basic surgeries, can number in the hundreds. A surgical technologist takes direction from the surgeon on handing instruments, holding retractors, and suctioning wounds. As you might expect, there are others here today that can go into much more detail about that. But to me, since surgical technologists perform such delicate duties during surgeries, I find it, I find it unnerving that they are the only member of the surgical team not to have any minimum, minimum competency standards. I believe there is a specific and significant need for surgical technologists to be regulated by the state for safety of our citizens. LB205 closes the circle by establishing a registry with competency and education standards under the Department of Health and, Health and Human Services, as recommended by two 407 reviews. I think that's a

key statement, so I'm going to read it again. LB205 closes the circle by establishing a registry with competency and education standards, under the Department of Health and Human Services, and it's been recommended by the Department of Health through two 407 reviews. This bill is being brought to you after about six years of discussions, negotiations, and compromise between physicians, hospitals, the Department of Health and Human Services. I think when you hear the testimony from its proponents, you will come to the conclusion that surgical technologists should be regulated under the Board of Medicine and Surgery. Opponents to my bill may say the registry should fall under the Board of Nursing. I do not believe this to be valid. Every single state that has adopted similar legislation to this have granted the oversight of the registry to the Board of Medicine and Surgery or a similar board. Other opponents may say this will create barriers to entry into the practice of private and-- or provide disincentives to join the field to do a registry fee. Nothing in this legislation prohibits surgical centers or hospitals from training their own surgical techs. It simply requires that a surgical tech have a minimum competency at the conclusion of their training. I'd like to address the fiscal note briefly. The fiscal note is, is quite a bit higher than we had previously, previously estimated from previous versions of the bill. But I'd like to point out that the proposed, proposed fee is simply that; it's an estimate. The registration fee for surgical techs, depending on the staffing needs and registry upkeep costs for the department, would be much lower by the time this bill is enacted into law-- could be much lower by the time this bill is enacted into law. I want you to know that I'm fully committed to continue working with the Department of Health and Human Services to help ensure the fees do not become overly burdensome. I honestly believe that if the surgical techs in the state felt that a registry was too burdensome and the fee was too burdensome, they would have opposed this legislation. Instead, not only do the surgical techs simply support this legislation, they brought it to me for introduction. After all these years, it's time to put this debate to rest and enact the legislation to ensure greater patient safety in the state. Thank you for your time today and, as I said, there will be several experts behind me that can go into greater detail on how we can come to, how, how we've come to this point. I'd be happy to try and answer any questions any of you might have. Thank you.

HOWARD: Are there questions for Senator Kolterman? Just one. Can you help us understand the difference between the cash funds versus General Funds and what that means?

KOLTERMAN: Yeah. The cash fund is, it's, it's where they're going to collect the money from the people that are putting the money in for their, for their registry, and then they will disperse that back out. There is no state General Fund monies, tax monies that are going to go to support this bill.

HOWARD: OK. Thank you, Senator Kolterman.

KOLTERMAN: Is that, is that what you want?

HOWARD: That was, that was what I was looking for.

KOLTERMAN: Thank you.

HOWARD: Thank you. All right, any other questions? Seeing none, are you going to stay to close for this one?

KOLTERMAN: I will be here.

HOWARD: OK, great. Thank you, Senator Kolterman. Our first proponent testifier? Good afternoon.

CASEY GLASSBURNER: Good afternoon. Thank you, Chair Howard and members of the Health and Human Services Committee. I am Casey Glassburner, C-a-s-e-y G-l-a-s-s-b-u-r-n-e-r. I am currently serving as the president of the Nebraska State Assembly of the Association of Surgical Technologists, which is the local chapter of our national association of AST, which represents the interests of surgical technologists, as well as surgical first assistants in the state of Nebraska. We'd like to thank Senator Kolterman for bringing this important patient safety issue forward again, as he did two years ago; he did mention that bill that moved unanimously out of committee last session. And then we would also like to thank Senator Howard, Senator Williams, and Senator Murman for expressing their support and cosigning onto the bill, as well. Nebraska's 800 surgical technologists are allied health professionals who are integral members of the team, but they are currently the only member of that immediate operating room team that surrounds the patient, that does not have those minimum education or competency standards in place. Due to this lack of regulation, they also are the only member that is not required to comply with mandatory reporting requirements, which adds an

additional potential for harm for our patients. Unqualified surgical technologists can cause harm to patients by poorly maintaining a sterile operating room, improperly putting together instruments and equipment that are going to be utilized for the case, and, also, poorly decontaminating and sterilizing instruments after the procedure, as well. They also can slow down a procedure, resulting in additional risk by the patient being under anesthesia for an extended period of time and potentially experience, experiencing excessive blood loss. Lack of coverage, under mandatory reporting, creates additional potential for harm by allowing individuals to move between healthcare facilities without requiring their potentially harmful actions that may have occurred towards a patient to be shared between employers, in order to protect future patients. And there have been instances in other states, specifically Colorado, where there have been surgical technologists who have performed actions that have been potentially harmful to patients. And they have moved between facilities, and that information was not shared, through requirements under mandatory reporting that were lacking. And they did harm additional patients in an additional facility. The same type of environment does exist here in the state of Nebraska, and that same potential does exist. As Senator Kolterman mentioned, this concern has been covered under two 407 review processes. The technical review committee, the Board of Health, and Courtney Phillips, who was functioning in the role of chief medical officer at the time, expressed their belief that there was a need to provide surgical, surgical patients with greater assurance of the competency of every member of their surgical team-- not everybody but the surgical tech-- every member of the surgical team. And they all agreed that a registry was the appropriate means to put those competency standards into place. So LB205 will establish this registry that has been recommended by both of those 407s, administered by the Board of Medicine and Surgery with minimum competency and mandatory reporting requirements in place. LB205 does not impose financial hardship to those individuals attempting to enter the profession. It does not require them to go back to school nor pass the national certification exam. It simply says that, within 180 days of employment, they need to showcase their ability to provide safe patient care so that all of us who are potential surgical patients can rest assured that every member of our team has demonstrated minimum competence. So there are currently 15 states that have established regulation of surgical technologists. Each one of those, as Senator Kolterman mentioned, has that regulation administered by a board of medicine or a board of health. As he mentioned, the opponents will say then it needs to be under the Board

of Nursing. However, as all the other states have determined, it is most appropriate to have this under the Board of Medicine and Surgery. Also, the surgical assistant license here in Nebraska is currently under the Board of Medicine and Surgery. The professions of surgical technology and surgical assisting are very closely related. Most surgical first assistants begin their career as a surgical technologist and then obtain additional education to become a surgical first assistant, and then obtain the license. We're talking about the same people, so it should be the same board that administers this. And placing this registry under that board does not alter the supervision of the surgical technologist in the OR; LB205 says nothing about the supervision of the surgical technologist. It's the firm belief of our organization that every surgical patient deserves nothing less than a surgical tech that has demonstrated minimum competence, which can be assured through the passage of LB205. At this time I will take any questions that you have, and thank you for listening and considering this important patient safety issue.

HOWARD: Are there any questions for Ms. Glassburner? Oh, Senator Cavanaugh.

CAVANAUGH: Yes, sorry. Thank you for your testimony. I just was curious. You talked about the, in other states the, the lack of tracking if somebody is not doing the job appropriately and endangering patients. How does having the registry impact eliminating that? And more specifically, if, if somebody is registered and they do a poor job, is it automatic that, at the next job, that-- will it become a requirement that employers check to see if they are on the registry?

CASEY GLASSBURNER: Yes, absolutely. So the registry is mandatory and, actually one, from one of the surgery centers here in town, one of the proponents is going to talk about how that piece is currently missing. When she goes to hire these individuals, there currently is not a place for her to look up if these individuals have had any type of negligent action which they have engaged in. Under mandatory reporting, if they are regulated, then that information has to be reported so that then it can be tracked. And then those individuals, when-- they would have to disclose that information upon attempting to be hired in an additional healthcare facility. Thanks.

CAVANAUGH: OK, thank you.

HOWARD: All right. Any other questions? Oops, sure. Senator Arch.

ARCH: If it's under the Board of Medicine, can the Board of Medicine take disciplinary action then against the surgical tech?

CASEY GLASSBURNER: They could, yes. So then-- but it's not a license, so they wouldn't be able to take away the license but they could take away their registration and, without being registered, since it would be a condition of employment, then yes, they would not be able to be hired within the state, yes. So there would be a means for that disciplinary action which currently does not exist, as well.

HOWARD: Other questions?

B. HANSEN: I have a couple questions, so--

HOWARD: Sure. Did he beat you, too? Senator Hansen.

WILLIAMS: I'm just sitting here.

B. HANSEN: Sorry. I always-- what, what I think-- when I feel like we're looking at expanding credentialing or licensing or trying to make a law for something, I always like to try and see trends that might justify why we want to do this. And I know that in your statement here, unqualified surgical technologists can harm patients by-- and you listed off the bullet points. Have we seen an increase in that, over the years, of surgical technicians doing a poor job or increasing site infections or not decontaminating or sterilizing instruments, like in the last few years, that would kind of be-- warrant why we want to start?

CASEY GLASSBURNER: So there have been some documented cases of infections that have been related to poorly decontaminating and sterilizing surgical instruments. That is a duty of the surgical technologists. In some facilities sometimes it's done by sterile processing personnel, as well. Some of those have hit the news, but you wouldn't necessarily-- it's hard to track a surgical site infection, right? There are lots of pieces that go into that. But what we know is that the surgical technologist is specifically trained in minimizing the risk that's associated with the patient getting that surgical site infection. Aseptic technique is what they're specifically trained in and also the processing of the instruments. And so it only makes sense that if the people are more educated, then they would be less likely to be creating an environment where the

patient would be likely to get those things. There are some states such as Virginia that does require the graduation from the program and the certification, and they tracked some hospitals before they actually required that. They tracked hospitals that had gone above and beyond and put that in place, and they showed that those hospitals that have those requirements did have less surgical site infections than those hospitals that did not require the graduation and the certification for their surgical technologists.

B. HANSEN: OK.

CASEY GLASSBURNER: Now to specifically track it back to one specific thing is really difficult because there's a lot of pieces in that surgical site infection. But we know that surgical site infections are a real thing, and we know they cost a lot of money and they can be deadly to patients. And we know that the environment that exists in Virginia exists here and in every other operating room that there is in the entire country.

B. HANSEN: And do you see creating a registry would decrease instances of--

CASEY GLASSBURNER: I do because I believe that, even though it still allows the on, on-the-job training, it would have to-- at some point these individuals have to prove that they have that minimum education, that that basic knowledge of sterile technique, asepsis counting procedures to make sure that nothing is left behind inside a patient, you know those kinds of things that are the basic duties of a surgical technologist. If they can demonstrate that they are competent in those skills, then they're demonstrating that they're capable of providing a minimum level of patient care, because right now anybody, without any education whatsoever, can be hired and put in an operating room and have somebody in there with their hands inside a patient. And nobody is tracking how they're trained, what they're being trained, or how competent they are in their practice.

B. HANSEN: And so would a registry-- this is kind of leads to another question I had. I don't mean to ask a bunch of questions here; I'm just-- you know, it appeases my curiosity, I guess.

CASEY GLASSBURNER: Of course.

B. HANSEN: So a surgical technician who does not-- do they-- so say they graduate from school and they want to become a surgical

technician in Nebraska. Do they have-- so say this gets passed. Do they, do they have to register? Or can they still practice without being on the registry?

CASEY GLASSBURNER: They would have to register but all they have to do is show that they graduated from a program.

B. HANSEN: OK.

CASEY GLASSBURNER: So, so--

B. HANSEN: So by law, they would have to say-- they have to be a part and pay the fee--

CASEY GLASSBURNER: Yes.

B. HANSEN: -- to be a part of this registry.

CASEY GLASSBURNER: Yes.

B. HANSEN: To be a part of it, OK.

CASEY GLASSBURNER: So that they could be tracked and so that they can fall under mandatory reporting, which offers that disciplinary action.

B. HANSEN: OK. And I noticed one of the justifications you mentioned was an incident in Colorado.

CASEY GLASSBURNER: Yes.

B. HANSEN: Does Colorado have the same laws as Nebraska's? Do they have a registry and do they have licensing?

CASEY GLASSBURNER: They now, they now have a registry. They did not before that instance happened, but they now have a registry in place similar to the one that we are attempting to enact here.

B. HANSEN: OK, all right. And is there-- again, whenever you want to pass a law, you're going to make sure that it's justified.

CASEY GLASSBURNER: Absolutely.

B. HANSEN: So is there any other way that we can make, create a registry in the state of Nebraska without having to pass a law? Like is there some kind of private way of doing it, like an association where they can kind of create their own registry, where then other,

you know, surgeons or other hospitals can then look back at that without having to create a law or have a registration fee, like a, like a state association for instance?

CASEY GLASSBURNER: I think that's a valid point. We, in the past, have attempted to go about it as a credential of-- or as a condition of employment and put it on the hospitals for them to regulate. But the hospitals did not want to go about it that way. And when we approached the 407s, they both recommended that it was a registry that was administered by the state, that that was the best way to do it.

B. HANSEN: OK, all right. Thank you. Oh, I have one more, sorry. I don't want to manipulate the time, sorry. I just wrote notes and I'm a nerd. So in Section, Section 6-- and it says a high school graduate of good moral character is one of requirements. Who determines what's good moral character and what, what does that mean?

CASEY GLASSBURNER: I agree. That language came from the Department of Health and Human Services, and that was what they wanted to have included. We--

B. HANSEN: Just curious, you know. [INAUDIBLE].

CASEY GLASSBURNER: Yeah I, I don't know. So we--

B. HANSEN: I also [INAUDIBLE].

CASEY GLASSBURNER: We did work very closely with the department to make sure that the language was appropriate, that the registry could actually be administered. So any suggestions they gave to us about how they wanted in that wording to be included, we did incorporate that into the bill.

B. HANSEN: OK, makes sense. I didn't know if there was something in particular.

CASEY GLASSBURNER: Yes, absolutely.

B. HANSEN: And the accreditation-- so they have to be accredited by certain groups or a certification of competency, competency assessment completed by a licensed healthcare professional. So what does that entail, like who is the licensed healthcare professional, and then how do they certify the person so they can get there in the registry?

CASEY GLASSBURNER: Yes, so we would assume that that will be defined in the rules and regs. But what has been discussed so far is that it would be either the OR director or the OR educator, because it has to be somebody who's competent with those skills. There are lots of licensed professionals out there that don't know anything about surgery because they're licensed in an area that doesn't work in surgery; these are very specific things. So it lists that the competency would include those very basic skills that are listed in the bill there. So essentially this individual would make sure and watch this person perform those skills and make sure that their skill level and their knowledge level is to a level of competence.

B. HANSEN: Thank you.

CASEY GLASSBURNER: Yes, absolutely. Thank you for your questions.

HOWARD: Other questions? Senator Murman.

MURMAN: Yeah. The incident in Colorado that you mentioned, now they didn't have a licensing requirement when that incident occurred.

CASEY GLASSBURNER: Yes.

MURMAN: If there would have been a licensing requirement at that time, would that have prevented the incident, because I assume it didn't get reported in any way?

CASEY GLASSBURNER: Right. So they would have had to have done background check on that individual. They would have utilized the registry to follow up with that specific individual. That specific individual had actually been fired from other states for the same. So the instance was this surgical technologist was stealing controlled substances off of the anesthesia cart, injecting themselves with the controlled substance, putting the dirty needle back on the anesthesia cart, and it was being injected into patients. And they were HIV positive, and it potentially infected thousands of patients. So if these individuals are regulated, then that information has to be shared. When someone is fired for that type of action that is potentially harmful to patients, that has to be reported under mandatory reporting if they are a regulated profession. So yes, it would have had to have been reported and shared whenever that individual attempted to become employed again.

MURMAN: So if there wasn't a registry, shouldn't it have been reported anyway?

CASEY GLASSBURNER: Not necessarily, because the profession wasn't regulated whatsoever. So the hospital, these individuals, so at the time in Colorado-- now they have a registry-- but at the time in Colorado they simply just, you know, hire individuals. There isn't a place for them to go and look and see what their education is, if they've had any disciplinary action because there isn't a means for them to have any disciplinary action whatsoever. They're completely unregulated and no way to follow up if these individuals do do something where they can potentially harm a patient.

MURMAN: Yeah, I'm just thinking there was dishonesty involved, you know, whether there was a registry or not.

CASEY GLASSBURNER: Sure, and that may be true. I don't know specifically, you know, when that individual was hired, but we would assume that if that same type of situation happened, then that information has to be disclosed. And then any potential future employer would know that that information and that specific situation had happened previously and, obviously, would not be interested in hiring that specific individual.

MURMAN: Sure, thanks.

CASEY GLASSBURNER: Thank you.

HOWARD: Other questions? Senator Arch.

ARCH: You made a statement earlier about, about this isn't going on right now. And I was just reflecting on accrediting bodies and Joint Commission. And I'm not familiar with ambulatory surgery center accreditation or even a, even a physician-based surgery center. But does not the Joint Commission on Accreditation require the, the competency test, the assessment of an individual on that? Do you know?

CASEY GLASSBURNER: I do not know specifically what Joint Commission requires. I know that Joint Commission does not have any education or competency standards for surgical technologists specifically, for hiring them.

ARCH: Right. That's up to the hospital, that's up to the hospital--

CASEY GLASSBURNER: Yes, exactly.

ARCH: -- to determine that.

CASEY GLASSBURNER: Yes, yes. Absolutely.

ARCH: But with the job description on the surgery tech, and then an assessment against that job description as part of the HR process, if that, if those, if those skills are identified within that job description, then I believe that the Joint Commission requires that you are, you are, you are testing to that job description as to, as to its qualifications.

CASEY GLASSBURNER: True, true. For those--

ARCH: I guess, I guess I was just-- the statement was so strong that like nobody knows what's going on with surgery techs. I'm not sure that that's as strong a statement as can be made.

CASEY GLASSBURNER: Sure, absolutely. For those-- and I mean there are institutions that choose to not be JCAHO accredited. They are accredited through other institutions where I'm not 100 percent sure what those regulations would be. But yes, there-- what I meant to say was that there is no regulation from the state's standpoint about what the minimum competence of those individuals is.

ARCH: That's fair.

CASEY GLASSBURNER: Thank you.

HOWARD: Senator Williams.

WILLIAMS: Thank you, Chairman Howard. Thank you, Casey, for being here--

CASEY GLASSBURNER: Thank you.

WILLIAMS: -- again this year and for your passion on this issue. You have been a surgery tech for a number of years.

CASEY GLASSBURNER: Yes, since 2005.

WILLIAMS: You represent and know a lot of other surgery techs, have worked with them at Nebraska Heart and the other places that you've

participated. Do you-- or any of them-- do, do you see this as a barrier to entry into this profession, and would you explain that?

CASEY GLASSBURNER: Yeah, absolutely not. Even with the fiscal note at higher than it has been in the past, it estimated that the fee was biannually at $100, so $50 a year. I do not see that as a barrier whatsoever because, as I mentioned before, this legislation does not require individuals to go back to school or even take the national certification exam. Even if they do choose to go to school-- I happen to be an instructor in the surgical technology program at Southeast Community College, as well. Our program is currently approximately $6,000, so it is very affordable even if they would choose to go to school. We have seen some individuals who have been on-the-job trained, and then their hospital says we want you to go to school, and they'll pay for them to go back to school so that they can get the actual education and become certified, as well. But I do not see $50 a year-- or even if that's what it is-- but we believe that would be on the high end. But even if it was $50, I do not see that as a financial hardship or a barrier to someone coming in to the profession. It simply would be a, a-- considered a professional due as a part of being a healthcare professional. I think there are very-- in fact I can't even think of a profession that's regulated that doesn't have a fee of some kind, right? Even a CNA or a medication aide, aide pays a fee. And when we talked about this registry, it was mirrored after the medication aide registry, so we assumed that the fee would be very similar to that when we went through the 407, some we're talking about that.

WILLIAMS: Thank you.

CASEY GLASSBURNER: Yes, thank you.

HOWARD: Senator Cavanaugh.

CAVANAUGH: Would the fee be-- would it be possible for the employer to pay the fee?

CASEY GLASSBURNER: Yeah, absolutely. I mean that would be up to an employer's stance, if they decided that that's something they would want to do. There are several employers out there that have paid for their surgical technologists to sit for their certification exam, and they've told them-- they've had them pay up front and, as soon as they

passed it, then they would reimburse them just because they felt that it was something that was good professionally for them to advance.

HOWARD: Any other questions?

B. HANSEN: Can I have one? Is that OK?

HOWARD: I don't know, Senator Hansen. No, go ahead.

B. HANSEN: I usually don't ask a lot of questions. This is--and again, whenever-- and thank you again for answering my questions. So again, when we look at passing something like this, I always like to look at future implications, too, as well. Do you-- and this might be a little irrelevant possibly-- but do you see creating this registry, passing this law, as a first step towards licensing in the future at all, by chance?

CASEY GLASSBURNER: No, absolutely not. There is not a surgical technologist license in this entire country, so every other state that, that regulates surgical technologists does it either through a registry or mandatory education and certification. There is not a single surgical technologist license out there, and that has never been the end goal whatsoever. Patient safety is the end goal and, if that can be achieved through a registry with minimum competency and mandatory reporting requirements, then that is plenty; and that's exactly what we're going for.

B. HANSEN: OK, thank you; appreciate it.

CASEY GLASSBURNER: Thank you.

HOWARD: All right. Any Other questions, last call? All right. Thank you for your testimony today.

CASEY GLASSBURNER: Thank you.

B. HANSEN: Thank you.

HOWARD: Are there any other proponents? Good afternoon.

CRYSTAL LIVINGSTON: Good afternoon. Chair Howard and members of the Health and Human Services Committee, my name is Crystal Livingston, C-r-y-s-t-a-l L-i-v-i-n-g-s-t-o-n, and I am the administrator for Doctors Outpatient Surgery Center in Lincoln, Nebraska. Our facility is an ambulatory surgery center that provides surgical services in

nine different specialties. We are licensed and accredited by the Joint Commission and members of the Ambulatory Surgery Center Association, the Association of periOperative Nurses [SIC], the American Society of PeriAnesthesia Nurses, and the Association for the Advancement of Medical Instrumentation. I have the privilege of speaking to you regarding my request for your support in LB205. I present my support for this bill from the standpoint of a healthcare leader, as well as a healthcare consumer. The creation of a surgical technologist registry improves the quality and safety of care provided to patients in Nebraska. As a leader, I am responsible for hiring safe and competent healthcare professionals for my facility. Additionally, as a consumer and potential patient, I have the expectation that all of those that may care for me in any healthcare setting receive, receive consistent oversight and regulation. According to the Association of Surgical Technologists, surgical techs are currently the only members of the surgical team not required to meet certain educational standards or to be certified. Surgical patients do not have the ability to decide who will care for them during their operative experience. Most will likely assume that all staff members are vetted by the same standard reviews and requirements. All patients deserve to have surgical team staff members that have proven to be educated, trained, and competent. This includes the surgical technologists. A registry for surgical technologists provides a means of mandatory reporting for these healthcare professionals. When hiring new staff, I have the responsibility to research each healthcare professional to determine if they are current in their license and certification, as well as whether they've had any disciplinary action on their license. These possible actions can include abuse, diversion of substances, falsification of documentation, abandonment, etcetera. The surgical technologists are the only care-providing employees that I cannot perform this important preemployment task on. Mandatory reporting helps to prevent an individual from continuing to transfer employment from one facility to another. In addition, reporting allows consistent disciplinary action to take place, similar to what is already established for other registered healthcare professionals. In summary, please support LB205, allowing the creation of a registry for surgical technologists in the state of Nebraska. I'm asking you to consider the safety of each surgical patient across our state and recognize that we have the right to receive care from surgical team members that are confirmed to have received a standard level of education, training, and competency in their skills. Thank you for your time and consideration.

HOWARD: Thank you. Are there any questions? Senator Williams.

WILLIAMS: Thank you, Chairman Howard. And thank you, Ms. Livingston, for being here today and testifying. So you're hiring somebody right now--

CRYSTAL LIVINGSTON: Um-hum.

WILLIAMS: -- and somebody comes in and applies for a job as a surgical tech. What do you do?

CRYSTAL LIVINGSTON: I call references. However anybody can--

WILLIAMS: Could you explain what that is?

CRYSTAL LIVINGSTON: Sure. Employees are-- potential employees will provide references upon request, and they'll also provide information on previous employment facilities and time when they worked in those facilities. I can call those facilities, and the majority of those facilities will just tell me the dates of employment; they will not give me a personal reference. So then I lean to the personal references that are presented to me. Now those are based on what that employee or that individual wants to give me. So it's their choice on who they give to me to call. And so I reach out to those individuals and ask about work history, you know, skills if, assuming that those are individuals that worked with them. Sometimes they'll provide just a personal reference, somebody that knows them, you know, on a personal side. And that's really all I have to work with.

WILLIAMS: So how do you, from that information, determine their technical competency?

CRYSTAL LIVINGSTON: When once hired-- and Senator Arch kind of touched on this-- once hired, we do our training, and then we have them go through as, a level of, as, a series of competency checks. So we will provide our baseline education on our facility, our policies, our procedures, and we will put them with a preceptor and they will work together as they go through different procedures. And then we will have them checked off on a competency level that we've established. But anything prior to that, any experiences prior to that, any issues they may have had in previous employments, any wrongdoings, I cannot see. If I would look at a nurse's or a CNA, a certified nursing assistant, look at their license or their certifications or their registries, I can pull that up and I can see if there's any

disciplinary action. But I would do the same, on a competency level, for all of my healthcare professionals because we have a Joint Commission accreditation that we have, we must live up to.

WILLIAMS: One final question then. Would you see this as a barrier to entry into the surgery tech profession?

CRYSTAL LIVINGSTON: I do not. Now I am a nurse; I am not a surgical tech. However, I've worked with many surgical techs over the years, and I have six on my staff right now. And of those-- there are actually seven-- of those we had over, overarching support for this. They see this as an advancement as a profession, and they see this long overdue.

WILLIAMS: Thank you.

HOWARD: Further questions? Senator Arch.

ARCH: You, you may not know the answer to this-- and that's fine, we'll ask somebody else-- but, but does-- by creating a registry, does it automatically imply mandatory reporting?

CRYSTAL LIVINGSTON: I don't know the answer to that, but what I can share with you is, as a nurse-- and I've been under the mandatory reporting law since I was licensed--

ARCH: Sure.

CRYSTAL LIVINGSTON: I am required, as part of that registry, to report anything that I see or, or do or witness, as part of that, as part of that registry, and as part of that belonging and as part of that licensure. So can that still get through the cracks? Absolutely, but--

ARCH: I just didn't know if you were required, or a physician or if you were--

CRYSTAL LIVINGSTON: As an, as an administrator, I am, yes.

ARCH: But if you were required to report someone that is not licensed but simply registered.

CRYSTAL LIVINGSTON: Oh I understand what you're saying. Yes if there is a registry--

ARCH: And that's a little technical--

CRYSTAL LIVINGSTON: Yes.

ARCH: -- question, but--

CRYSTAL LIVINGSTON: .Yes. If there is a registry, absolutely. So if I, if I terminate an employee that is a registered, is a part of a registry or a licensure, I am required to report them in it, and at that time-- and I have done that when I have terminated employees in the past. Specifically I can think of nurses. I had to call the state, the Department of Health and the, the state, the state Board of Nursing and report them. Then the state takes it from there, as far as what to do on that licensure and disciplinary actions, but yes.

ARCH: So, so registry and licensure separate. In other words, you-- if you-- nurses obviously have a license, you know.

CRYSTAL LIVINGSTON: Correct, correct.

ARCH: So, so is there another, is another example of a, of a--

CRYSTAL LIVINGSTON: A nursing assistant is another one, um-hum.

ARCH: OK, that's a registry but not a license.

CRYSTAL LIVINGSTON: Correct, that's correct.

ARCH: OK, thank you.

HOWARD: Other questions? Senator Cavanaugh.

CAVANAUGH: Thank you for being here and your testimony today. So when you're doing your hiring practice now for surgical techs, do you currently do background checks or--

CRYSTAL LIVINGSTON: I do.

CAVANAUGH: Or drug tests?

CRYSTAL LIVINGSTON: All of the above.

CAVANAUGH: OK.

CRYSTAL LIVINGSTON: Yes.

CAVANAUGH: So this would be in addition to that.

CRYSTAL LIVINGSTON: Absolutely.

CAVANAUGH: Or is, or is this still a requirement? Would that be part of the requirement of the employment background?

CRYSTAL LIVINGSTON: Well my, my current employment is all of our surgical techs are required to be certified. But I would still, even with the certification-- I get a copy of their certification-- I look, I would, if it's a, if it's somebody that's on a registry, so all of my nurses, I go on the board of, the State Board of Nursing, and I pull up all of their licenses, licenses. I take copies of that, I look for disciplinary action; it would be all in addition to. We do background checks, we do drug screens.

CAVANAUGH: Well, just as a prior patient, I'm curious to know what the--

CRYSTAL LIVINGSTON: Yes, all of the above.

CAVANAUGH: -- what loop or what, what space where we're shoring up here.

CRYSTAL LIVINGSTON: Absolutely.

CAVANAUGH: So that part is, at least at your facility, currently covered.

CRYSTAL LIVINGSTON: Absolutely. And that is, that is part of the Joint Commission accreditation requirements, as well, so--

HOWARD: Senator Hansen.

B. HANSEN: I think the biggest question, what a lot of this is, isn't so much competency, the reason for registry, because it seems like you do your due diligence as an administrator to check competency, and follow somebody, and shadow somebody for a while, check-- you have a checkoff whether they're competent or not. It seems like whether they're having disciplinary issues that maybe we have missed, such as the incident in Colorado, that you don't want to have happening in your hospital, which might be a reason for registry. When you make professional references-- calls-- would you expect them to tell you that, like if they had some issue with somebody, like we've found these people using a wrong needle on people, you know?

CRYSTAL LIVINGSTON: You know, I think, Senator Hansen, it all depends on what kind of individuals they give you to call.

B. HANSEN: Sure.

CRYSTAL LIVINGSTON: So--

B. HANSEN: That's fair.

CRYSTAL LIVINGSTON: -- knowing that that is, is really what, what are they forthcoming with. If, if somebody really wanted the job, most likely they probably would not provide individuals that would give that information.

B. HANSEN: Sure, makes sense.

CRYSTAL LIVINGSTON: Yeah.

B. HANSEN: And maybe Senator Arch touched on this but, as an administrator or as even an employer of a surgical technician, whether in your status or not, if there was a disciplinary action, you would have to report it?

CRYSTAL LIVINGSTON: Yes.

B. HANSEN: OK, all right. And then--

CRYSTAL LIVINGSTON: If we, if I terminated an employee and if I found, if I had any diversion of drugs, abuse, neglect, abandonment-- any of those things-- I would report that.

B. HANSEN: Does that get reported to the Department of Health? Or is that--

CRYSTAL LIVINGSTON: I think it would be dependent on how this, this bill is set up. You know right now for nurses and for CNAs that goes to the State Board of Nursing. So it sounds like that is kind of all part of this bill. So that would be whatever.

B. HANSEN: I'm just trying to figure out like if we had an incident like Colorado here, without this bill, and you had that happen--

CRYSTAL LIVINGSTON: I wouldn't have any place to-- if the registry didn't exist, I wouldn't have a place to report it.

B. HANSEN: OK. You would just fire them, and then nobody would know anything.

CRYSTAL LIVINGSTON: Yep, yeah. And I would hope that somebody would call me before they were hired someplace else, and I would have the opportunity.

B. HANSEN: I think there'd be a place for you to be able to report it, like the Department of Health or somewhere else, and then in the state, as it, you know--

CRYSTAL LIVINGSTON: There's not a, there's not a receptacle; there's no kind of, you know, there's no place for that information to go.

B. HANSEN: OK, just wondering. Thank you.

CRYSTAL LIVINGSTON: Yeah.

HOWARD: Other questions? Senator Murman.

MURMAN: Yeah, now I'm a little bit confused. If, if there was no registry and someone called you as a reference, you could tell the person that called you that there was a problem and what that problem was--

CRYSTAL LIVINGSTON: I would, yes.

MURMAN: -- with that employee.

CRYSTAL LIVINGSTON: So we don't have any rules within our facility from an HR perspective that says that I can only tell another person for an individual seeking employment that the, of the dates. So many, many hospitals-- in fact the hospital I previously worked at-- the HR department was only allowed to tell somebody the dates that that individual was employed. They weren't able to tell any additional information. So myself, I don't have those, those rules within our HR at our facility, so I absolutely would have that conversation. But, but again, I'm assuming that that individual put me down as a reference. And, and again, if I was the one that terminated them, they're probably not going to.

MURMAN: So if, if, if they were employed at a hospital that wasn't, well, wasn't under the same regulations or rules or, or had the same honesty, I guess, maybe that you have, would, would it still be reported if someone would call that place for a reference, or would

they just give the dates of employment? You know, maybe they didn't necessarily give that hospital as a reference, but the person that was going to hire them, you know, discovered they worked there somehow.

CRYSTAL LIVINGSTON: Yeah. I can't speak to what everybody, what every hospital's rules are within their HR. I just know from my experiences that several of the hospitals here in Lincoln, that that's the rule that they have, is that they'd only give those dates. It doesn't stop me. I still call them and verify dates of employment, but that's generally the only information that I get.

MURMAN: That, and then, also, if there was a registry, that would take care of that problem that you--

CRYSTAL LIVINGSTON: That would give me an additional place to go and look if there was any disciplinary action on that individual. So if they were found, by the Board of Medicine or whomever is their regulatory body, if there was anything on their license-- if they had been suspended, if they had been found to be, you know, to have any kind of infractions-- that I would find out there and then I would not-- I would stop my hiring process at that moment.

MURMAN: OK, thanks.

CRYSTAL LIVINGSTON: Um-hum.

HOWARD: All right. Any other questions? Seeing none, thank you for your testimony today.

CRYSTAL LIVINGSTON: Thank you, too.

HOWARD: Any other proponent testifiers? Good afternoon.

ROBAK: Good afternoon, Senator Howard and members of the committee. My name is Kim Robak, K-i-m R-o-b-a-k. I'm here today on behalf of the Nebraska Medical Association, in support of LB205, specifically the amendment. Let me give you a little bit of background. It goes back to 1890 [SIC]. There was a-- literally 1890 [SIC]. There was a physician practicing in North Platte, Nebraska. His name was Dr. Bedell. And Dr. Bedell must have been very busy because he had two people working with him who were not doctors but were actually acting like doctors. And in fact, one of them was a man by the name of Howard Paul, and Howard Paul actually amputated someone's leg. And the, the case-- there's actually a Supreme Court case called State v. Howard [SIC], and it doesn't actually say what happened to the individual whose leg was

amputated, but there was a lawsuit. It went all the way up to the Supreme Court. And in this lawsuit, Mr. Paul said the reason that I'm, I shouldn't be found guilty for practicing medicine without a license is because I was following Dr. Bedell's orders. He told me what to do, and I was simply delegated the responsibility to amputate the leg. He actually won in district court. It got appealed up to the Supreme Court, where he lost. But because of that case, State v. Howard [SIC], the Department of Health and Human Services has taken the position that medical providers-- physicians-- cannot delegate duties to people who aren't licensed or credentialed. And as a result there have been a number of instances where individuals have had to become licensed or credentialed in recent years. One of them was a surgical first assist. Some of you who have been on this committee know that case or know of that. The surgical first assists have now been licensed. Dialysis techs were also asked to be licensed; I think that ultimately there was an agreement made that they didn't have to be licensed. And now we have surgical techs. So the Nebraska Medical Association supports this bill, but specifically, what we support is on page 9 of the amendment, lines 3-12. And those are the pages, that's the page, the last page of the bill that-- and it sets out the underlying language on the last page of the bill. And what that language does is say doctors can delegate to people within what's reasonable in the medical community and what's reasonable as to the training of an individual so that everybody doesn't have to be licensed or credentialed in some regard in order to be able to delegate. That language would be very helpful to physicians and to the Nebraska Medical Association, and so for that reason, we support this bill with that language in it. And I would be happy to answer any questions that you have with that, in that regard.

HOWARD: Are there questions?

WILLIAMS: I won't ask it.

HOWARD: I have one. Thank you for drawing our attention to this area in page, on page 9 of the amendment-- and this is the first time I'm seeing the amendment. So essentially what this provision would allow, it allows delegation?

ROBAK: It allows delegation. What it does is it actually-- I didn't want to get into this but I will-- there are actually two categories: those that have licenses and those who are, what are called in this language nonprofessionals--

HOWARD: Right.

ROBAK: -- and so it allows you to delegate to both within the standard of care within the community, and also within the training of the individual who's being delegated to. So in, prior to this, before the surgical techs would be licensed or, or registered, if the doctor or the person who was delegating thought this person had sufficient credentials, they could delegate to them without the Department of Health and Human Services coming after them. Same thing with surgical first assists-- if they weren't licensed, a physician could do that.

HOWARD: Do we have a definition of what a nonprofessional assistant might be?

ROBAK: That I couldn't tell you, Senator; I don't know that. I do know that the department has seen this language. I believe the department has seen this language, and I believe that the department is OK with this language, but I think Senator Kolterman can answer that question when he, when he closes.

HOWARD: There's no possibility that a nonprofessional assistant could be like the janitor working at the hospital; we don't delegate--

ROBAK: The physician is responsible in that case. If, if-- I'm imagining if there were an emergency, and someone needed to hold somebody, and a physician thought the only person around that could do that, then the physician. But if the physician was, was delegating to somebody who didn't have proper training, the physician is liable and, if it's in a hospital facility, I'm guessing the hospital facility is also liable.

HOWARD: And then this would make moot the 1890 [SIC] decision.

ROBAK: This would make moot the 1890 [SIC] decision.

HOWARD: Thank you. Other questions? Senator Hansen.

B. HANSEN: Kim, this doesn't have-- this hasn't too much to do with-- does this have a lot to do with the registry itself still? Or just more like--

ROBAK: This has very little to do with this bill. This has to do with other instances that have happened in the past couple of years and

ones that we hope not to happen in the future. So it has very little to do with this particular credential. Um-hum, um-hum.

B. HANSEN: Just was, just was wondering. All right, thanks.

HOWARD: Other questions?

WILLIAMS: I can't resist. [LAUGHTER]

HOWARD: Senator Williams.

ROBAK: You have, you have me so-- I'm so curious, I'm so curious.

WILLIAMS: Thank you, Chairman. And if we pass this amendment, Dr. Paul's patient would have been OK because he didn't have a leg to stand on [LAUGHTER].

ROBAK: Oh, oh.

HOWARD: You've been saving that.

WILLIAMS: I've been saving that.

ROBAK: Very good, very good.

HOWARD: All right. Any other questions? Thank you for your testimony today.

ROBAK: Thank you, Senator.

HOWARD: Our next proponent testifier? All right. Before I move to opponents, I'll read into the record. We have several letters: one from Stephanie Whalum from the Association of Surgical Technologists; John Tennity, representing himself-- he's a Lincoln foot and ankle surgeon; Ben Greenfield, he's associate, an associate professor at Nebraska Medical Center; Meagan Carter, she's representing herself-- she's a nurse, an RN first assistant and certified surgical technologist at SurgiCenter in Norfolk; Heather Ware, representing herself-- she's a nurse at Bryan Health; Marcene Elwell, representing herself-- she's an RN and certified surgical technologist and surgical technology program director/educator; Casey. Glassburner, representing herself-- an instructor of surgical technology program at Southeast Community College; Crystal Livingston, representing herself-- administrator for Doctors Outpatient Surgery Center in Lincoln; and Andy Hale, representing the Nebraska Hospital Association. I will now

open the floor for any opposition testimony. It's faring well. Good afternoon.

MAGGIE SUMMERFELT: Good afternoon, Chairman Howard and members of committee. My name is Maggie Summerfelt, M-a-g-g-i-e S-u-m-m-e-r-f-e-l-t. I am the administrator at Advanced Surgery Center in Omaha Nebraska; we've been a center for 13 years. And I am here in opposition of senate, of senate bill, of LB205-- you can tell I'm not a Nebraska local-- introduced by Senator Mark Kolterman. You've heard testimony that LB205 is being presented as a tool to increase safety for patients undergoing medical procedures. I definitely defer to agree with that statement. I do not believe it's a safety issue, but it is legislation intended to increase barriers to entry for a profession that's already facing a shortage of workers. I'd like to summarize my four points of objection to this proposed bill. There are no safety issues to address. Over four years the proponents of the bill could not cite one instance in Nebraska of patients harmed by a certified or uncertified surgical technician-- technologist. At our facility, the operational structure of the operating room mandates teamwork, and a surgical tech is a member of that team that works together to ensure patient safety and quality. The process includes checklists. I think many of you probably have heard that we followed the, the pilots' checklist; that's kind of how they all got started. So the whole team participates in that checklist. It includes whether there's-- the patient has any kind of allergies, what the procedure is, which side the procedure is going to be presented on, etcetera. It's a whole, a whole line of, of checklists, and everybody has their part in that, including the scrub tech. And I'm sorry, I will enter-- I should say that scrub tech, to me, is-- surgical technologist is a scrub tech to me, so I apologize for my language. The CMS and our accrediting bodies for surgery centers also require that same kind of information. And to answer something that everybody's been talking about, as the administrator of a surgery center, if something happened in my surgery center that happened in Colorado, my call would be to the police. So we do have ways of mandating things like that. Patients have not asked for this bill. I think it's been said before that most patients don't even know what a scrub tech is or a surgical tech, but they do play a very important role; that certainly is never going to be argued by anyone in a surgical setting. But their role is to assist the OR nurse and the surgeon. And it's important to remember that they do not perform independently and, to me, that's the idea of what's behind a registry, registry or licensure is that the practitioner can independently practice; their surgical tech does not. They follow the

direction of the circulating OR nurse, to be specific, and ultimately the surgeon. I think it's been stated that there is approximately 15 states that currently require registration, and it's only 15 because, again, surgeons are responsible for the supervision of these individuals. Nebraska historically does not have a history of overregulation but I believe that LB205 puts Nebraska ahead of some of those kinds of states. As I said, it's a team that functions in the OR; however the surgical tech is a member of that team, not the leader of the team and, therefore, does not require registration. At our center as in most centers, as I said before, the circulating OR nurse takes that responsibility with the ultimate direction being done by the surgeon. I do believe that LB205 would increase barriers to the entry of surgical technology field. The basic tenets of economics reflect that increased barriers to a profession will restrict the supply of workers in that profession, which would lead to higher costs for hospitals and surgical centers. With fewer surgical techs to hire, facilities would be forced to use RNs and, as you can probably know, RNs are much more costly than surgery techs. And we already are experiencing an RN shortage in the state of Nebraska. Now at our facility we've been very fortunate to have surgical techs that have worked at our facility for over 10 years. All, all four of them have graduated from accredited schools, but only one is certified and yet they all work equally, they meet the same requirements, and they perform the same duties. If you went up to one of our surgeons and asked which one was certified, which one graduated from a school, which one had on-the-job training, they would not be able to tell you. They are all treated the same, they are all given the same responsibilities, and they take on the same roles. So to us, our center and our surgeons, it's not important whether they're certified; it's how their job, job performance is and, obviously, the facility is responsible for that. So I believe it's not about safety. I think it's more towards trying to move towards licensure or a national certification or some kind of, of ability to control this. The barriers to entry created by LB205 and its follow-up legislation would reduce the labor supply, increase costs and-- to both the tax and the consumers-- and add to government overregulation.

HOWARD: All right. Are there any questions? Senator Williams.

WILLIAMS: Thank you, Chairman Howard. And thank you for being here for your testimony. I just have one question. You mentioned the team

concept and working as a team. Who else on that team is not certified or not registered?

MAGGIE SUMMERFELT: The team really consists, in our facility-- and I'm going to speak just solely on mine-- is the surgeon, the nurse, and the scrub tech.

WILLIAMS: So is there any other member besides the surgeon--

MAGGIE SUMMERFELT: Well, we have, we also have instrument techs, but they're not necessarily in the OR at the same time. Their responsibility is to clean the instruments.

WILLIAMS: OK, so my question then is, in the OR-- and you talked about this team working together-- there is no one else on that team that is not registered or certified?

MAGGIE SUMMERFELT: Correct.

WILLIAMS: Thank you.

HOWARD: Other questions? Seeing none--

B. HANSEN: Whoop, whoop-- got one.

HOWARD: Whoop, whoop, Senator Hansen. All right. You got to jump in.

B. HANSEN: So you mentioned about some of this might cause some increased barriers to the profession. What do you see as being a big barrier if this was passed? Is it more the financial obligation that they pay every year, or is it increased, you know, compliance that they have to do to follow up with the law now? Or is there something specific?

MAGGIE SUMMERFELT: I think a lot of it's cost. I mean I had the opposite. I asked my scrub techs. I said you know, how do you feel about this? And they were all very much against it; they don't feel it's necessary. I mean, when you asked that question about whether-- who else isn't licensed or registered, the other people have much more of a direct contact with the patient. And again, to me, that's what the sign of registry or licensure is more of an independent practice. I mean nurses and doctors obviously practice independently. A scrub tech can't go put a shingle on a door. I mean, they cannot do anything independently. So I mean, our, our scrub techs see no reason for it. There are certainly ways of man, of controlling their behaviors in the

OR. I mean, as, as it's been said, they are a very important part of sterile technique. But we certainly would not-- they wouldn't have a job if they weren't good at what they did. So I think it's financial. Yeah, I mean they're not high paid professionals. They--

B. HANSEN: Thank you.

MAGGIE SUMMERFELT: I think it would be a financial barrier for them. And that-- again, that's what they told me.

HOWARD: Senator Walz.

WALZ: Yeah, thank you. Thank you for coming today. In the beginning of your testimony, you talked about that you haven't had any reports. Can you go over that first sentence that you talked about, in that you haven't-- there haven't been any problems or--

MAGGIE SUMMERFELT: Oh, in the state of Nebraska, no. We have not had any issues with the-- at least to my knowledge.

WALZ: Right.

MAGGIE SUMMERFELT: And we certainly haven't had any at my facility.

WALZ: OK. So then my question was going to, going to be, how, how would you know if there were problems?

MAGGIE SUMMERFELT: Well, if there's anything that affects patient care, we are really obligated to report that to the state, if anything major would happen like that. And we also, if anything happens in the OR room that's going to have a negative effect on the patient, we are also obligated to talk to the patient about what happened.

WALZ: Um-hum. If it's reported to the state, is there a way that, if that person moved on to another, to apply for another position, that that facility would know that there was a problem?

MAGGIE SUMMERFELT: That I don't, I, I would be guessing. Maybe there's somebody else more adequate to answer that question; I don't know. I mean, one of the questions that I-- whenever I look to hire scrub techs, one of the first questions I always ask the past employer is, would you hire them again, because a, a lot of companies don't let you ask very personal questions about their performance. And I think that's a very easy way for someone to say no. And I can tell you that

I would never hire someone that their past employer would not hire them again. I think that's a very good safeguard for most of us.

WALZ: Thank you.

HOWARD: Other questions? Senator Cavanaugh.

CAVANAUGH: Thank you.

MAGGIE SUMMERFELT: I'd rather take care of your baby than sit up here and talk to you guys.

CAVANAUGH: Yes, he's behaving for the time being. I appreciate you coming here and your testimony. Kind of in line with Senator Walz's questions, so this bill would create the automatic reporting of incidences, and the conversation about what happened in Colorado is sort of illustrative of a huge mistake. But there's a lot of other mistakes that can happen in an OR with any of the individuals there. And without that automatic reporting, it's not something that's going to show up in a background check, it's not going to-- something that's going to show up on any sort of registry, as you and Senator Walz were just discussing. So kind of piggybacking on her question, do you have a thought as to-- I mean, I know you can call an employer and they can tell you no, I won't hire them again. But do you have a thought as to how we can solve for these mistakes that are half-- that could potentially be happening that could be life threatening, that could be causing infections, that are going unreported and undocumented?

MAGGIE SUMMERFELT: Again, the, the surgical tech is not the responsible person in the OR. If something happened in the OR to-- whatever bad thing happened, the nurse or the physician would be ultimately responsible, and that would be reported.

CAVANAUGH: OK, thank you.

HOWARD: Any other questions? Seeing none, thank you for your testimony today.

MAGGIE SUMMERFELT: Thank you.

HOWARD: Other opposition testifiers? And could I see a show of hands of how many folks are still wishing to testify on this bill? Just a few, OK. So now, good afternoon.

TIFFANY WEEKS: Thank you, Chairman Howard and members of the HHS committee. My name is Tiffany Weeks, T-i-f-f-a-n-y W-e-e-k-s. I'm a registered nurse and currently serve as the clinical director at Urology Surgical Center here in Lincoln. I'm testifying today in opposition of LB205. LB205 is being presented as a means to increase safety for patients undergoing surgical procedures by requiring surgical technologists to register and complete additional competency requirements. I've served in a nursing leadership role directly responsible for patient safety, quality, and accreditation in the surgical environment, both in a hospital setting and ambulatory surgery center, for the last 15 years. I was awarded the South Dakota quality professional of the year award in 2013 for significant improvements made in patient safety. I have a passion for quality and uphold the values and scope of my registered nursing license, as a patient advocate. I'm here to tell you today that this bill is not about safety or quality. The surgical technologist functions as an important part of the surgical team. Teamwork and communication in the operating room are key to quality and patient safety. There are already reporting structures in place, mandated by CMS regulation, clearly delineating that surgical technologists are under the supervision of the RN. The Association of Operating Room Nurses sets forth accepted best practice for patient care in the operating room environment. Its accepted physician statement is that the perioperative RN circulator delegates, supervises, and evaluates the activities of other team members while simultaneously executing immediate directives and interventions in urgent and emergent situations. A key facet in quality is that structure facilitates process, which facilitates outcomes. The current structure is effective because the RN circulator has received training and leadership and delegation, and can also function in the scrub role as a surgical technologist. These roles are regulated under the Board of Nursing currently. This alignment facilitates competency development and supports team-based orientation and education in the perioperative department. In addition, the current structure promotes shared accountability for patient safety and facilitates teamwork in a highly complex and high-risk environment. Through this proposed bill, the reporting structure and team-based competencies at the local level could be disrupted, which, which will have a negative impact on teamwork, communication, and ultimately patient safety. In addition to the disruption this will cause in the operating room, there are also important implications for the work force. In previous testimony to the HHS committee, and in the DHHS 407 credentialing review process, the supporters of this bill have repeatedly made claims that adding

barriers to entry for the surgical technology field will not reduce the number of surgical technicians in Nebraska. This really defies logic and ignores that hospitals and surgical centers are already finding it difficult to hire surgical technologists. Personally I've been trained to recruit a surgical technologist for an open position since the beginning of December and have had less than five qualified applicants during that time-- since that time. I'm concerned that this registry will be perceived as additional burden for surgical technologists who may move across state lines for better opportunities or seek jobs in other fields with less regulation. If there aren't enough surgical technologists in Nebraska, hospitals and surgery centers will have to start using registered nurses for this role. If a registered nurse is functioning in that role, then we are forced to hire another registered nurse to take his or her place, and that's what I'm currently doing in our surgery center right now; I'm backfilling that surgical tech role with a registered nurse. This creates higher demand for nurses, nurses' wages will increase, and downstream costs of care increase for all consumers. We already have a nursing shortage and LB205 could make it worse. When barriers to entry increase for specific occupations, labor supply falls-- excuse me-- labor supply falls further, wages increase even more. Most importantly of all, there has not been rationale or documentation of harm to patients as a result of unregistered surgical technologists in Nebraska. Competencies are already defined and required through CMS, there is already a reporting structure that facilitates teamwork and communication in a high-risk environment, and several evidence-based protocols are in place in the operating room that rely on these aforementioned principles to keep patients safe and promote quality outcomes. The additional regulation proposed will certainly have a negative impact on the work force and will increase cost at facilities and patients across the state of Nebraska. And I apologize, I forgot to give you my form. I would welcome any questions.

HOWARD: Are there questions? Senator Walz.

WALZ: I just have to have some clarification, because I'm a little confused. You talked about additional competency requirements. How today, how are you making sure that they are competent to do the job?

TIFFANY WEEKS: So similar to what was described previously, upon hire-- well, let me take a step back. During the application process, a lot of questions to better understand their experience, their competency, are asked of the applicants. We do background checks, we,

you know, make reference calls, all of those things. When the individual starts, then we ask them to help us understand where they currently are at in their practice, and so they do kind of a self-assessment of competency. They're paired up with a preceptor, so somebody who is already-- we've already defined as qualified in our facility, another surgical tech in this situation who is really side-by-side with them. And they're side-by-side with them until they go through a checklist of multiple different requirements of the job, competencies. Can you do this? Can you do this? Can you do this? And Can you do this independently? And are you skilled and are you proficient? Do you still need oversight? And so we go through that process, and it's not until that individual-- and it's not until the individual says they feel comfortable and their preceptor says I feel comfortable that this person can practice independently, that they are allowed to do so. In addition we received, you know, significant feedback from the RN circulator who's present for these cases, as well as the surgeon, who, who can provide firsthand feedback as to whether or not that person, you know, is competent, you know, practicing safely, you know, meeting the requirements of the job.

WALZ: So would that be, would that be the same thing as certification of competency assessment completed by a licensed healthcare professional? Would that be the same?

TIFFANY WEEKS: In terms of what's proposed in the bill?

WALZ: Um-hum.

TIFFANY WEEKS: I guess I don't, I don't know. I would say it could-- in my opinion it could certainly meet that requirement. And you know that current structure is something that's in place for any individual, really, that comes, that comes into the facility. I know you asked about other individuals who are not currently registered and, not in my current facility but in previous hospitals, you know, we have sterile processing technicians who process instruments and assist with OR room turnover. So they come in, they help clean the room, they help set it up for the next patient. They're not registered or licensed, but they go through that exact same competency process to make sure that they can do their job safely. Not until they're checked off are they allowed to do so independently. Anesthesia technicians do the same thing; they help set up anesthesia carts and medications and make sure that all of the anesthesia equipment is clean and prepared

for the next patient's use, so kind of a similar situation. And they would go through that same competency process, so--

WALZ: OK.

TIFFANY WEEKS: I don't know if that answers your question.

WALZ: I guess I'm just trying to, to determine whether or not there really is additionally, additional competency requirements that you talked about, because I'm not, I'm just trying to determine if there really are--

TIFFANY WEEKS: Yeah.

WALZ: -- or if they're being met--

TIFFANY WEEKS: Right.

WALZ: -- without having to go to school or--

TIFFANY WEEKS: Right. And my understanding-- or my understanding of the intent of the bill, at least in previous renditions of it-- is that there were additional competencies attached. And it is a little bit vague in how it's currently-- so I'm not 100 percent sure if that's the intent also.

WALZ: OK.

TIFFANY WEEKS: But I do know that there are already currently competencies that are in place and, you know, that is part of our CMS, part of our Medicare or, if you have an accrediting body, that is a requirement to make sure that individuals are competent, so--

HOWARD: All right. Senator Williams.

WILLIAMS: Thank you, Chairman Howard. And thank you for your testimony. In your testimony you talked about the fact that, in your judgment, this legislation would cause disruption in the operating room. In your testimony, through this proposed bill, "reporting structure"-- reporting structure, I'm not sure there is any-- "and team-based competences at the local level are disrupted, which will certainly have a negative impact on teamwork, communication, and ultimately patient safety." I'm not following your testimony.

TIFFANY WEEKS: Yeah, so when Mrs. Glass--

WILLIAMS: I don't know what the reporting requirement is you're talking about and how this would be disruptive in the operating room.

TIFFANY WEEKS: Sure, sure. So in the operating room, as it currently stands, the AORN has designated the circulating nurse as responsible to be the patient advocate. The circulating nurse is responsible to watch all of the activities in the operating room, to supervise, to delegate, and to really be the voice for the patient, who is unable to speak for themselves. Currently there's multiple people that come in and out of an operating room, so you could have, you know, the individuals I just mentioned, you could up radiology staff, you could have laboratory staff. The registered, the registered nurse is trained and responsible to oversee all of that. The surgeon is very focused on the operative field, so focused on, you know, what is right in front of him or her, and is very focused on taking care of that patient. The surgical tech-- and often there's more than one surgical tech in an operating room-- the surgical tech is responsible for setting up equipment and supplies, and making sure that we have a sterile field. And they're human and so they're very task focused, the surgeon is very task focused, the person that's running the X-ray machine is very task focused. And so the operating room nurse is there to observe the entire process and speak up if something isn't right. And so in the event a surgical technician-- or excuse me, a surgical technologist-- breaks sterile technique, it's the operating room nurse's ultimate accountability to say, oh, I think you just bumped your table, or, that instrument was dropped; we need, we need to stop, we need to, to do something before we can proceed. And as this, as this bill is currently written-- and my understanding was with it falling under the Board of Medicine-- that some of that accountability to the, to the nurse really being the leader in that operating room and really being that advocate and having supervision for the surgical technologist, some of the balance of that is shifted and so that's where-- I think you'll hear from the Nebraska Nurses Association and also the American Operating Room Nurses Association [SIC]. That's where the concern is, is that you potentially disrupt some of that-- it's not reporting structure that you're probably right, that's not the right word, but more so you create almost two different, two different paths for, for who's actually observing and, and supervising that surgical technologist; and I think that's what the concern is.

WILLIAMS: Thank you.

HOWARD: All right. Other questions? Seeing none, thank you for your testimony today. Our next opponent testifier? Good afternoon.

DOUG WYATT: Good afternoon, Senator Howard and the rest of the committee. My name is Doug Wyatt; it's D-o-u-g W-y-a-t-t, and I'm the administrator at the LOC Surgery Center, and I'm testifying in opposition of LB205, adopted by the Surgical Technologist Registry Act [SIC], introduced by Senator Kolterman. We've entered into a phase where legislators across the country are rigorously rooting out unnecessary vocational licensing, and LB205 is kind of a poster child for this unnecessary regulation. From the, from a statutory standpoint, the initial two requirements of Section 71.6221 of Nebraska statutes indicate that the health profession shall be regulated only when: a) the unregulated practice can clearly harm or endanger the public; or b) the regulation does not impose significant new economic hardship on the public or significantly diminish the supply of qualified practitioners or otherwise create barriers to service that are not consistent with the public welfare and interest. LB205 fails to meet these requirements. First, there is no data to suggest that the patients are receiving substandard care under the current delivery model. Surgical technologists have assisted in over 29,000 surgical procedures in our surgery center since it opened in 1999, all of them done with a surgeon right by their side and all done without incident or concern about their performance. The surgical tech lobbyists have previously discussed Rocky Allen, the HIV-infected scrub tech from Colorado, who is one of 60,000 surgical techs in the United States. He is one out of the few examples the surgical techs have brought forward to support their push for regulation. Patients are not asking for registration, and there is no evidence to support the claim that unregistered surgical technologists are providing substandard care. Registering surgical technologists won't make the public safer. In fact, the most egregious example of public harm by a medical personnel in Nebraska was the Fremont hepatitis C outbreak in 2001. The outbreak arose from the conduct of two licensed individuals, a doctor and a nurse. Second, the proposed registry does create an economic hardship for the public. The registry would require a registration fee which is yet undetermined but would possibly be significant. LB205 also requires that each registrant submit a competency assessment by a qualified individual, which would require additional cost. This is clearly the first of a two steps, step process by the surgical technologists. They've attempted to pass a, have a bill passed in 2016 that would require all surgical technologists to be licensed. That effort failed. So in 2017, 2018,

and now 2019, they've asked for mandatory registration and competency assessments. Next year, or the next year after that, they'll ask for mandatory licensure. Once mandatory, once mandatory licensure is enacted, the surgical technologist labor pool will shrink because surgical technologist society believes that the only technologists with associated degree would be practicing. In fact, this shortage of technologists in the medical field now-- in the past week I've had a discussion with area hospital that is struggling to open up needed surgical suites hours for orthopedic procedures because they are unable to hire OR nursing and surgical technologists to staff these operating rooms. This will definitely compound this situation. If an associate's degree is required, the college offering the surgical technology degree, at a tuition cost of up to $35,000 or more, not to mention housing costs and loss of income, will reap the rewards. The surgical, surgical technologists who are pushing for this bill are primarily full-time or adjunct professors at a surgical technologist training program. They will win if this bill is passed, but the public will not. Thank you very much.

HOWARD: Thank you. Are there questions? Senator Walz.

WALZ: I-- being a teacher, I just have to ask these teaching questions.

DOUG WYATT: Sure.

WALZ: So you, you said that this bill would require a competency assessment completed by a licensed healthcare professional. How are you making sure that your surgical techs are competent today then?

DOUG WYATT: Sure. I think it was just like previous testimony. We have a, an in processing that, that works off of a very rich, rigorous orientation program, and they have to pass that orientation program before they're even allowed to be in that position. As previously stated, the CMS has, you know, documentation that we have to, you know, adhere to as far as making sure that everybody is competent and credentialed. The, it may not be an official state license or a state registry, but we're required to make sure that that person is competent to perform their duties. And I will tell you one thing, a surgeon will tell you whether they are or not.

WALZ: Yeah. And I am not doubting that at all. I'm not doubting the fact that, you know, they're, they're being trained very well. I'm

just still trying to make sure that what is said in the bill is not saying that there is additional requirements for competency.

DOUG WYATT: Sure. And I don't know what they're proposing for that competency.

WALZ: Just certification that--well, maybe I'm wrong-- but certification of competency assessment completed by a licensed health healthcare professional. That would be--

DOUG WYATT: Could be a nurse.

WALZ: Yeah, so--

DOUG WYATT: We don't know, we don't know who that person is. And right now it is done by a nurse, our director of nursing, and also surgical staff that I think, if she talked pretty closely about the team and the circulator, that's an experienced nurse that's making sure that that person is proficient at what they do.

WALZ: Yeah, OK.

HOWARD: Any other questions? Seeing none, thank you for your testimony today.

DOUG WYATT: Thank you.

HOWARD: Our next opponent testifier? Good afternoon.

JAY SLAGLE: Good afternoon, Senator Howard and the committee. My name is Jay Slagle; that's J-a-y S-l-a-g-l-e. I represent both Midwest Eye Surgery Center and Ophthalmology Surgery Center, located in Omaha, and also the Nebraska Association of Independent Ambulatory Centers. Surgery centers are the second largest employer of surgical technologists in Nebraska. We are a stakeholder and we have not been invited to any of these meetings that Senator Kolterman has been talking about. There's no need for mandatory registration. All surgical technologists work under the supervision of a registered nurse or physician, most often in a licensed facility. The facilities are subject to strict licensure requirements established by the state, Medicare, and accrediting organizations. The facilities and the surgeons are responsible for maintaining professional liability insurance, and they have a vested interest in ensuring that their surgical technologists are well-trained. The Board of Medicine has already stated, in the 407 process, that they don't want this to be

under their purview. The surgery centers don't support it, the registered nurses' associations are opposed to it, and patients have not requested it. In fact, the Hospital Association has testified-- it will testify that it's neutral to LB205, even though it's acknowledged that the barriers to entry will reduce the supply of surgical techs. Previously the proponents testified that they're not asking for licensure, nor have they ever. However in 2015 there was a 407 process where they actually did ask for licensure. In that hearing, the Nebraska Hospital Association lobbyist testified that, that surgical technologists had not provided evidence or data to support their contention that the current practice situation of surgical technologists is a source of harm or danger to the public health or welfare. Ms. Hurst, the lobbyist, added that the proposal would create significant economic hardship for surgical facilities in Nebraska, as well as limit the pool of available employees for surgical, surgical technology jobs in such facilities. She went on to state that it would be most, it would mostly be the smaller surgical centers and those in rural areas that would be impacted. Ms. Hurst stated that the public has every reason to trust Nebraska surgical facilities to provide assurance that those who maintain, work to maintain a sterile field in the surgical suite are capable of doing their job safely and effectively. Ms. Robak, from the Nebraska Medical Association, has testified that they are neutral on the creation of a registry. In fact the only part of this, if you heard, she supports lines 3-12 on page 9 of a nine-page proposal. The Nebraska-- so they only support the portion of the bill that addresses the Howard Paul ruling from 1898 that established case law that they couldn't delegate to any unlicensed personnel. The Howard Paul issue should eventually be fixed, but it's not an emergency. And in the 120 years since the Howard Paul ruling, it has been raised exactly once, when we addressed the surgical first assistant issue. Please don't use Howard Paul and the Medical Association's lukewarm support as a reason to advance this bill. The push for legislation in LB205 also raises a question of where regulators should draw the line when identifying professions that could have an impact on patient safety. Should we license the hospital janitors that could have, who are responsible, with virtually no supervision, for terminal cleaning of operating rooms since that role is a key part of a comprehensive infection control program? How about the hospital handyman who monitors humidity levels and air purity? The supply personnel who are responsible for sterile supplies until the day of surgery? The central instrument processing that we referenced earlier? The computer programmer who adapts the alerts in a hospital, hospital's electronic medical records system? In short, does

every healthcare employee need to be registered and licensed? A few comments on things that we've already talked about today. There was a comment that we've seen an increase in infections, which I haven't seen any evidence of that; it's certainly not attributable to surgical techs or their behavior. And so Mrs. Glassburner referenced an increase in surgical site infections. Again, that's an entire chain, a process leading from the central processing all the way to the surgeon. There's certainly no evidence that the surgical technologists are causing that. And I think that I agree with Ms. Summerfelt. Rocky Allen committed a crime. So Rocky Allen is this gentleman from Colorado. He's getting thrown, all over the country he's getting thrown under the bus at every legislature that there is. He should have been called, the police should have been called. And a registry would not have stopped a bad actor like that. Finally, if you've ever been through a reporting process for a regulatory agency, if Rocky Allen had done something today, they won't know about it tomorrow. He does something today; we fire him. We could call the registry reported, even though mandatory reporting, as I understand, is not part of this. But it could take 12-18 months through the regulatory process to find out that he should be kicked off the registry. In the meantime, meantime he's already in another place and so the registry does not solve this. Thank you for the opportunity to testify.

HOWARD: Are there questions? Seeing none, thank you for your testimony today.

JAY SLAGLE: Thank you.

HOWARD: Our next opponent testifier? Good afternoon.

KARI WADE: Good afternoon, Senator Howard and the Health and Human Services Committee. My name is Dr. Kari Wade, K-a-r-i W-a-d-e, and I'm a registered nurse, speaking on behalf of the Nebraska Nurses Association, in opposition of LB205. The Nebraska Nurses Association is the voice of registered nurses in Nebraska, and patient safety is a priority. Improved health is a priority also for our association. NNA seeks to support the delivery of safe, cost-effective care for Nebraskans, and we support the concept of a registry for surgical technologists. But we oppose the current format proposed in LB205, specifically the super, supervision of the registry by the Board of Medicine. It is the position of the NNA that the proposed surgical technologist registry should be supervised by the Board of Nursing, consistent with the findings of Part B of the 2015 407 review. The report, the report further goes on to recommend that the department

use the current Medication Aide Registry as a potential model, as the registry has been successfully supervised for many years by the Board of Nursing. The recommendations of the credentialing review committee are also consistent with the supervisory relationship that has been described earlier between the circulating RN and the surgical technologist. It's the RN who is responsible for the OR suite when the surgeon is out of the room. This is common during periods of patient preparation, positioning, as well as during the care and transfer of the patient post procedure. While many tasks can be delegated or assigned to others in the OR suite, the responsibility for maintaining that safe environment rests with the registered nurse. Maintaining that supervisory relationship is especially important in situations that have arisen when the surgeon will leave, go on to another case, and leave someone else to close the patient. The circulating RN is then the licensed person in the room and left to oversee the situation. NNA recognizes the valuable role that surgical technologists play in the operating room. The creation of the registry will allow identification of those who are working in those environments. We feel that it is important and can help to serve hospitals in their due diligence of hiring safe personnel and will help to ensure patient safety in the operating room. Supervision of the registry, however, by the Board of Nursing is the most practical means to achieve that goal. There is no compelling evidence to support placing it under the Board of Medicine. The Board of Nursing is already prepared to manage such a registry and, therefore, we ask you to oppose LB205 in its current form. Thank you.

HOWARD: Thank you, Dr. Wade. Any questions? Senator Williams.

WILLIAMS: Thank you, Chairman Howard. And thank you, Doctor, for being here. I just want to be sure I understand. So you support the concept. Do you think it would increase public safety? Is that a yes? Do you believe this would increase public safety?

KARI WADE: It would provide a registry as a way to track the individuals and, and their practice.

WILLIAMS: OK. Do you believe it would create a significant barrier to entry?

KARI WADE: I don't believe so, based on the Medication Aide Registry, as it is in place.

WILLIAMS: So your concern is where it's placed--

KARI WADE: Correct.

WILLIAMS: -- that end. Thank you.

KARI WADE: Um-hum.

HOWARD: Other questions? Seeing none, thank you for your testimony here today.

KARI WADE: Thank you.

HOWARD: Our next opponent testifier? Good afternoon, Senator.

DON WESELY: Good afternoon. Chairwoman Howard and members of Health Human Services Committee, for the record, my name is Don Wesely, D-o-n W-e-s-e-l-y. I'm actually here to read a letter from the organization AORN, which is the Association for [SIC] periOperative Registered Nurses, And there's a-- the actual letter is being passed out. I won't read it to you. I will simply say that this organization represents 160,000 operating room registered nurses across the country. Some of what they have to say is similar to what was just testified on behalf of the NNA. They do offer an amendment to LB205 that is seen at the second page of this letter, that clarifies-- it states a registered surgical technologist may perform tasks and functions at the direction of the surgeon and others under the supervision of the registered nurse circulator including, but not limited to, One of the things they cite in this letter is that the Medicare regulations are clear that surgical technologists serving in the scrub role do so under the supervision of a registered nurse. And they have a site; they're on the Federal Register. It is important to clarify that surgical technologists perform tasks and functions under RN supervision, consistent with CMS regulations. On a personal note, I want to welcome the new members of the Health and Human Services Committee for your first hearing on, on, on this committee. I spent 20 years on this committee, went through a lot of hearings over that time. You don't face that threat, and good for you about that. But these scope of practice issues are tough. They're-- as you're sitting here, my guess is-- trying to think well, which is the right direction? What's the right choice to make? And obviously I have a bias against the bill and I'm here testifying against it. But I also know Senator Kolterman is a good man and is trying to do what he thinks is right. And I think the surg techs are good people that are serving this state well. So what,

what is the right course of action? We think that currently there isn't a problem that needs to be addressed, and we don't anticipate that there will be a problem that needs to be addressed. I mean sometimes people say, well, let's wait till there's a problem. We don't want that; we don't want anybody getting hurt. But I think the way it's set up right now-- and Senator Walz asked questions about the education requirements under this which are-- and versus what's being done now. The difference is these surgical centers and the hospitals train people that come in to do specifically what they will be doing, so they know what to do. It means that they're going to be the, they don't want any problems; they don't want to be sued. They want things done right. So they bring somebody in, they know exactly what they need to do, they train them to do that. They've, they've had a great success record. They should be applauded for the work that they've done, not faced with the legislation like this that, that in a sense is questioning whether they're doing a good job. They're doing a good job; I think they are doing an excellent job. But that's a difference that I would like to point out is that they're not trying to have courses at Southeast Community College or wherever. They're trying to get somebody trained and extremely capable at exactly what they're going to be doing, and to understand what they're doing and to do it well. So that's one point that the current system is working because it focuses and it gets done what needs to be done. I also-- they talked about 15 states have some kind of regulation. That means 35 states do not have any kind of regulation-- 35 states. And so it's-- there are some states that have added this. Some may argue well, there's a trend. I don't think there's a trend. I think Nebraska is one of those places where things are done right and we don't do something that doesn't need to be done when it comes to government intervention. And I don't think there's a cause for, for, for that in this situation. I would also add I attended those 407 committee hearings to try to get an understanding of this. And there was a proposal to license surg techs; there was legislation to license surg techs. They clearly would like that, ultimately, as their goal. But there were recommendations about a registry and that has been acknowledged. But this registry carries with it far more restrictions and requirements than a typical registry, I think. I think it, it's overkill and unnecessary, and our current situation is one that has worked well and ought to be allowed to continue in the way it's functioned extremely well. I'll end my testimony.

HOWARD: Any questions for Senator Wesely? Seeing none-- oops. Senator Williams.

WILLIAMS: Thank you Chairman. Thank you, Senator, for being here.

DON WESELY: By the way, that was--

WILLIAMS: And we got to start our day at 1:00, hearing about the 407 process and--

HOWARD: Yeah, about what you did in 1985.

WILLIAMS: -- what you started; and thank you for that. I have one quick question. In your prepared-- the letter that you have presented us--

DON WESELY: Um-hum.

WILLIAMS: -- from that--

DON WESELY: The AORN?

WILLIAMS: Reading it very quickly, but I interpret it to say that their, their testimony would go to support if this amendment were adopted. Is that correct reading?

DON WESELY: No. I don't think that's the case. I think that they have been particularly concerned about this question of oversight and would definitely not support this legislation in its current form. If an amendment was adopted, of course we'd have to go back and see what they would say. I don't know for sure.

WILLIAMS: OK. Well, I was just reading this because they're proposing in this letter a recommended amendment that I think goes to the issue of who is in charge, you know, the--

DON WESELY: Right.

WILLIAMS: And who oversees. But--

DON WESELY: Well, if you go-- Senator, I'm sorry to interrupt.

WILLIAMS: No.

DON WESELY: If you go to the first three paragraphs, they go through why they don't see any need for this, that they don't, they don't obviously support this. They see it as unnecessary.

WILLIAMS: OK.

DON WESELY: And they also talk about the different national reports that call for overregulation in the country, and we need to step back from that.

WILLIAMS: Right.

DON WESELY: So, so their position is we don't need this regulation, but then they go on to say if you're going to, if you guys decide that you want to do something, at least make this change; this is what we recommend.

WILLIAMS: OK, thank you.

DON WESELY: Um-hum.

HOWARD: Any other questions? All right. Thank you for your testimony today.

DON WESELY: Thanks, Senator.

HOWARD: Any other opponents for LB205? Good afternoon.

NICOLE FOX: Good afternoon. Nicole Fox, N-i-c-o-l-e F-o-x, director of government relations at the Platte Institute. For sake of time, I'm going to skip over some of my testimony. But I just do want to briefly review. In the 1950s one in twenty occupations in the country required an occupational license. And fast forward to today, about one in three occupations in the country require occupational licensing, and Nebraska falls in line with this trend. Last year the Nebraska Legislature passed LB299, which establishes a legislative review process to examine the state's nearly 200 occupational licenses, to assess for overly burdensome regulation. If LB205 advances and ultimately passes, this will add one more occupation to this review process. Now what I'd like to do is provide some insight to the committee, using the LB299 framework. And for those of you that were here last year, LB299 was modeled after the Institute for Justice's inverted pyramid. And it's just lesser, lesser restrictive methods for regulating professions. Now I might confuse you but listen to my testimony to the end. One lesser restrictive method is registration.

Registration is when the government does not mandate any personal credentials or qualifications, such as educational requirements or competencies. But providers must notify officials of their names, their address, and the services they provide before they can work. So think of it as just a basic database. The basic requirement to register with the state may be sufficient, in and of itself, to deter a potentially questionable worker. Registration gives consumers access to a list of service providers. A second potential option that is less, less restrictive is voluntary certification. Voluntary certification sends a signal to consumers that a provider has a certain level of training and experience. Volunteer certification allows employers, not the government, to choose whether they wish to require private certification as a condition of employment. So in other words, different hospitals can have different requirements based on what their needs are for who they're looking to hire. Voluntary certification therefore provides the presumptive benefits of occupational licensing without the cost, because everything is voluntary. A third, less restrictive option is insurance. Insurers will pay damages for harm that is the result of a provider's malpractice. Hospitals and outpatient medical care centers often require physicians to carry malpractice insurance. Having to carry malpractice insurance incentivizes safety. Just like car insurance, fewer payouts results in lower provider premiums and, ultimately, lower consumer costs. This sends a signal to consumers that the provider cares about safety and quality. Dr. Ed Timmons, a professor of economics and director of the Knee Center Study for Occupational Regulations at St. Francis University, who is a leading scholar, reported in his April 2018 Harvard Business Review that, 1) if licensing were improving the quality of-- and in his article he said optician services-- we'd expect to observe lower malpractice insurance premiums in licensed states. We found no evidence of higher premiums in unlicensed states. And when healthcare professionals are licensed, these fees may increase wages, but they do so at the expense of consumers. So why don't we let potential workers and hospitals decide? Why don't we allow the potential surgical technologists decide if they'd like to pursue voluntary certification to increase their chances for hire? Why don't we allow hospitals to decide if they're OK hiring a worker and providing on-the-job training or they prefer to hire those who have pursued voluntary certification? Now I know that it's been brought up several times that there has been a 407 review process for surgical technologists; and that is true. And I think 2016 was the most recent one, and I read through the reports, as well. In reviewing the Board of Health and the director's reports, it was made

clear that they recommend against licensure. OK? LB205 may be titled "Adopt the Surgical Technologist Registration Act," but in reviewing the details of this bill, it is not creating a database of demographic information or a list of who is practicing as a surgical technologist in the state as it would be expected for a registry, which is what the 407 review pretty much said; they wanted a registry. But this bill is not creating that. Instead it mandates the completion of an application, it mandates the completion of educational or experience requirements in Section 6. Along with these requirements, it proposes statute to spell out the surgical technologist scope of practice. LB205 creates a job license, regardless of what it is titled. When discussing a variety of policy issues in this Legislature, we often ask, how does Nebraska compare? And what about our neighbor, neighboring states? Well, currently only 11 states regulate surgical technologists and, of those 11 states, only one of our neighbors-- Colorado-- regulates this profession. Currently Nebraska falls in line with most of the country. Therefore we are competitive as of today. But LB205 would reverse the status. We oppose the creation, the creation of new occupational licenses when there are other ways to assure safety of the public. We view LB205 as an increased burden to those wanting to work as surgical technologists, and I ask committee members to please not advance this bill out of committee. And with that, I conclude my testimony, and I'm happy to answer any questions.

HOWARD: Thank you, Senator. Any questions? Seeing none--

NICOLE FOX: OK.

HOWARD: -- thank you for your testimony today. Any other opponent testifiers? All right. Seeing none, we do have a few opponent letters: one from Dr. Tiffany Weeks-- or no, just Tiffany Weeks, not a doctor; Nebraska Association of Independent Ambulatory Centers; Amy Miller from the ACLU of Nebraska; Dr. Peter Whitted from the, from Midwest Eye Care, PC; and Jay Slagle from the Nebraska Association of Independent Ambulatory Centers. Are there any, any-- is there anyone wishing to testify in a neutral capacity? Seeing none, we do have two letters: one from Dr. Travis Teetor from the Nebraska State Board of Health; and Bo Botelho from the Department of Health and Human Services, who also sent the 407 reports on to the committee. With that, Senator Kolterman, you are welcome to close.

KOLTERMAN: Thank you, Senator Howard. Well, this has certainly been an interesting afternoon. For those of you that are sitting new on this committee, this is what it's like. I just have a couple of things to

say. First of all, the amendment has been signed off by HHS that we brought; that was a question that was raised. There was someone that indicated that the Hospital Association was not supportive of this bill. I believe we have testimony, written testimony, that they support the bill in its entirety. We currently allow voluntary certification; that is going on as we speak right now. But what we're really looking at here is minimum competencies and a registry. This is not a license. It was a, there was an attempt three or four years ago for licensure, and we backed off on that. You heard them say that they aren't interested in a license, that there's no other place licenses surgical techs. The reason we put in the bill that we can self-train was at the request of the Hospital Association, and we did that simply because there are people in western Nebraska, and even this part of the state, where the employer would like to bring somebody in and train them. And we don't have a problem with that, and there's nothing in this bill that discourages that. So when people say that they're having a hard time finding people and they're not trained properly, that's OK. We want them to be trained and we want the people to train them if they want to, whether it's a surgical center, whether it's a hospital, or if it's just in a doctor's office. We think that that's necessary and that's why we changed the bill to improve on that. The last thing I'm going to talk about is cost and barring entry into the profession. You know when we started out, it was going to be probably $26, $30 a year. It might be $50 a year; that's kind of a work in progress by the Fiscal Office. It's going to be paid by the entrant, the person that wants to become part of the registry. I'm an insurance agent. I pay $100 a year, minimum, to sell insurance. I guess my concern is we're talking about people here that are in a surgery setting; they got their hands on your guts. Think about that. How minimal is $50 to ensure that we aren't going to have a problem? And will it take time just to sniff out the bad people? Sure it will. But do we want to have something that happened in Colorado happen here when we could cure the problem for $50 a year? It's not a lot of money. And this is also a self-imposed situation by the-- all these, all these young men and women want to do is increase the value of their, their-- not their license-- their certification. So that's where we're at on this bill. The rest of it's all turf. Ben, you know turf's like. Everybody in this room knows what a turf bill, turf bill is and a turf war is; we're right in the middle of one. So I would ask that, just like last year, you advance this to the floor; we can have this discussion on the floor of the Legislature. Let's let 49 senators decide whether or not we should have a registry that the 407 has approved, or we shouldn't have a registry; it's simple as that.

Minimum competencies are something that I think we ought to have in any aspect of healthcare. I don't want somebody working in me, in the emergency room or in an operating room, that's not at least minimally educated. So with that, I'd like to thank you and try and take any questions you might have.

HOWARD: Are there any questions for Senator Kolterman?

WALZ: I just have one quick question.

KOLTERMAN: Yes.

WALZ: So I must have missed that. It's an annual fee? Or once you're on the registry, you're always on the registry?

KOLTERMAN: No, it's, in, in, anytime-- you have to register once a year.

WALZ: OK.

KOLTERMAN: That's the way it would work, and it would-- and you'd pay for that registration yourself.

WALZ: OK, thank you.

HOWARD: Any other questions?

B. HANSEN: Just one quick question.

HOWARD: Senator Hansen.

B. HANSEN: It's just-- I think that there's been some conflicting information, maybe from different testimony, or maybe I just didn't hear it right. And so is it, so would this bill make it mandatory, or not mandatory, to report an incident, if something would happen? That's-- because I've heard some people say it is, it's not.

KOLTERMAN: I'm going to have to double check that.

B. HANSEN: It's not a huge deal. I just--

KOLTERMAN: I believe by stat, I believe that when you have a registry and you have somebody that's broken the law, you have to-- or done something that's going to harm someone-- you have to report it.

B. HANSEN: OK, that's all I have.

KOLTERMAN: But I, I'll have, I'll double check that for you.

B. HANSEN: That's fine. Yeah, OK. Thank you.

KOLTERMAN: Correct.

HOWARD: Other questions? So my only concern was the page 9 section that was brought up by the NMA. That, to me, is sort of a bigger issue than what we're dealing with, with a registry for surgical technologists.

KOLTERMAN: Correct.

HOWARD: Because If, if, if we, if we as a Legislature fail to define what a nonprofessional assistant is, that, that really broadens the delegation authority. I'm curious as to your thoughts as to, sort of, why this got in here.

KOLTERMAN: Well, we brought, well, if you remember three, four years ago when I first got here and you were already here, we had a cease and desist for surgical assists.

HOWARD: For first assists.

KOLTERMAN: For first assists, and we had to deal with that. The same issue was a concern then as it is today. And they, they kept going back to that law that-- or that trial. So we addressed that directly with the Medical Association, as well as the Board of Health. And they felt that this language took care of that problem.

HOWARD: OK, thank you. Any other questions? All right. With that, we will close the hearing for LB205. Thank you, Senator Kolterman.

KOLTERMAN: Thank you.

HOWARD: All right. And we are done for the day.