HOWARD: [RECORDER MALFUNCTION]-- chair of this committee. I'd like to invite the members of the committee to introduce themselves, starting on my right with Senator Murman.

MURMAN: I'm Senator Dave Murman, District 38: Clay, Webster, Nuckolls, Franklin. Kearney, Phelps, and part of Buffalo County.

WALZ: Lynne Walz, District 15: Dodge County.

ARCH: John Arch, Sarpy County: Papillion, La Vista.

WILLIAMS: Matt Williams, District 36, from Gothenburg, which is Dawson, Custer, and the north portions of Buffalo County.

CAVANAUGH: Machaela Cavanaugh, District 6: west-central Omaha, Douglas County.

HOWARD: And we are joined by our legal counsel, Jennifer Carter, and our committee clerk, Sherry Shaffer, and our committee page, the very capable Erika over there. A few notes about our policies and procedures. We ask that you turn off or silence your cell phones. This afternoon we will be hearing three bills and we'll be taking them in the order listed on the agenda outside of the room. On each of the tables near the doors to the hearing room, you'll find green testifier sheets. If you are planning to testify, please fill that out and hand it to Sherry before you come, when you come up to testify. This will help us keep an accurate record of the hearing. If you're not testifying at the microphone, but would want to go on record as having a position on the bill, there are white sign-in sheets at each entrance, where you may leave your name and other pertinent information. Also I would note, if you are not testifying but do have written testimony, our, our committee's policy is that you submit it 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 handouts, that you please bring ten copies and give them to the page. We do use the light system for testifying. We have a five-minute light system. You get a green light for four minutes, a yellow for one, and then at red we would ask you to conclude your comments. When you come up to testify, please begin by stating your name clearly into the microphone, and please spell both your first and last name. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters, then those in opposition and those wishing to

testify in a neutral capacity. We have a strict no-prop policy in this committee, and we have been joined by Senator Hansen. Would you like to introduce yourself?

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

HOWARD: And with that, we will open today's hearing with LB29, Senator Kolterman, to provide and eliminate telehealth provisions.

KOLTERMAN: Good afternoon, Chairwoman Howard.

HOWARD: Good afternoon.

KOLTERMAN: 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. I represent District 24 in the Nebraska Legislature, which encompasses York, Seward, and Polk Counties. I'm here to introduce LB29, a bill that amends the Uniform Credentialing Act to establish provider-patient relationships through telehealth without the requirement for an initial face-to-face visit. LB29 is an extension of LB701 from last year, that passed unanimously and was signed into law. I'm bringing LB29 at the request of the Nebraska Hospital Association and other parties interested in increasing telehealth services in the state. For those of you that are new to the committee, let me briefly explain why we needed to pass LB701 last year, and then I will tell you what LB29 does. In addition to defining telehealth and telemonitoring, LB701 amended the Uniform Credentialing Act to establish physician-patient relationships through telehealth without the requirement for an initial face-to-face visit--only for physicians and physicians' assistants. Physicians were using telehealth for initial visits without first seeing their patient face-to-face. However, the [INAUDIBLE] were silent on telehealth practices outside Nebraska Telehealth Act which technically only applies to Medicaid telehealth services. In addition, regulations relating to physician practices were unclear as to whether or not a physician would be engaging in unprofessional conduct by seeing a patient via telehealth for initial contact. LB701 from last year provided certainty and stability to the telehealth providers by clarifying that current telehealth practices are supported by Nebraska law and the regulations. It made it clear that a physician can provide treatment or consultation recommendations, including issuing prescriptions through telehealth without the need for an initial face-to-face contact. When I introduced LB701 last year, some people asked me to expand the intent of the legislation to include other

scopes of practice. I respectfully declined such requests, not because I oppose expanding the use of telemedicine, but because the intent of the bill is to provide certainty and stability to telehealth providers by clarifying what current telehealth practices are supported by Nebraska law and regulations. I told those interested stakeholders last year that I would consider expanding LB701 to add additional scopes of practice at a later time. The later time is now, and I agreed to carry LB29 on behalf of the Nebraska Hospital Association, whose members feel that expanding telehealth services continues to be a key issue in the state in Nebraska. LB29 expands the provider-patient relationship, without the requirement for an initial face-to-face visit, for 26 of the 36 scopes of practice listed under the Uniform Credentialing Act. Any barriers to telehealth services should be examined and removed when necessary. Telehealth and telemedicine are becoming increasingly more important as we try to find ways to improve access to healthcare, especially in our rural communities where individuals may be hundreds of miles from their nearest healthcare facility. Access to mental health and psych, psychiatric health services in rural Nebraska are scarce. Almost one-third of Nebraska continues, one-third of Nebraska counties lack a behavioral health provider of any kind. The shortage of mental health professionals is expected to grow in the next decade, as over half of the practicing psychiatrists, psychologists, and psychiatric nurse practitioners are over the age of 50. Telehealth offers a pathway for ensuring access to services in both urban and rural areas. One last note-- I have submitted AM86 for your consideration, because I've heard from the athletic trainers that they would like to be included in this bill. They've already been using the process and wanted to be included. And the veterinarians informed me that they would like to be excluded from this bill at this time. I have also-- I passed out that amendment and I've also given you a list of those that would be included and those that would be excluded. So with that I would be happy to try and answer any questions. I will stick around for closing because this an important bill and we need to advance it. Thank you very much.

HOWARD: Thank you, Senator Kolterman. Are there questions?

B. HANSEN: I have one.

HOWARD: Senator Hansen.

B. HANSEN: So does this include any physician, like even in primary care facilities, or is it just like hospitals or does it matter kind of where it's at? Or--

KOLTERMAN: If, if they're a physician or a physician assistant, that was taken care of last year.

B. HANSEN: OK.

KOLTERMAN: Correct.

B. HANSEN: Cool. No, so location does not matter, where they're at.

KOLTERMAN: No.

B. HANSEN: OK. And I see under the list those who do not apply. How about chiropractors?

KOLTERMAN: They're, they're applied.

B. HANSEN: Wow. I don't know-- all right-- how that'd work, but--

KOLTERMAN: Yeah, we've got you in there [LAUGHTER]. We, we didn't want to take you for granted, Senator.

B. HANSEN: That's good; I appreciate that. And maybe just one other one. And is there, there is, is there a reason why there was a physical-- a physical location before was required and now it's not?

KOLTERMAN: I can't tell you the answer to that.

B. HANSEN: OK, just curious.

KOLTERMAN: It all came back from credentialing. It was actually brought to us last year by Telehealthdocs, which do this on a nationwide basis. And so I think we, we establish the fact that you couldn't be in Kansas and still see somebody. And I think that takes care of a lot of the health insurance concerns, or they may be having a telehealth aspect to their policy and they get somebody else doing it for them. But I know in-state we've got a lot of doctors that work for the different health insurance companies that do see them through a telehealth process.

B. HANSEN: Thanks.

HOWARD: Other questions? Seeing none, thank you, Senator. We'll now invite our first proponent testifier. Good afternoon.

JASON ENSRUD: Hello. I am Jason Ensrud, J-a-s-o-n E-n-s-r-u-d. To begin with, we'd like to extend a sincere thank you to Senator Howard and the Health and Human Services Committee for having us out here today. And a, as well, a thank you to Senator Kolterman for the introduction of this bill, as well as the amendment to include athletic trainers in there. I am here today as the chair of the Governmental [SIC] Affairs Committee, representing the Nebraska State Athletic Trainers' Association Who we are-- we have over 580 members throughout the state, and we provide an array of healthcare for active individuals-- athletes-- whether they are high school, college, weekend warrior, club, team, professional sports. If you're, if you're an active athlete, we are here to help with your healthcare. We are-- as you know, in the bill we are licensed under the Uniform Credentialing Act here in Nebraska. And we're also an-- recognized allied health care professional through the American Medical Association. This bill, bill, as, as Senator Kolterman said, can definitely benefit us. I can see in three main areas it will definitely provide, help us provide our services to some underserviced areas in Nebraska. I have a couple examples of patients that I worked with just within the last couple of weeks. A student athlete from Osceola was complaining about how she was a, she was a student athlete and she could not see an athletic trainer except for maybe once a week, so their parents had to get appointments in Lincoln or Omaha, make the drive, take a day off of school, whatnot, where with telehealth we could establish that relationship and help with that, with that athlete and their needs. That being said, we can also save patients time and money. Another example of a student athlete who was down in Humboldt, Nebraska, over Christmas break-- needed some exercises for a knee injury that he had sustained. He had to take a whole day out of his Christmas break to drive up to Lincoln, spend five-ten minutes with myself, and drive back, where telehealth could definitely save some time and money for that patient. I think it will help us continue to serve as an integral, integral member of the healthcare team. We want to provide the best care for that patient. That being said, another example, just this week, was a wrestler that we had with a skin infection. And it's hard to describe that over the phone where, if you have that telehealth relationship and you can see that, we can help that athlete see who they need, whether we need to get them to a dermatologist, a gen-med practitioner or if it's a simple solution that we can take care of. So those three ways are, I

think, very, very beneficial examples of how this bill can help us. If I have these examples, the 580-plus other athletic trainers can probably give you hundreds and thousands of examples. So that being said, in closing, the Nebraska State Athletic Trainers Association supports LB29, along with this amendment that includes athletic trainers. I want to again say, say a sincere thank you to Senator Howard and the committee, as well as Senator, Senator Kolterman for all of his hard work. And I would like to open up for any questions.

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

JASON ENSRUD: Thank you.

HOWARD: Our next proponent testifier. Good afternoon.

REBECCA OHLINGER: Good afternoon. My name is Rebecca Ohlinger, R-e-b-e-c-c-a O-h-l-i-n-g-e-r, and I'm here on behalf of Children's Hospital and Medical Center. Thank you, Senator Howard and committee members, for having us here today, and Senator Kolterman. I will soon echo what person did before me, as we are definitely supportive of athletic trainers being included in this. But I do want to speak to some of the things that Senator, Senator Kolterman spoke of at the beginning, and that's-- I think everybody is aware of the shortage of medical professionals, especially in the rural areas. One statistic I read was in 2026, I think, the patient-to-provider ratio was going to be somewhere around 1 in 786. That speaks volumes to me, especially when in Nebraska we have a third of our residents, at least in rural areas, according to the federal government, that have been deemed to have inappropriate or insufficient medical care. Telehealth is part of Children's Hospital and Medical Center's strategy to deliver quality care, but also to increase access to service for those families and patients in rural areas. We performed just short of 2,000 virtual visits last year. About 1,700 of those were in behavioral health. We're slowly starting to expand our services into specialty care and primary care, as well. At Children's, our physicians work very closely with NPs, PAs, all members of the healthcare team, whether it be physical therapists, athletic trainers, anybody that is part of that team-based model of care. This model, complemented with telehealth and what virtual care can offer, will greatly improve and equip our providers and staff to, again, deliver that quality care. In order to do that, we have to be open to new ways to establish those relationships, and that is virtually. There's a lot of research that says that that can be established virtually. One of the questions on

our post-visit patient surveys that our families are asked after every visit is, how satisfied are you? And I can speak to our benchmarks that have been set, where about 85 to 90 percent patient-- our patient population is actually satisfied saying that they felt that the visit was just as good, if not better, than an in-person visit, because they had their provider's undivided attention-- again, a lot of satisfiers in that they don't have to spend money driving, and take paid time off, and, you know, set their kids in a busy waiting area that-- and expose them to, you know, other, maybe, diseases and things that kids are there for. So the other question that is asked on our surveys is that, what would you have done had you not had the ability to have a virtual visit? And the options are: ER, urgent care, nothing, or an office visit. And the two most popular responses are nothing, or I would have gone to urgent care. So that speaks volumes when you are looking at, you know, 2,000-- in, in size of close to 2,000. Recently-- January 15, 2019, the American College of Physicians just published their seventh edition of their ethics manual. And in that ethics manual, they spoke to telemedicine and developing that provider-to-patient relationship. In that manual it says: A telemedicine encounter itself can establish a patient-physician relationship through real-time, technically-appropriate audiovisual, audiovisual technology. Currently there are 31 U.S. jurisdictions that explicitly permit the initial patient examination to be done virtually. So that means they don't already have to have that patient or that relationship established one-on-one. On behalf of Children's Hospital and Medical Center, I do want to, again, thank Senator Kolterman for offering this bill, as well as the amendment to the athletic training, among those licensures, that would be included to be able to create that relationship. At Children's, as we continue to expand our virtual care model, we recognize that a lot of schools in the state of Nebraska don't have the budgets to hire athletic trainers, especially out in those rural areas. A lot of school districts will even contract with one athletic trainer, and then you have the distance of that athletic trainer having to travel to many different locations, which then increases the chances that maybe those kids that have concussions wouldn't have sought care or the appropriate care. Or maybe they did initially, but then they don't have those follow up visits, and then they might have additional injuries that would go unnoticed. So again, I just want to say that we support. Do you have any questions?

HOWARD: Are there any questions?

B. HANSEN: I just have one quick question.

REBECCA OHLINGER: Yeah.

HOWARD: Senator Hansen.

B. HANSEN: In your opinion, is there any concern-- maybe there's not-- of somebody not being in a physical, physical location, as opposed to on a monitor and prescribing medications? You know part of it is like sometimes you have them in your office, you can see them-- you know, the color of their fingernails or, you know, what, what they look like a certain way-- I'm all for telehealth. I like the idea of this whole thing. I'm just, I just kind of want your opinion. I just kind of curious if there is any or--

REBECCA OHLINGER: So what I can speak to is our behavioral health program which, like I said, has had the majority of the visits through Children's, and they're prescribing, you know, psychiatric drugs. I think that's a great question and certainly one that has been discussed in telehealth forums and meetings and such. We do have an emergency action plan, and all of our behavioral health visits, the majority of them are occurring facility-to-facility. So if you're not familiar with telehealth and telemedicine workflows, health is to the home and medicine is facility-to-facility. So those psychiatrists are able to ascertain a lot about that patient. The mom is there, the child is there. They can watch the behaviors, they can watch the interactions. In some cases the telepresenter, which would be a nurse or, you know, somebody on the other end, presents that case ahead of time to that psychiatrist or psychologist to say: Hey, this is what mom said. Everything seems to be going OK, or these are concerns, so that maybe that can be addressed ahead of that child being in there. They do have the ability to zoom in with the technology so they can see color, they can see the behavior of the child in the room. I've sat in on several different visits just to see what the demeanor is like and of how things go, what the flow is like. And we haven't had any issues thus far. So that was a great question.

B. HANSEN: And, and I think that's kind of one of my concerns, yeah, 'cause now, if we're going to start expanding this or we're going to start getting into this more, which I think is good, or maybe not so much because of behavioral health. Maybe when it comes to pain management--.

REBECCA OHLINGER: Um-hum.

B. HANSEN: --and all of a sudden we're prescribing opioids through telehealth, like is there, you know, you know, to help somebody with their pain-- and I just, I just want to make sure that I, we're-- well, we're addressing any concerns there might be if we're going to start expanding this, and--

REBECCA OHLINGER: Again, I think that's a great question. You know, all of our doctors, providers, staff-- everybody operates within scope. And we're not asking that every visit be deemed appropriate for telehealth.

B. HANSEN: OK.

REBECCA OHLINGER: There are still going to be those visits to where, you know, at any given time our providers could say: You know what? I think I need to see you in person. As part of the training that I do with our providers, I reiterate to the, you know, that to them to say that, you know, you may start an initial conversation with a patient and go: You know what? I'm sorry; I'm going to have you come into clinic. I feel that I can better facilitate the exam, or maybe there's pieces of the exam that I can't do virtually that I need to see you in person for. So they always have that option. There's not going to be every diagnosis under the sun that's going to be appropriate for virtual care, and that's where our providers have to use their judgment.

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

REBECCA OHLINGER: So you know--

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

REBECCA OHLINGER: Thank you.

HOWARD: Our next proponent for LB29. Good afternoon.

TARA WHITMIRE: Good afternoon, Chairman-woman Howard and members of the Health and Human Services Committee. My name is Tara Whitmire, T-a-r-a W-h-i-t-m-i-r-e, and I'm here to testify in support of LB29. I am a nurse practitioner in a large community health system in Omaha, and I'm also the president of Nebraska Nurse Practitioners, the statewide nurse practitioner organization. Nebraska Nurse

Practitioners supports the inclusion of advanced practice registered nurse, or APRNs, and specifically nurse practitioners, as telehealth providers. And we would like to think Senator, Senator Kolterman for his leadership on telehealth issues these past four years and for introducing LB29. Including nurse practitioners as telehealth providers will allow for increased access to healthcare services, both physical and mental health, especially for those in rural counties. Nebraska Nurse Practitioners supports LB29, and we'd like to thank you for your service to the state. You are receiving a handout that talks more about nurse practitioners, and I am happy to take any questions at this time. I was asked to make it short and sweet, [LAUGHTER] so--

HOWARD: You were successful. Thank you. Are there any questions?

WALZ: I have--

HOWARD: Senator Walz.

WALZ: --just a quick question, just because I'm curious on how this works. This is my first year on the Health and Human Services Committee. So are telehealth services incorporated into a physician's day, daily activity in between seeing other patients? Or is a physician there only to provide telehealth services?

TARA WHITMIRE: So I personally do not provide telehealth to my patients, but my experience is, is that they may have like the morning devoted to telehealth visits, or I think that they block off time so they're not trying to rush to an in-person patient and then try to get on telehealth. So I think they are blocking off time to see those patients from a distance.

WALZ: OK. Just curious; thanks.

HOWARD: Um-hum; that's great. Any other questions? Seeing none, thank you for your testimony today--

TARA WHITMIRE: Thank you.

HOWARD: --your speedy testimony. All right, our next proponent. Good afternoon.

MANDI CONSTANTINE: I feel a little short in this chair.

HOWARD: It is a low chair.

MANDI CONSTANTINE: Good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. My name is Mandi Constantine, M-a-n-d-i C-o-n-s-t-a-n-t-i-n-e, and I am here today to testify in support of LB29, on behalf of CHI Health. Headquartered in Omaha, the combined CHI Health organization consists of 14 hospitals, 2 stand-alone behavioral health facilities, a freestanding emergency department, 136 employed physician practice locations, and more than 11,000 employees in Nebraska and southwestern Iowa. As division director of virtual services for CHI Health, I oversee our comprehensive virtual services program, also known as our telehealth program. My responsibilities span from the development of pilot programs, to ongoing daily support of administrative, educational, and clinical virtual services, to strategic planning and partnerships. We currently have 24 different telehealth services that we offer throughout the region from, all the way to Scottsbluff and into western Iowa. Introduced by Senator Kolterman, LB29 will expand the current category of providers allowed to establish a provider-patient relationship through telehealth. Only a handful of states have expanded their telehealth statutes to include providers in such areas as: occupational therapists, physical therapists, respiratory therapists, and speech language pathologists, although we know the need exists for these providers in many locations where there is no local access to care. By passing LB29, this Legislature would create access where there is none and designate Nebraska as a state where access to care is not limited to where a person chooses to live. On behalf of CHI Health, I would like to thank Senator Kolterman for his work to advance telehealth in Nebraska, and I would kindly ask for this committee to advance LB29. Thank you for your service, and I would be happy to answer any questions.

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

ARCH: You may not be the person-- thank you, by the way, for coming today. You, you may not be the person to ask this question and so, if you can't answer it, we'll just wait until somebody can.

MANDI CONSTANTINE: Sure.

ARCH: How is the list, as to who should be included and who should be excluded, drawn up?

MANDI CONSTANTINE: That list was drawn up by Senator Kolterman, sir.

ARCH: OK. Then I'll wait, I'll wait for that question.

MANDI CONSTANTINE: OK.

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

MANDI CONSTANTINE: Thank you.

HOWARD: Our next proponent testifier. Good afternoon.

LYNN BORSTELMANN: Good afternoon. Chairperson Howard and members of the committee, my name is Lynn, L-y-n-n Borstelmann, B-o-r-s-t-e-l-m-a-n-n, and I am testifying as a member of the Nebraska Hospital Association ad hoc committee on telehealth, in support of LB29. I am a resident of Lincoln and have been employed at Nebraska Medicine for 14 years. I'm a registered nurse with a doctoral degree in nursing practice and I'm certified in the specialties of nursing informatics and nursing administration. My current role at Nebraska Medicine is executive director of enterprise applications, and I have oversight responsibility for electronic health record applications and telehealth services. For patients seeking care from a practitioner who is credentialed in Nebraska under the Uniform Credentialing Act, it is advantageous to be able to meet needs for diagnosis and treatment from qualified practitioners appropriate to their individual need. Patients should not be limited in seeking telehealth services from a restrictive subset of healthcare professionals. The state practice acts of different professions should be sufficient to provide the guidance, with appropriate enforcement to ensure that the services, whether provided face-to-face or remotely, are meeting legal and regulatory standards. Broadening provider eligibility can help make appropriate services available to individuals in shortage areas or where distance impedes access. Telehealth services are growing rapidly in Nebraska and elsewhere. Telehealth services can provide access to care for patients who live at significant distance, and can also provide access for patients where it may be unduly burdensome to seek care outside of the home or their local community healthcare center. Survey data has shown that telehealth patients state they may not seek care at all if they are unable to access care locally or conveniently. This can be detrimental to their health, as well as increase the cost of care that they need when the condition is more advanced when they seek it. With the aid of technology innovation, we are living in an age when many care activities that previously required travel and time off from work can be accomplished using mobile devices with software

applications or computers connected to the Internet. While telehealth services provide advantage, advantages to a patient, the provision of telehealthcare can also provide flexibility to healthcare practitioners, who may benefit from working remotely themselves to meet their own personal or family needs. Such flexibility can help Nebraska retain active workers in professions that are experiencing shortages now or in the future. This can further improve access to care for the citizens of our state for both physical and mental healthcare. While the quantity of healthcare professionals in Nebraska has increased over the last decade, there are still shortages of medical specialists and other health professionals across the state. Practitioners may also be able to handle larger patient volumes more efficiently when telehealth is used, due to decreased time for travel and other tasks involved in the face-to-face visit. This can have a positive impact on access and cost care. By broadening eligible providers, as outlined in LB29, Nebraskans can benefit from the remote counseling, coaching, teaching, and monitoring that multiple different healthcare professionals can provide to promote health and improve chronic illness. Remote patient monitoring and care coordination have been demonstrated to improve patient outcomes and to contribute to less healthcare costs. Nurses, pharmacists, therapists, and other practitioners have evidence-based practices that can improve the health of our state residents. One danger in not broadening the definition of eligible providers is that practitioners would not be able to practice at the top of the license. Being able to practice to the full scope allowed by law and regulation enables care to be more cost-effective. If only particular members of the healthcare profession-- that is physicians and physician assistants-- are permitted to establish a provider-patient telehealth relationship, then highly remunerated healthcare professionals may be providing services that could be more cost-effectively provided by a different healthcare practitioner. It is important that we conserve, time, talent, and resources in healthcare. Nebraska has been more progressive than other states in supporting the standards practice and reimbursement of telehealth. This supports benefits and practitioners, and contributes to a healthier Nebraska. I recommend that the Legislature approve LB29.

HOWARD: Thank you. Are there questions?

LYNN BORSTELMANN: Any questions?

HOWARD: Senator Hansen.

B. HANSEN: Yeah, sorry to ask another question, but thanks again for coming. So just, then again, I don't know, this may be a better question for Senator Kolterman, but does this bill allow-- is it just mainly for people in Nebraska, like practitioners in Nebraska to use telehealth or for people to receive it, or for, just for patients to receive telehealth? I think like, but like, to me it, and I might have heard this from when I was on the campaign trail, but some people were a little concerned about telehealth, like somebody in Nebraska getting care from somebody like in a different state or a different country.

LYNN BORSTELMANN: So you, in order to provide telehealth in Nebraska, you must be licensed or credentialed in Nebraska. Now if you're part of the multi-compact license there are other ways, but you have to be licensed in the state of Nebraska to provide care to a patient who resides there; that's my understanding.

B. HANSEN: Oh, yeah; thank you.

LYNN BORSTELMANN: And I think there are others in the room that may even have more authority on that topic, but--

B. HANSEN: OK, [INAUDIBLE]. Thank you; appreciate it.

LYNN BORSTELMANN: OK.

HOWARD: Any other questions?

LYNN BORSTELMANN: Thank you.

HOWARD: Seeing none, our next proponent. Good afternoon.

EDISON McDONALD: Good afternoon. My name is Edison McDonald, E-d-i-s-o-n M-c-D-o-n-a-l-d, with The Arc of Nebraska. We are an organization that advocates for people with intellectual and developmental disabilities, and we're in strong support of LB29. I think that this bill really addresses-- one of the largest issues that our members see is trying to go and find access to transportation. We have 1,500 members across the state and nine chapters, significantly in [INAUDIBLE] rural areas. In a lot of the western portion of the state, however, we do not have a local chapter, so I tend to take most of those calls. And as we try and go and deal with those issues, trying to find local doctors, or doctors even where they won't have to travel all the way to Omaha, is a tremendous difficulty. And I especially want to point out, in particular, one of the highest areas of needs that we found is the area of dual diagnosis on mental health

and disability, and I think that this bill would really help to address those issues, help our members in a variety of chapters and outside of those regions, and ensure that they're able to have that access to care because, as it is right now, I pretty much am left saying, well, you can go and move closer or you can be ready to pay for regular transportation costs; and for our members, that's tremendously limiting. So thank you very much for your time. Any questions?

HOWARD: Thank you. Are there questions? Seeing none, thank you.

EDISON McDONALD: Thank you.

HOWARD: Our next testifier. Good afternoon.

JONI COVER: Good afternoon, Senator Howard. Members of the Health Committee, my name is Joni Cover; it's J-o-n-i C-o-v-e-r. I'm the CEO of the Nebraska Pharmacists Association I'm here today on behalf of the Nebraska Pharmacists Association, in support of LB29, and I want to thank Senator, Senator Kolterman for sponsoring this legislation. Allowing all health care providers to care for patients via telehealth is a necessary and important tool for patient care, particularly in the rural and underserved areas of Nebraska. Pharmacists provide vital services, such as: chronic disease management, medication therapy management, and drug reviews, to name a few, all of which can be provided in-person or safely via telehealth. This bill is a great advancement for Nebraska healthcare providers and patients in Nebraska, and we lend our full support. I was going to just comment with your question about the-- whether you can prescribe opioids via telehealth. And the answer is yes; it's already going on.

B. HANSEN: OK.

JONI COVER: It's already happening, and that was covered under the bill that passed last year, so it happens--

B. HANSEN: But they had to--

JONI COVER: Was it last year? Yeah.

B. HANSEN: But they had to be in the physical location to receive the--

JONI COVER: No. Well, the prescription can either be sent via electronic prescribing--

HOWARD: She has to finish her testimony before you can ask questions.

B. HANSEN: Oh, OK. I thought she was-- OK.

JONI COVER: Yeah, sorry. No, I heard you ask the question so it would be somebody else; sorry. Anyway, so you can have, you can, they can already prescribe via telehealth. They can see the patient via telehealth and then prescribe either by phone call or prescription or electronic prescriptions. I'm just answering that question.

B. HANSEN: Thank you.

HOWARD: Are you done?

JONI COVER: I'm done.

HOWARD: OK, just so-- are there any questions from the committee?

B. HANSEN: No, I think she answered it [LAUGHTER].

JONI COVER: A preemptive question.

HOWARD: Anybody else have a question? No? Seeing none, thank you.

JONI COVER: Thank you.

HOWARD: Our next proponent testifier. Good afternoon.

DAVID SLATTERY: Good afternoon. Thank you, Chairman Howard, and good afternoon, members of the Health and Human Services Committee. My name is David Slattery, D-a-v, D-a-v-i-d S-l-a-t-t-e-r-y, and I'm here today as the director of advocacy for the Nebraska Hospital Association. I'd like to thank Senator, Senator Kolterman for introducing LB29, and we appreciate all the testifiers who have come to support this bill. You've heard a lot, from a lot of our experts from our member hospitals on reasons to pass LB29 and expand telehealth services. The NHA is committed to increasing work force and telehealth among hospitals in the state. Telehealth is becoming vitally important to the delivery of healthcare services, especially to rural areas. LB29 allows 26 scopes of practice, under the Uniform Credentialing Act, to be able to establish a provider-patient relationship via telehealth without the need for initial face-to-face

consultation. This is an important next step to ensure that Nebraskans have access to physical and mental health care. And I just came up here to address Senator Arch's question. We, when we are looking to expand these scopes, these scopes of practices, we're basically looking to expand them in a hospital setting. That was kind of our thought process behind this. So we're just kind of looking, looking out for our own scopes in our hospital setting.

HOWARD: Thank you.

DAVID SLATTERY: Yeah.

HOWARD: Are there questions? Senator Arch.

ARCH: I just noticed perfusion was on there. Is that a, is that a-- how do you do that, telehealth? It wasn't excluded, in other words.

DAVID SLATTERY: It was not.

ARCH: Yeah.

DAVID SLATTERY: I cannot answer that one specifically. When we were working with Senator Kolterman, we said we'll let the committee and Senator Kolterman decide if there's additional ones you want to take out or add, or certainly we'll have to work with the committee on that one.

ARCH: As a group, as a group, you might want to take a look at that--

DAVID SLATTERY: OK.

ARCH: --and see if that maybe should be on the exclusion.

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

DAVID SLATTERY: All right; thank you.

HOWARD: Our next proponent testifier? Good afternoon.

NIKI EISENMANN: Good afternoon. Senator Howard, members of the committee, my name is Niki Eisenmann, N-i-k-i E-i-s-e-n-m-a-n-n. I am here testifying in support of LB29, on behalf of the Nebraska Nurses Association. I'd like to start by thanking Senator Kolterman for thinking of the Nebraska Nurses when introducing this bill, which will now authorize nurses, as well as many other providers, to establish

the patient-provider relationship. This bill provides for expanded access to telehealth services for consumers of healthcare in our state. Telehealth services are important to many of our citizens as it allows for better access to care, especially those specialty services not geographically accessible to our rural patients. The Nebraska Nurses Association encourages you to support LB29 to expand the provision of healthcare services to our patients in every part of Nebraska. And short and sweet, too.

HOWARD: That was wonderful. All right, thank you. Any questions? Senator Arch.

NIKI EISENMANN: Yeah.

ARCH: As are you talking about patient education, those types of calls, because obviously you're not practicing medicine?

NIKI EISENMANN: Correct.

ARCH: Can you do a nurse visit on telehealth? Can that be a billable service, as a nurse visit?

NIKI EISENMANN: Nurses, registered nurses-- there's different types of nurses-- but registered nurses do, do not have billable services. We're part of telehealth services generally in emergency situations. Like in a rural hospital in Nebraska, they may connect to telehealth with, for instance, Bryan. And so they could walk them through some of the care that might be necessary. But nurses are definitely one of the providers in that scenario.

ARCH: Are you using that then for face-to-face in education, answering questions, any of that?

NIKI EISENMANN: It could be. Currently nurses are providing those services over the phone.

ARCH: Right.

NIKI EISENMANN: As long as you're licensed in the state of Nebraska, taking care of a resident of the state of Nebraska, you could make the phone calls. So it would expand our abilities to take care of patients.

ARCH: Um-hum, OK. Thank you.

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

NIKI EISENMANN: Um-hum, thank you.

HOWARD: Our next proponent testifier. Good afternoon.

JESSICA ROBERTS: Good afternoon. Chairperson Howard and members of the Health and Human Services Committee, my name is Jessica Roberts, J-e-s-s-i-c-a R-o-b-e-r-t-s, and I'm here representing the Board of Athletic Training, and we'll be testifying in support of LB29, with the amendment to remove Athletic Training Practice Act, previously listed on line 29. The position, as stated in this testimony, represents the position of the Board of Athletic Training and does not necessarily represent the position of the Department of Human Health, Health and Human Services or the Division of Public Health. The board understands LB29 outlines professions within the Uniform Credentialing Act to provide telehealth practice. As introduced today with AM86, athletic trainers would be able to render service in a timely fashion, with evaluation or treatment for their patients, through an electronic means while being president in an alternate location. Athletic trainers are healthcare professionals responsible for the management of athletic injuries. For years, parents and patients have phoned athletic trainers to discuss patient presentation and a plan of care but not immediately available on-site. With technological innovation and the evolution of a smartphone, athletic trainers have continued to use telehealth to safely provide patient care through prevention, evaluation, emergent care, first aid treatment, and to provide rehabilitative recommendations for athletic injuries. With the amendment, with the amendment, the board supports LB29. Athletic trainers and their patients capitalize on the benefits that telehealth provides. Infusing telehealth into practice helps to minimize risk for those who are participating in sports and recreation, the patient population that athletic trainers serve. This technology is used in a manner that is consistent with the standard of care and provides an alternative to the traditional face-to-safe, face-to-face patient experience. As reported by the Korey Stringer Institute Athletic Training Locations and Services report, while 83 percent of Nebraska's secondary schools have athletic training services available, only 23 percent of those schools have a full-time athletic trainer. For the health of the athlete, it's proven much better for the patient to see an athletic trainer quickly and determine a plan of care or for all what necessary. Through this important communication, patients are

empowered to begin appropriate treatment or rehabilitative protocol and avoid delay. A critical patient benefit for those who use telehealth includes increased access to athletic trainers in an efficient and cost-effective manner, especially to those on traveling teams or in rural areas. As participation in sport and recreation continues to rise, so does the chance for injury. While athletic trainers are valued in providing immediate and proper care for musculoskeletal injuries and common illnesses, telehealth is a useful tool that offers opportunities for successful patient outcomes. Examples of athletic trainers employing telehealth within their practice include the following scenarios: a collegiate athlete is to report on campus for competition but experiences stomach flu-like symptoms in their dorm room, the patient uses video conference technology to reach their team athletic trainer for a clinical evaluation and receive treatment recommendations and participation guidelines to minimize exposure for their teammates from a highly contagious condition. Additionally a secondary school basketball player may suffer a concussion at an away game. The on-site athletic trainer evaluates the patient, completes and transfers medical documentation to the team's assigned athletic trainer at another site for follow-up care. Further, a rural patient, if a rural patient needs to be seen by an orthopedic specialist but the travel distance is a barrier, with direction from an orthopedic physician, athletic trainers may use video conferencing to perform a physical exam on a patient and report real-time clinical findings to the physician electronically. And finally, a parent, if a parent notices abnormal skin condition on their son, a youth wrestler in club sport, a parent may text a picture of the affected area to the athletic trainer and inquire about a condition and treatment recommendations. These are ways athletic trainers may use telehealth currently in a safe manner. In closing, athletic trainers in Nebraska are licensed credential holders who use telehealth to reduce risk, control health care costs, and avoid unnecessary emergency department visits. Telehealth is vital to job performance and positive patient outcomes. The board supports LB29 with the amendment, AM86. Thank you for your attention, and I'm happy to answer any questions as I am able.

HOWARD: Thank you. Are there questions? Seeing none, thank you for your testimony today. Our next proponent testifier. Proponents? All right. Seeing none, we do have some letters for the record, in support: Bruce Brodersen from the Nebraska Veterinary Medical Association; Terry Werner of the National Association of Social Workers-Nebraska Chapter; Connie Benjamin from AARP Nebraska; Annette

Dubas, Nebraska Association of Behavioral Health Organizations; Dr. Britt Thedinger from the Nebraska Medical Association; and Brian Krannawitter from the American Heart Association. Is there anyone wishing to testify in opposition to LB29? Seeing none, is there anyone wishing to testify in a neutral capacity? Seeing none, Senator Kolterman, you are welcome to close.

KOLTERMAN: Thank you very much, Senator Howard. I'd just like to say we'll take a look at the perfusionists. We, we did take the list from the credentialed people that were in the act originally, and, or had been requested. We have made some changes based on requests that we've had, as you can see from the amendment. We'll take a look at that and see if-- actually we'll probably talk to perfusionists and see if they want to be included or don't want to be. I can't imagine how they, how it would work, but you never know. As far as being licensed, we took care of that last year and we feel like we have it, we have it set out already in statute. So all we're doing is adding licensed people that are already credentialed, but they do have been in the state, credentialed in our state, as was indicated. With that, I would like to thank all the testifiers that came. I was shocked to see all the people show up; told them to keep it brief. And I've got to go testify at Judiciary, and it is another bill. So I would take any questions you might have.

HOWARD: Are there questions for Senator Kolterman? Seeing none,--

KOLTERMAN: Thank you very much.

HOWARD: --this closes the hearing for LB29, and it opens the hearing for LB112. And I will hand it off to Senator Arch.

ARCH: All right, are we ready?

HOWARD: Yes.

ARCH: OK. We'll open the hearing for LB112, and Senator Howard, you may proceed.

HOWARD: Thank you. Good afternoon, Senator Arch and the members of the Health and Human Services Committee. My name is Senator Sara Howard, S-a, S-a-r-a H-o-w-a-r-d, and I represent District 9 in midtown Omaha. Today I bring before you LB112, a bill that would waive initial licensing fees for certain individuals, to allow them an easier transition into the Nebraska work force. The licensing fees that would

be affected by this bill are covered by the UCA, but these credentials are also listed on pages 2 and 3 of the bill. I've also passed out a fee schedule for your review. This bill is actually a reintroduction of LB834, a bill I did last year but, due to a short session and time limits, we ran out of time to work on it. LB112 sub, specifically affects three groups of people: first, low income, who are identified as a household at 130 percent of the federal poverty level or lower. For one person in a household, that would be about $15,000 a year and for a four-person household that's about $31,000 a year. If the Division of Public Health wanted to raise that number, this legislation would allow them to do so. A low-income person may also be identified as anyone who is enrolled in a state or federal public assistance program. The second group is military families. These are active duty service members, honorably discharged veterans, spouses of active duty service members, and surviving spouses of deceased service members. And finally, young workers. These are individuals between the ages of 18 and 25. I first learned about this potential legislation about two summers ago. In 2017, we'd had a broader committee discussion around occupational licensure and how sometimes there can be a barrier to entry if our standards are too high or too onerous for individuals. And a young man came and testified. His name was Jared, and he was from the Foundation for Government Accountability. And he said that they have this model legislation that basically gives you your first year free to help you overcome that barrier. So in a 2012 study by the Institute for Justice that looked at licensing requirements, they found 102 different low and medium occupations had an average requirement of $209 in fees. Many individuals who are looking at paying this fee, especially for the first time, might be fresh out of school and likely facing the burden of beginning to pay off student loans, something that I can tell you personally is very stressful. When I graduated from law school in Chicago my bar fees were $1,000 in order to enter the Illinois bar, and I was already looking at six figures in student loan debt. And so just thinking that that was another $1,000 that I needed to find in order to even consider practicing law, felt very onerous. So other states are also addressing this issue. In 2017 the Arizona legislature passed a bill that allows individuals with household incomes below 200 percent of the federal poverty level to obtain an occupational license without paying the accompanying fee. A similar bill passed in Florida last year grants fee waivers to those with household incomes less than 130 percent of the federal poverty level and extends a fee waiver to military members and their spouses. Other states that have also passed laws are Missouri, New Mexico, Oklahoma, Utah, and Wisconsin. Other

states have considered reduced fees for occupational license, licensing requirements, and we have a broader list. But our neighbors, specifically, are Iowa and Missouri who have, who have offered reduced fees for these populations. And I would never want somebody who's looking at starting their career to say, well, I can have--it's easier for me to get my license in Iowa than it is in Nebraska, so I'll go and get my, and jumpstart my career in Iowa instead of in our state. So in my opinion, not being able to afford a license shouldn't be a barrier to gainful employment and following a career path for an individual. And by creating a career path to employment for individuals, we will be benefiting those who want to work and profiting from a better economy. I would be happy to answer--try to, try to answer any questions you have, but I would also like to just touch base with you on the fiscal note. So we did have, we had an initial fiscal note and then we have a revision. And for those of you who are new, the revisions are noted at the top right. And they say "Revision: 01." And so there was, there were a couple of things that I want to highlight in, in our conversation about the fiscal note. First, these are all cash funds. So essentially these are not general funds. They're rotating funds that come in to process the licenses. Second, most of the people that they would be looking at licenses for are actually these young individuals, that 18-25 age range, where you want to get them into employment as soon as possible. And then finally, I fundamentally disagree that they will need two additional people in the department to process these applications. In my opinion, you can prove your age very easily, you can prove that you're on a social benefit program, and you can prove your military status by sending in a form along with your application. So in my opinion, I disagree that they would need two additional individuals. The one point that is new, that I do think that I will have to work on, is the fingerprinting question that's at the bottom. So clarification is needed as to whether or not those licensures that require a fingerprint, if we will still have to charge for that, because I would never want the state to work at a deficit when we have to do those background checks. So those are the issues within the fiscal note that I wanted to highlight. And I'm happy to try to answer any questions you may have.

ARCH: Questions for Senator Howard? I have one.

HOWARD: Yes.

ARCH: Technically this is the initial application, right? Not the first year application, so you may have a two-year license, and so--but it's that initial application that is, that fee is waived.

HOWARD: Um-hum, as long as you fall into these specific categories, absolutely.

ARCH: OK, all right.

HOWARD: Thank you.

ARCH: Yeah. OK. Are you going to be staying for your close?

HOWARD: I believe I will.

ARCH: Okay. Thank you for doing that.

HOWARD: Thank you.

ARCH: All right. Are there proponents for this bill? Welcome to the Health and Human Services Committee.

NICOLE FOX: Good afternoon, Vice Chair Arch and members of the Health and Human Services Committee. I'm Nicole Fox, N-i-c-o-l-e F-o-x, with the Platte Institute. Thank you for the opportunity to testify. I would like to thank Senator Howard for introducing this bill once again, which the Platte Institute supports. And I agree with many of the statements she made so I'll try to, not to be too duplicative. In the 1950s, 1 in 20 occupations in the country required a government permission slip, also known as an occupational license, to work. Fast forward to today. Now 1 in 5 occupations in the country require this. This national trend holds true in Nebraska. Occupational licensing laws for those original and most necessary 1-in-20 occupations were initially created with good intentions of protecting the public from negligent and unqualified practitioners. But as more occupations over the years have required individuals to obtain licenses, many Nebraskans are now subject to the unintended consequences of occupational licensing, making it difficult for them to enter the work force. LB112 waives initial licensing fees for applicants who are identified as low-income. Of note, 102 occupations have been deemed low-income by the U.S. Bureau of Labor Statistics. Forty-five of those 102 occupations require licensure in Nebraska. A low-income occupation is defined as an occupation where the average income is less than half of the national average. In the Institute for Justice's November 2018 publication "At What Cost," their report revealed that licensing laws

require, on average, up to a year of education, at least one exam, and $260 in fees to work in one of those 102 low-income occupations. Keep in mind that workers applying for these licenses may have experienced loss of income while obtaining needing, needed training and may have had significant tuition costs and, in many cases, may also have to pay for continuing education to maintain that license. The report also points out the following statistics related to Nebraska: 12.4 percent of workers are under the age of 25; 16.9 percent have a high school diploma or less, 18 percent have some college; and 64 percent of workers have a college degree and/or graduate level education. According to the Foundation for Government Accountability, not only are more and more Americans needing an occupational license to gain employment in their chosen career field, more and more Americans carry the burden of student loan debt, as Senator Howard mentioned. 40 percent of young workers see 12 percent of their take-home pay consumed by loan repayments. Student loan debt is the second largest source of debt in this country. The barriers created by occupational licensing fees can be overwhelming, not only to low-income individuals, but also those who have taken on significant debt for pursuing higher education. Occupational licensing greatly impacts military families. According to the Obama administration's 2015 occupational licensing report, 35 percent of military spouses in the labor work force, or in the labor force, worked in professions that are regulated, and they are ten times more likely to have moved across state lines in the last year than their, than their civilian counterparts. These military spouses may have difficulty acquiring a new license each time they move and, given the fact that Nebraska is home to Offutt Air Force Base, we need to assure our occupational licensing requirements allow military spouses and veterans to readily enter our state's work force. LB112 waives first year licensing fees for occupations under the Uniform Credentialing Act for individuals who are identified as low-income, part of a military family, or a person between the ages of 12 and 15. Before I conclude my testimony, I do want to also talk about the fiscal note. And as Senator Howard indicated, the fees for these licenses do go to a cash fund. And in reviewing the fiscal note, there are a couple of things that stood out to me that I'd like to point out to the committee. First of all, they said that, of the eight-- for HHS-- of the agency's 149,000 licenses that they issue each year, 9,000 would fall under LB112; so we're talking only about 6 percent of the total licenses that they're issuing. I found it interesting that they noted that 42 percent of initial licenses would fall under the young workers, or the age, under the age of 25. And personally, I think that this is alarming. I think

it's proof that licensure creep is, is happening, and licensure creep is just that expansion of licensing. So I think it's something that this Legislature needs to take into consideration. Also, too, looking at the fiscal note, the two FTEs that the, that the department was requesting, I find this alarming, too. If this is the amount of money that government is spending on 6 percent of the applications for one agency, I think it should be motivation to carefully consider the approval of new licenses and to critically look at those that are in existence and evaluate if they're necessary. And also I'd like to talk about LB12 really quickly. This was a military, or military spouse fee waiver for real estate brokers that came out of Banking Committee a few weeks ago and was voted out of committee, voted onto the floor. And everybody here voted to advance that bill to Select File except for one, and they were present, not vote-- or no, they were excused. So in just-- of note, that didn't have a fiscal note at all. So with that, I just want to say, you know, this bill is really-- it's about getting people working, and the Platte Institute strongly supports it. And I ask members to advance LB112 to General File. With that, I'll take questions if there are any.

ARCH: Thank you. Are there any questions for Ms. Fox? No? All right; thank you.

NICOLE FOX: All right.

ARCH: Thank you for coming. Other proponents?

JAMES GODDARD: Good afternoon. My name is James Goddard; that's J-a-m-e-s G-o-d-d-a-r-d. I'm the director of the economic justice program at Nebraska Appleseed. I think we'd all agree that people who work hard should get ahead in our state. But despite working hard, a lot of families still struggle with poverty. Nearly 28 percent of working families in Nebraska earn 200 percent of the poverty line or less. That's only about $41,500 a year for a family of three. Excuse me. I can tell you in the work that we do in the community, what we hear from people are difficulties paying for the cost of housing, wages that are stagnant, the difficulty that there is in paying for childcare. But the reality is to get a better, higher-paying job, you often need additional education and skills training. By one estimate, by 2022, 58 percent of Nebraska's overall labor market will be made up of middle skills jobs. We are not ready to meet that demand, and that's why this bill is important. We need to make the path to better-paying jobs as simple as possible. Under the bill, low-income Nebraskans, as well as youth and veterans, would be able to have the

costs of applying for their first occupational license waived. Even this small licensing fee could be a barrier to folks who are earning incomes that low. So with that, I would urge you to support LB112, and I would be happy to take any questions.

ARCH: Thank you. Any questions that you have today? All right; thank you very much.

JAMES GODDARD: Thank you.

ARCH: Other proponents for this bill. Opponents.

HOWARD: Letters.

ARCH: Letters. Letters, as proponents. Read them all in? Dr. Britt Thedinger for the Nebraska Medical Association; Amy Miller for ACLU Nebraska; Daniel Ullman, Nebraska Psychological Association; Jared Meyer, Foundation for Government Accountability; Andy Hale, David Slattery for the Nebraska Hospital Association. And we'll put those into the record. Opponents. Anyone, anyone like to testify?

RONALD BANSE: Good afternoon. Vice Chair Arch and members of the committee, my name's Ronald Banse, R-o-n-a-l-d B-a-n-s-e. I'm here on behalf of the Nebraska Board of Cosmetology, Electrology, Esthetics, Nail Technology, and Body Art. As a board, we are opposed to LB112, as introduced this legislate, legislative session. LB112 was read and discussed at our board meeting held on February 4th. As the state is faced with a nearly $95.1 million revenue shortfall in the current two-year budget cycle, we are unable to support a bill that would decrease funds that contribute to the state's budgeted expenses. While the members of the board acknowledge the intent of the bill, we do not believe removal of the initial licensing fees will help with the expenses Nebraska is currently facing. In regards to the Nebraska Board of Cosmetology, Electrology, Esthetics, Nail Technology, and Body Art, in the year 2018 alone there were approximately 352 initial professional licenses issued for roughly $23,410 in much needed revenue for the state. These fees are a minimal investment. New licensees entering the work force are helping to support vital programs that meet the essential needs of all Nebraskans. We feel Nebraskans must do their part to support our economic, economic stability. Thank you.

ARCH: Thank you. Are there any questions? Seeing none, thank you very much for coming. Other opponents? OK, there was, there was one letter

that was submitted and this was the Nebraska Board of Cosmetology, Electrology, Esthetics, Nail Technology, and Body Art. And that will be recorded as well. Anyone want to testify in the neutral position? Seeing none, there were a couple of letters that were submitted. Terry Werner from the National Association of Social Workers, Joni Cover from Nebraska Pharmacists Association submitted letters in the neutral. And Senator Howard, you may close.

HOWARD: Thank you. And thank you for your time and attention to LB112. I would like to address the opposition testimony that I was unaware of prior to this hearing. To me, it shows sort of a, maybe a fundamental misunderstanding of where our general funds come from and where the funds for this would be coming from. These are cash funds; these are used from licenses. And the way that we have general funds comes from income taxes predominantly, and so-- and property taxes. And so when we have people who are able to get into a profession more quickly, they obviously generate more income and then those income taxes go into our general funds. However, the use of funds for this bill are from cash funds and licensure fees, not from the state's general funds. So I just want to be really clear that our revenue deficit-- this, this does not contribute or touch on our revenue deficit in any way. With that, I'm happy to try to answer any questions you may have.

ARCH: Do you have any questions? Senator Howard, thanks for clarifying that.

HOWARD: Thank you.

ARCH: And seeing no questions, we will close the hearing on LB112. And thank you--

HOWARD: Thank you.

ARCH: --very much.

HOWARD: You know what? Let's take a quick break before the next hearing. How does that sound? Well, we will come back at a quarter to three; that's quarter to three.

[BREAK]

HOWARD: [RECORDER MALFUNCTION]-- hearing for LB730. Senator Walz, you are welcome to open.

WALZ: Thank you, Chairman, Chairwoman Howard. Senator Howard and members of the Health and Human Services Committee, my name is Lynne Walz, L-y-n-n-e W-a-l-z, and I proudly represent 15th District, 15th Legislative District. And I'm here this afternoon to introduce LB730. There seems to be some confusion about LB730 and what it does and doesn't do. So let me explain what I believe to be the intent of the bill, and there will be others who will follow who explain the bill more in detail. LB730 is a bill to clarify the process for licensure of an APRN. An APRN is an advanced practice registered nurse. Nebraska currently recognizes APRNs through the Advanced Practice Registered Nurse Act [SIC] which was created in 2005. The purpose of the Advanced Practice Registered Nurse Practice Act is to encourage registered nurses to perform advanced roles in nursing. In Nebraska and nationally, and nationally, there are four categories of APRNs: nurse practitioners, certified nurse midwives, certified nurse anesthetists, certified nurse specialists. LB730 has the goal of making it easier to be licensed as an APRN. Currently, in order to be licensed as any of the four APRN categories, you must first be licensed as a registered nurse in Nebraska. Then, if you would like to be certified with an advanced designation in one of the four areas I just mentioned, you would need to get a second certification as a nurse practitioner, a nurse midwife, a nurse anesthetist, or a nurse specialist. If you are certified as one of the four specialty areas, the Department of Health and Human Services will issue you, issue you a license as an APRN. This bill would combine the Nurse Practitioner Practice Act, the Certified Registered Nurse Anesthetist Practice Act, the Clinical Nurse Specialist Practice, Practice Act, and the Certified Nurse Midwifery Practice Act into a single practice act, act: the APRN Practice Act. This bill would also eliminate the practice acts of, or for each of the four categories of APRNs. Finally, the bill reconstitutes the APRN Board, changes the membership, and gives the board the authority to determine the services that each specialty can perform. I understand that there is some objection to the bill's expansion of scope in allowing nurse midwives to practice independently without a practice agreement and without a collaborating physician. It is not my intention to expand the scope of nurse midwives without a 407 review. I'm happy to work with interested parties to ensure that there's no unintended expansion of scope of practice. I'm happy to try to answer questions about the bill; however, there will be testifiers following me that will provide you with more information and who will be able to give you much better answers in much greater detail. Thank you.

HOWARD: Thank you. Are there questions? Seeing none, our first proponent testifier. Good afternoon.

NICOLE LIVANOS: Good afternoon. Chairwoman Howard, members of the Health and Human Services Committee, good afternoon. My name is Nicole Livanos, N-i-c-o-l-e L-i-v-a-n-o-s, and I'm a senior associate with the National Council of State Boards of Nursing. The National Council is one of nearly 50 leaders in nursing, who created the consensus model for APRN regulation. The purpose of the uniform standards outlined in the consensus model is to ensure that APRNs in every U.S. jurisdiction meet the same qualifications and are able to provide the care to patients for which they were educated and trained to do. With passage of LB730, Nebraska will be further aligned with the national standards for licensure, certification, education, and practice, and also join the state's bordering neighbors of Colorado, Iowa, South Dakota, and Wyoming in removing these state-mandated contracts governing nurse midwife practice. This bill aligns Nebraska with the model that ensures public protection, promotes consumer choice, increases access to care, and moves Nebraska towards the uniformity necessary to join the APRN licensure compact. APRNs include: CNPs, CNMs, CRNAs, and clinical nurse specialists, CNSs. APRNs are highly valued, an integral part of the healthcare system, and they have the necessary knowledge and skills to care for patients and can tremendously improve access to healthcare in rural areas of Nebraska and for those in underserved populations. Nebraska has made significant progress in adopting the consensus model but still has yet to streamline the regulations for APRNs and remove the barriers that exist for certified nurse midwife practice. Current Nebraska law require, requires CNMs to enter into a state-mandated contract with a physician in order to practice. Numerous studies, published over the last many years, have shown that CNMs provide safe, high quality care without a state-mandated physician agreement. The communication, coordination, and collaboration between providers does not end when these restrictions are lifted, as is evident by the restrictions that this body has already lifted on other providers. LB730 will recognize, will modernize nurse, Nebraska's nursing statutes by: first, removing that state-mandated contract certified nurse midwives must enter in order to provide care; and also, by consolidating the state's five practice acts governing APRNs into one streamlined, uniform, and model statute. With passage of LB730, Nebraska will be further aligned with the national standards, and join over half of the states across the country by removing the state-mandated contracts for certified nurse midwife practice. And further, I just want to add into that we are

aware with concerns with the bill, and we will work with Senator Walz's office to draft an amendment after the hearing. Thank you for the opportunity to testify here today.

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

WILLIAMS: Thank you, Madam Chairperson. And thank you for being here. I do have a question as it relates to-- scope of practice versus barrier to practice is what I heard you testify to. Can you explain in some detail, so a nonmedical person could understand? You're talking about that, in particular, for the certified nurse midwives that, if I'm understanding your testimony, this bill does not change scope; it changes the barrier to practice. So can you explain that to me?

NICOLE LIVANOS: Yes, exactly. And also, as a nonhealthcare professional, I will explain it to you in my words that, hopefully, will translate to yours. So the, this bill does not change the scope of practice for certified nurse midwives. You will hear later testimony from certified nurse midwives who will talk about how the practice that they perform today-- the care that they provide to their patients today is the same care that they will provide if, if LB730 is enacted into law. It is the same care. However, there's a state-mandated contract that is governing over their practice that they're required to enter into with a physician. This does not impact the type of care that they, the patients that they see nor the type of care that they provide to those patients, simply the ability for them to practice in the state of Nebraska. They are required to have this contract, unlike many of your neighboring states.

WILLIAMS: So with that explanation, the argument would be it would not need to go through a 407 process. Is that what you would say?

NICOLE LIVANOS: So I will let others speak to that, who are more familiar with the Nebraska 407 process.

WILLIAMS: Thank you.

NICOLE LIVANOS: Yeah.

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

NICOLE LIVANOS: Thank you so much.

HOWARD: Our next proponent. Good afternoon again.

TARA WHITMIRE: Good afternoon. I won't be so short and sweet this time; sorry. Chairwoman Howard and members of the Health and Human Services Committee, my name is Tara Whitmire, T-a-r-a W-h-i-t-m-i-r-e. I am here to testify in support of LB730 on behalf of the Nebraska Nurse Practitioners, our statewide nurse practitioner organization. As a nurse practitioner working in a large community health system in Omaha, I also serve as the director of a baccalaureate of nursing to doctoral nurse practitioner program, a BSN to DNP program at a private health College in Omaha. As it relates to LB730, I also serve as the head of the APRN Coalition, which is a working group of the four APRN practice groups and the Nebraska Nurses Association. At first glance I know LB730 may appear complicated, but I can assure you it was the coalition's goal to eliminate complex red tape wherever possible. I have included with my testimony a one-pager on B730 which I hope clarifies the changes we are seeking. As you have heard, the bill proposes to remove duplicitous licensing language, consolidating five separate nurse practice acts into one which, or while allowing each APRN group to practice to the full extent of their license and education, without changing any scopes of practice. In October 2017, the Nebraska APRN coalition was formed to begin work on the National Council of State Boards of Nursing APRN consensus model. The consensus model provides guidance for states to adopt uniformity and consistency of the regulation and rules for the different APRN roles. Members of the coalition include leadership from the APRN roles or organizations, Nebraska Nurses Association leadership, and leadership from the NCSBN. Over the summer and fall of 2018, the APRN coalition continued to meet, and the decision was made to pursue additional elements of the APRN consensus model, elements main, many of our neighboring states have advanced. Adoption of the APRN consensus policies that are outlined in LB730 will ensure uniformity in licensure, accreditation, certification, and education to facilitate the really, regulation of safe, safe and competent APRNs in Nebraska. On behalf of the Nebraska Nurse Practitioners and the work undergone in the APRN coalition, I would like to say-- thank Senator Walz for introducing LB730 and her commitment to Nebraska's APRN work force. I would respectfully request LB730 be advanced from committee, and I want to thank each of you for your service. I'd be happy to try and answer any questions at this time.

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

TARA WHITMIRE: Thank you.

HOWARD: Our next proponent. Good afternoon.

KRIS ROHDE: Good afternoon, Chairwoman Howard and members of the DHHS [SIC] Committee. My name is Kris Rohde, K-r-i-s R-o-h-d-e. I am currently the president of the Nebraska Association of Nurse Anesthetists. I am a certified registered nurse anesthetist, working at Nebraska Medicine in Omaha. I am here representing the Nebraska Association of Nurse Anesthetists, in support of LB730. Certified registered nurse anesthetists, or CRNAs, are highly educated advanced practice registered nurses who deliver anesthesia to patients in every healthcare setting in which anesthesia is delivered. This includes traditional hospital operating rooms, ambulatory surgical centers, the offices of dentists, podiatrists, ophthalmologists, plastic surgeons, and pain management specialists. CRNAs also serve in the U.S. Military, where we are the primary anesthesia providers to military personnel on the front lines, Navy ships, and aircraft evacuation teams. In Nebraska, CRNAs also provide nearly 100 percent of the anesthesia in rural hospital settings. There are approximately 400 CRNAs in Nebraska currently providing anesthesia. Nurse anesthetists are required to have a minimum of seven to eight and a half years of education, training, and experience before they can become a CRNA. This includes a bachelor's degree in nursing, a minimum of two years working in a critical care setting, and then a master's or doctoral program for nursing anesthesia. In 2001, CRNAs in Nebraska were granted independent practice and opted out of physician supervision. Not only has this increased access to care for patients all across the state of Nebraska, but it has also lowered costs significantly for patients requiring anesthesia for procedures. Independent practice has allowed CRNAs to provide anesthesia services to patients close to their homes. Patients no longer have to drive to the larger urban hospitals for routine surgeries. And this increased access to care helps to keep the critical access hospitals open and running. It creates jobs in the rural communities, and it gives residents of these communities more options for their own healthcare. Currently across the United States, there is an effort to create licensure compacts for advanced practice registered nurses. In order to create these compacts, we must first have the consensus practice laws in place. These laws will ultimately allow APRNs to move to Nebraska and

seamlessly enter the work force. Independent APRNs increase the supply of qualified healthcare professionals, it lowers the costs, and improves access to care. Are there any questions?

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

CAVANAUGH: Thank you so much for your testimony. And I like your pin, that CRNA.

KRIS ROHDE: Thank you, thank you.

CAVANAUGH: So just to clarify what we're talking about that this bill would do, is already how the nurse anesthetists are operating.

KRIS ROHDE: Correct, correct.

CAVANAUGH: OK. That's what I was-- since 2001.

KRIS ROHDE: Correct.

CAVANAUGH: So in 2001 you no longer had to enter into the contract with the physicians and we're looking to expand that to these other classifications of nursing.

KRIS ROHDE: Correct.

CAVANAUGH: OK, thank you.

KRIS ROHDE: Yes. So our jobs would be the same--

CAVANAUGH: I got you.

KRIS ROHDE: --just without the supervision.

CAVANAUGH: Thank you.

KRIS ROHDE: Yes.

HOWARD: Other questions? Senator Hansen.

B. HANSEN: Unless I missed it somewhere else, what's a licensure compact?

KRIS ROHDE: A licensure compact is-- so first we need a consensus model, that we're working on, and the licensure compact would allow

people to move across state lines seamlessly so you don't have to get a new license in every single state.

B. HANSEN: Oh, OK, OK.

KRIS ROHDE: Yeah.

B. HANSEN: Oh.

HOWARD: So In 2001-- and you may not know this question-- but did the CRNAs have a 407 in order to remove their supervision?

KRIS ROHDE: That I am unaware. I know that we had to go through a 407 process at some point, and I imagine that's probably when it, when it was, but I could be mistaken. I don't know if there's anybody to ask.

HOWARD: No. And maybe somebody behind you can answer that question, as well, and I should have asked the previous testifier. For nurse practitioners, they went through a 407 to remove their supervision, and they were granted that removal in 2014-- '15. OK. Thank you so much. I just wanted to clarify.

KRIS ROHDE: Yeah.

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

KRIS ROHDE: Yeah, thank you.

HOWARD: Our next proponent? Good afternoon.

ALICE KINDSCHUH: Good afternoon. Good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. My name is Alice Kindschuh, A-l-i-c-e K-i-n-d-s-c-h-u-h. I am here today in support of LB730. I am licensed as an advanced practice clinical nurse specialist in Nebraska, working in practice in a large community health system in Omaha, and serve as the director of doctoral studies at a private health professions college in Omaha that has a clinical nurse specialist doctor of nursing practice track. I am also a member of the Nebraska Advanced Practice Registered Nurse Board, the regulatory body governing APRN licensure and practice. Clinical nurse specialists are one of the four advanced practice roles licensed in Nebraska. As a clinical nurse specialist, I have advanced education and training in a specialized area of nursing practice, specifically geriatrics. I am certified by the American Nurses Credentialing Center. I must

recertify every five years by demonstrating ongoing education and competency as a clinical nurse specialist and in geriatrics. A clinical nurse specialist's specialty may be defined by several different parameters such as: populations, settings, disease subspecialties, and type of care or problem. According to the National Association of Clinical Nurse Specialists, clinical nurse specialists' education prepares graduates to influence patients' outcomes through diagnosis, treatment, and ongoing management of health conditions. Clinical nurse specialists provide expertise to nurses at the bedside and provide expertise to health systems by driving practice change throughout the organization that reflects evidence-based care to achieve best patient outcomes. In Nebraska, clinical nurse specialists can practice without a supervisory or collaborative agreement. Clinical nurse specialists do not have prescriptive authority in Nebraska and LB730 does not grant prescriptive authority. However, the benefits of LB730 are plenty. LB730 ensures uniformity in licensure, accreditation, certification, and education to facilitate the regulation of safe and competent APRNs in Nebraska. By consolidating the five advanced practice, advanced practice nurse practice acts, Nebraska will advance to a more streamlined and digestible practice act that governs all four APRN roles and aligns Nebraska more closely to the national standards. LB730 is important to me, as a practicing APRN, as it recognizes the skill and safety with which all of our roles treat our patients. It is important to me, as the director of a doctoral program graduating APRNs, as removing restrictions will make the practice environment more attractive to those wishing to pursue, pursue a degree as an advanced practice nurse in Nebraska. Lastly, it is important to me, as a member of the Nebraska Advanced Practice Registered Nurse Board, as it streamlines our regulation and aligns us with the national model. On February 1, 2019, the Nebraska Advanced Practice Registered Nurse Board discussed LB730 at their quarterly meeting. The Nebraska Advanced Practice Registered Nurse Board supports LB730, as evidenced by a majority vote in favor. Thank you for your time and attention and consideration of LB730. I would be happy to answer any questions.

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

WILLIAMS: Thank you, Chairperson Howard. And thank you for being here. We've had a, this ongoing discussion in this committee over the years about licensure compacts and moving from state to state; and certainly I support that concept. I want to be sure, though, that what, LB730 is

not changing the licensure requirements that are in our state currently. Correct?

ALICE KINDSCHUH: They are not.

WILLIAMS: OK. So if we have a person that is licensed in another state and they want to come to Nebraska if we pass this. Tell, take me through the process of how they qualify and how they become licensed in Nebraska.

ALICE KINDSCHUH: So the process would not change with LB730. So they have to apply for a license and they go through the same credentialing process that any of us, even living in Nebraska, would go through to get an advanced practice license. We have to demonstrate that we have the appropriate education, that we, and we graduated from a school that is approved or accredited, that we have passed the certification, that we-- our criminal background check comes back negative, that we don't have any disciplinary action on our license. And so that goes through the Board of Nursing. If there's anyone who is an advanced practice nurse that has a question, or if there's a question about licensing that person, then it comes to the Advanced Practice Board for discussion and review.

WILLIAMS: So how will it be different with LB730?

ALICE KINDSCHUH: To get a license in Nebraska?

WILLIAMS: Yes.

ALICE KINDSCHUH: It will not be different. You still have to meet the same requirements to get a license. It's that we are moving these five bills into a single bill so that we're all governed by the same practice bill.

WILLIAMS: OK, thank you.

HOWARD: Other questions? I just have one. As a clinical nurse specialist, do you know-- have they always been able to practice without a super, supervisory physician?

ALICE KINDSCHUH: Um-hum, as far as I know.

HOWARD: OK, perfect. thank you.

ALICE KINDSCHUH: You're welcome.

HOWARD: All right, thank you for your testimony today.

ALICE KINDSCHUH: Thank you.

HOWARD: Our next proponent. Good afternoon.

NIKI EISENMANN: Hi, good afternoon. Senator Howard and members of the Health and Human Services Committee, my name is Niki Eisenmann, N-i-k-i E-i-s-e-n-m-a-n-n, and I'm here to testify in support of LB730, on behalf of the Nebraska Nurses Association. I am not an advanced practice nurse; I'm a registered nurse. This bill would consolidate the practice of the, the, consolidate the practice acts of the advanced practice nurses-- these, these nurses are nurse practitioners, nurse midwives, nurse anesthetists, and clinical nurse specialists-- in Nebraska to one bill, to one law. Nurses provide high quality, accessible care to Nebraskans, no matter what specialty we function in. Nurses work to maintain and improve the health status of our patients, assessing and monitoring, identifying potential complications and intervening to prevent them, no matter what specialty we work in. We work in collaborative teams. Many healthcare providers are in these teams. We seek the best outcomes for our patients. This practice is the same with an APRN, simply further adding training and education and certification in different specialty areas to serve specific populations. This bill does not change any of the current practices of these highly trained nurses. It only simplifies regulation and allows for better access to care. Nebraskans deserve high quality, cost-effective healthcare, and advanced practice nurses provide this care. This bill would simply combine the five practice acts, which would be the APRN act-- the overarching APRN act-- and then the four practice acts of the four different types of nurses to one act and bring the APRNs into consensus with all of our neighboring states. The APRN consensus model seeks to make APRN licensure, education, accreditation, and certification uniform, uniform across the country and reduce confusion to our consumers of healthcare. Thank you. And any questions?

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

NIKI EISENMANN: All right, thank you.

HOWARD: Our next proponent testifier. Good afternoon.

HEATHER SWANSON: Hi. Chairperson Howard and committee members, my name is Heather Swanson, H-e-a-t-h-e-r S-w-a-n-s-o-n. I currently serve as president of the Nebraska affiliate of the American College of Nurse-Midwives, of which I'm here to testify on behalf of, in support of this bill. We were also anticipating an amendment that would be presented today. That's going to be presented later so I'll reference an amendment. So that's, that would have been-- in my testimony it'll mention a potential transition to practice addition for nurse midwives, and then tying up a little bit regarding where we practice, so the home birth restriction would be left in. On a personal note, I've been a certified nurse midwife for 17 years and a family nurse practitioner for 12. I'm originally from central Nebraska, and I now live up in Long Pine. I work for the Indian Health Service in Rosebud, South Dakota, and teach on-line for a college of nursing. I am not representing either of my employers today. My testimony will address CNMs in Nebraska, our state affiliate's support for the provisions in the bill, 407 review history, and I'll end with some personal comments regarding my work. I provided you with some handouts. The first one, from the ACNM, is a chart about the types of midwives. Nebraska only licenses CNMs, and that is the only type of midwife this bill addresses. Certified nurse midwives are trained in the professions of nursing and midwifery. We have to maintain an RN license, go to grad school, pass a national certifying exam-- credentialing exam-- maintain that certificate with continuing ed every five years. Degree wise, entry to practice used to be a certificate. Now it's a master's degree, and some CNMs, like myself, have doctorates. CNMs are educated in maternal, newborn, and primary GYN care for women. We usually practice in clinics and attend births in hospitals, though some practice out of hospital. Nebraska has two birth centers, one here in Lincoln and the other in Omaha. Regarding home birth, Nebraska and Alabama prohibit CNM-attended home birth, and this bill retains that restriction. Because of that, we don't feel our scope of practice is changing at all with this bill. The next handout with colored blocks notes that Nebraska currently has 46 CNMs with active licenses, though only 37 practicing in-state. Most practice in urban areas. Not all are attending births; some are working in clinic only. We have several student nurse midwives across Nebraska. Most attend distance programs and complete clinical rotations in-state. We have had prospective students who have not started grad school due to our practice restrictions, notably one in Senator Williams' district, who was admitted and elected not to attend due to Nebraska statutes. The next

handout was a joint document from the ACNM and the American College of OB, of Obstetricians and Gynecologists. Ginger Breedlove, the national ACNM past president will testify later regarding an interprofessional collaboration. But of note, this document does not call for written practice agreements or supervision by CNMs, by physicians or OB-GYNs. If you'll look at the next handout with the heading "Nebraska Affiliate of the ACNM," this bill aligns us-- oh, I'm going to skip that part because you have already heard all of that. So let's see. One of the provisions that's in the bill right now added obstetrician from another place in the bill to a new spot on page-- I believe it's 19 or 20. If that went through, it would be disastrous for some of our nurse midwives that practice in, practice in settings where there's not an OB in their practice; there's one that'll testify today to that. So we are only supportive of this if that amendment would, would go through; and you'll be seeing, hearing more about that later. And regarding transition to practice, they have not demonstrated to improve patient outcomes, so we're initially hesitant to support a provision like that. But we do think professional mentoring is valuable so we're agreeable to a provision such as that. Regarding 407: two 407 reviews have been conducted on the topic of midwifery. In 1993/94, the review of the Technical Review Committee, Board of Health, and director recommended removing CNM practice restrictions. No legislative action was taken on that review, and legislative efforts after have been unsuccessful. With that favorable review in hand, in 2005 this committee heard a bill again regarding removing restrictions and, despite having three cosponsors on the committee, the chairperson insisted to go back to 407. The 2005/2006 Technical Review Committee-- would you like me to continue?

HOWARD: Oh, yes. Yellow's fine.

HEATHER SWANSON: OK, OK. Well like now I'm getting to the good stuff, OK. So the 2005/2006 Technical Review Committee recommended removing the written practice agreement, though the Board of Health and state medical director did not. We don't feel like this is worth going back to a 407 because it's, it's not a scope of practice change. The previous, the two previous 407s did include home births, so that would have been a scope of practice change. So that's why they went to 407 previously as-- let's see-- oh, and regarding CRNAs, I did look it up. I'm not seeing a review on-line of them having a 407, so I don't believe that they had one. Let's see. Senators usually ask about safety, and opposition usually mentions practice agreements ensure public safety, which is not the case. Rather, they have shown to

reduce the number of practicing CNMs. Let me direct you further down the handout. Federally CNMs are recognized as licensed independent practitioners. The FTC has recognized practice agreements as an antitrust matter. The FTC Web site has multiple letters to states, supporting legislation that removes APRN practice restrictions, including removing practice agreements. Regarding the next three points, studies published in 2016, one by the National Bureau of Economic Research, both show that states that reckon, that require practice agreements have fewer practicing CNMs, and states that do not require practice agreements do not demonstrate increased risk to those they care for, rather show lower C-section rates. I'll let you read the quotes yourself. On a personal note, I currently practice in a federal facility in a rural and high-risk population. I'm recognized as an independent practitioner. I don't always have an OB-GYN around during my time at work. The closest FP that does OB is approximately 45 minutes away for routine maternal healthcare; and high risk care even further away. So I consult with physicians via phone, as needed, to collaborate regarding established, established plans of care for high-risk women, and I transfer care out as indicated. Not all CNMs would want to practice how I do, but there are some of us that want to live in rural areas and provide care to women there. I hold CNM licenses in six states. That's partly because I teach on-line for a college of nursing and I have FNP students. So I have to have a license in any state I have an-- FNP students.

HOWARD: We're gonna, we're gonna see if the committee has any questions.

HEATHER SWANSON: OK. Good, 'cause I'm pretty much done there. [INAUDIBLE].

HOWARD: Perfect. OK, all right. Are there any questions? Senator Cavanaugh.

CAVANAUGH: Thank you for your testimony.

HEATHER SWANSON: Um-hum.

CAVANAUGH: I have a few questions. First, what are the six states that you have licenses in?

HEATHER SWANSON: South Dakota, Colorado, Texas, Arizona, and Iowa.

CAVANAUGH: OK. So I'm gonna get a little personal here, but bear with me. I have three children. All have been delivered by midwives at Methodist Women's Hospital. So with my most recent-- who everyone here knows, Barrett, seven months ago-- I had some complications in the delivery room, and it was the middle of the night and the OB on call was called in. So just an opportunity for you to, to clarify for all of us, that is still the procedure that would happen?

HEATHER SWANSON: Yeah. So this wouldn't change how hospitals require nurse midwives to practice.

CAVANAUGH: Sure.

HEATHER SWANSON: So they could still require some sort of collaborative relationship, and most facilities will ensure that, if there is assistance needed, every facility usually has somebody on call [INAUDIBLE]--.

CAVANAUGH: Right.

HEATHER SWANSON: -- so usually there would be somebody available to assist with that. Now in a rural area there are times where that might be a transfer of care, like where I work I don't have an OB-GYN, OB-GYN on, so we, we manage that based on how we manage care in areas where you don't have a surgeon available.

CAVANAUGH: Sure. And that would be the same if you had a family practice doctor and that you needed a surgeon in a rural area.

HEATHER SWANSON: Um-hum, yeah.

CAVANAUGH: There would be a transfer of care.

HEATHER SWANSON: Potentially. It depends on what the situation was.

CAVANAUGH: Well, right. Yeah.

HEATHER SWANSON: And we're trained to handle a lot of the common complications that come up. In a hospital setting when there's an OB close, I am quicker to call somebody. In the setting where I am now, I'm quick to call the ambulance and to hop in the ambulance and get to where we're going, so--

CAVANAUGH: Sure. Thank you for that. So additionally, the midwives that I see are not part of the hospital; they're part of Mid-City OB

in Omaha. But I know that they're-- well, Mid-City has a whole practice of doctors, but the midwives actually, obviously, have a contract with the doctor. So if this were to go through that the contract didn't exist, sometimes there are tests that come back that need a doctor's sort of review and things like that. Would that, how would that work? Or is that something that is only currently reviewed by a doctor because of the contract?

HEATHER SWANSON: I suppose it would depend on the test. All tests that I order come back to me. All imaging, ultrasound results, x-rays come back to me to review and then, if things are-- if there's a complication, something needs further evaluation, I consult with the maternal-fetal medicine specialist, and then they would go and see them. So in regards to just signing off and acknowledging lab results, that's something within the scope of a nurse midwife.

CAVANAUGH: So again-- all learning a lot about me-- my first child-- I ended up being induced because there was a drop in the fluid in the placenta, which I have no idea who looked at that information. I just know that Marilyn, my midwife, said, we're admitting you. Is that something that a midwife would, would look at? Is that something that would go to a doctor? Those are, those would have been test results.

HEATHER SWANSON: So in most places that would be a decision that a nurse midwife could make. Some nurse midwives do do ultrasounds; I don't know if Marilyn did your ultrasound or not, or if a ultrasound tech did it.

CAVANAUGH: Ultrasound tech.

HEATHER SWANSON: Some nurse midwives have expanded their practice to include OB ultrasounds. And so like I do that, and I would do the ultrasound if the, if oligo was presence [SIC], if this, if the fluid level was low, based on a certain score, then we could proceed to induction. That wouldn't necessarily require a physician be involved. If it was very, very low and we didn't have a really good reason, and if my antennas of suspicion were up about something else, I might call a maternal-fetal medicine provider and asked them their opinion. But in most cases, if everything else seems fine and looks, appears fine, for a situation like that a nurse midwife could manage it.

CAVANAUGH: Thank you. I'm just asking to clarify the scope for everyone--.

HEATHER SWANSON: That's OK, and I have [INAUDIBLE]--

CAVANAUGH: --since I have so many examples. Thank you very much, and I obviously enjoyed my experience with midwives since I went through it three times, so thank you.

HEATHER SWANSON: You're welcome.

HOWARD: Other questions? Senator Williams.

WILLIAMS: Thank you, Senator. Howard. And thank you for being here today. In your testimony, you made mention of a prospective student that did not start the program due to practice restrictions. Can you describe those practice restrictions?

HEATHER SWANSON: Yeah. I'm gonna be bold and say her name. She's probably watching; I don't think she'd mind. Emily Tvrdy was one that was admitted to a graduate program, a nurse midwifery program. And she felt like, due to the low number of nurse midwives practicing it in rural Nebraska, that for one thing, she'd have to travel a great distance for clinicals and that, once she got done with grad school, she didn't know if she would be able to work in a setting that was gonna be-- work well for her. She does have children. And a lot of nurse midwives don't prefer to be in a solo practice; they want to be in a practice with other nurse midwives. And so to be in a state where there's-- there's so few nurse midwives working in rural Nebraska at this time, and largely because of the practice remake, because there are some providers that don't want to take on the potential risk of vicarious liability and be responsible for what we, what we do rather than responsible for, for the, like the advice they give us when we call on the phone. So largely it was because of the statutes right now. She would probably be happy [INAUDIBLE].

WILLIAMS: But I noticed that, unless I missed it in there, you didn't mention that the practice restriction was the fact that they had to have oversight. I don't believe you mentioned that.

HEATHER SWANSON: Well, supervision of--

WILLIAMS: Or supervision.

HEATHER SWANSON: So we have to have a written practice agreement. And, and that's-- we have to maintain that relationship. There-- supervision is--

WILLIAMS: So is that the practice restriction of why Emily Tvrdy did not--

HEATHER SWANSON: Just getting a written practice agreement with the physician to be licensed and then practice, yes.

WILLIAMS: OK. Previous testifier testified that this bill does not change any of the current practices of these highly trained nurses. Do you agree with that statement?

HEATHER SWANSON: Yes. I would still be providing maternal healthcare, with or without this-- maternal healthcare, newborn care, GYN care.

WILLIAMS: So is lifting the requirement of supervision not a change in current practice?

HEATHER SWANSON: It's not a change in current practice; it's a change in how many nurse midwives we get licensed where they can practice.

WILLIAMS: OK.

HEATHER SWANSON: I think I phrased it correctly. Does that answer your question?

WILLIAMS: I'm trying to make the distinction between a scope and a barrier to practice. And the comment that was made says this bill does not change any of the current practices of these highly trained nurses.

HEATHER SWANSON: Um-hum. I can give you an example, like where I live right now. So right now I work in Rosebud. I do two-week rotations, so I drive up there, I stay there during the week, work, and then come home when I'm off. I would love to work closer. My area hospitals-- the closest facilities that are doing OB right now are over an hour, are at least an hour away: 58 miles, 55, and like 63 miles away. So if I was to practice-- now I'm also family nurse practitioner, so I'm a little bit unique. So I could work in Bassett or Ainsworth if I wanted to, under my FNP license, provide everything a nurse midwife does with the exception of catching babies. But if I was just a nurse midwife, and if I wanted to work in Ainsworth and do women's healthcare, do prenatal care, maybe collaborate with a provider in O'Neill or Winner or Valentine to plan their delivery and one of those towns, I, it would probably be up to the Board of Nursing whether or not they would authorize me being able to practice there, because there's not a physician there practicing obstetrics right now. That's-- there's

nobody doing OB. So for me just to be able to provide that care local, close to home so they could have prenatal visits, you know, in their hometown versus having to drive an hour, two hours round trip, every time for a prenatal visit, they would allow that. And regarding scope, for those practicing in, in like Lincoln and Omaha, I don't, I don't foresee this changing that much, how people are practicing in Lincoln or Omaha or urban areas or practices that they currently have. They already are privileged at facilities; they already have practice relationships set up. So I think this has a greater impact for, for those that are in rural areas.

WILLIAMS: Thank you for your help with that.

HEATHER SWANSON: Um-hum, yep.

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

HEATHER SWANSON: Thank you.

HOWARD: Our next proponent. Good afternoon.

JENDA STAUFFER: Hi, Chairperson. Senator Howard and members of the Health and Human Services Committee, my name's Jenda Stauffer. I've been an RN for 30 years [INAUDIBLE]

HOWARD: Could you spell your name for the record?

JENDA STAUFFER: J-e-n-d-a S-t-a-u-f-f-e-r. I've been an RN for 30 years. I've been a nurse midwife in Omaha for 20 years I am a CNM, and I'm speaking on behalf of myself today. As a member of the Nebraska APRN Board, I am aware of the national efforts to adopt the APRN consensus model. This uniformity cannot happen unless we have the removal for the state-required practice agreement between a CNM and a supervising OB provider. I know firsthand the difficulties associated with state-required OB-CNM practice agreements. I testified in 2017, as then president of the Nebraska affiliate of the ACNM, in support of LB466. I testified then knowing that my employer would be moving out of state within a few months. I had a short time to prepare for transition and seek another physician willing to assume liability. In, I'm sorry-- a physician willing to assume the responsibility of signing a practice agreement with me. Many physicians were willing to be available as I needed them, as is a common practice among healthcare professionals, but were hesitant to sign a practice

agreement which certified responsibility over all my actions, even when they would not be involved in the patient's care. To meet this criteria, Dr. Barsoom, a high-risk maternal-fetal OB specialist in Omaha-- he has been kind enough to agree to be responsible for supervision, and we have a signed practice agreement with two other area OB-GYNs. My current practice is unique to Nebraska because we do not have an OB-GYN in our office. I and another CNM are employed at Heartland Family First, which was a pediatric office when we joined them. We think it's an amazing fit for us because many of our families continue to have continuity of care on the pediatric side. This has been rewarding. On any given day I can wave at a new mom or hug a toddler or see little kids coming in for their kindergarten physicals. I just want to make sure that the language allows that we can all continue practicing in the settings that we do today. This bill will not change the scope of what I do. All the scope of what I do every day will all remain the same. From this office setting, I refer patients to a variety of specialists, according to their needs. It might be an endocrinologist I'm calling, a mental health nurse practitioner, or a family physician to manage a health condition which is outside of my scope of practice. Just two weeks ago I sent a 47-year-old patient to CHI Health Lakeside Hospital who was extremely hypertensive. I don't have a practice agreement with that ER physician who accepted my transfer. Collaboration, referral, and consultation between CNMs and physicians and other healthcare providers exists nonetheless. I deliver babies at Methodist Hospital and at CHI Health Creighton University Medical Center-Bergan Mercy. To have admitting privileges at both hospitals, another practice agreement, with at least two physicians, is required. These are practice agreements in addition to the state-required practice agreement. These practice agreements must be updated and resigned every two years. Bergan Mercy prohibits consultation or referral with any physician who is not on the practice agreement, unless there is an emergency. The hospital practice agreement clearly explains that, if a certified nurse midwife were disciplined and lost points, that the supervising physician could also lose points. And that's one of the things that makes it harder for us to find physicians who would sign these agreements. To provide the highest quality and seamless care, CNMs should have access to a system that fosters collaboration among licensed independent providers, not limitations. Methodist Women's Hospital also requires their own signed practice agreements, but no limits on who I can consult with. For instance, I've had in-house perinatal staff to be available, available for me on several occasions. Certified nurse midwives recognize the high level of responsibility that is assumed

when providing care to women, so we by nature see a different, unique patient set. We do not need to be competitors but rather work within a healthcare network. We need to work in collaboration to care for all subsets of female patients. When nurse midwives take care of healthy, low-risk obstetric, we rarely need emergency assistance. But when we do, we're trained to respond to the same obstetric emergencies that family practice physicians do. We manage shoulder dystocias, fix abnormal fetal heart rate tracings, and manage postpartum hemorrhages. Our practice only has a 30 percent epidural rate and, because of that, our patients rarely need any medical intervention. They're less likely to need an operative delivery and less likely to need a Cesarean, which costs our healthcare systems 50 percent more than a vaginal delivery does. There might be testimony following mine, opposing the removal of the state-required practice agreement. Usually it's from a designated practicing OB-GYN, who will cite concerns for patient safety if a state-required practice agreement is removed from the statutes. Normally, studies demonstrate we are safe and-- nationally, studies demonstrate we are safe and qualified providers and achieve great outcomes for our patients. In our practice we have had two spontaneous prolapsed cord emergencies in last few years. Because we are with our patients during labor, we are managing this emergency instead of a labor and delivery nurse. We notify the on-call staff to prepare for an emergency Cesarean and we do not wait for the physician who happened to sign the state-required practice agreement to arrive. On-call staff respond to all emergent needs, those of physician peers as well as nurse midwives. We're aware of our scope of practice, we're aware of hospital protocols, and these things are in place. I will finish with just saying that I think women across Nebraska deserve choices, and I think that nurse midwives provide safe care.

HOWARD: Thank you. Let's see if the committee has any questions. Any questions? Seeing none, thank you for your testimony today. Our next proponent testifier. Good afternoon.

LISA WHITCOMB: Good afternoon. Hi, sorry. I'm Lisa Whitcomb; it's L-i-s-a W-h-i-t-c-o-m-b. Good afternoon, Senator Howard and members of the committee of Health and Human Services. Again, I'm Lisa Whitcomb. I'm a pediatrician. I practice in Omaha. I've been in practice for 20 years. I'm board certified and a member of the Academy of Pediatrics. I'm here today speaking on behalf of LB730, which combines these statutes into one, and also removes the CNM/OB-GYN supervisory practice agreement. I do practice in Heartland Family First; it's a private practice. I practice with two midwives. Through my years of

practice I've had lots of patients that have been delivered by midwives and really have seen a trend of very good care and good patient satisfaction. And so when the opportunity came about for me to practice in the same building as a couple midwives, I jumped on that opportunity. And it's been-- we've been together for two years now, and it's been a very positive experience for me and my patients. So again, there's lots of studies that show that, in states where we don't have these practice agreements, there's more midwives available. And I think having midwife availability is really important for our patients. I see lots of patients who are looking for a more natural approach, a more hands-on approach, and I think midwives can offer that. There are a couple of studies that show that there are actually decreased low-birth-weight babies, fewer preterm babies, and less interventions when you have a midwife involved. So again, as my, as my, as a pediatrician, my concern is about the health of babies and the health of moms, and I think midwives offer very good, offer a very good option. I've been seeing more and more patients choosing midwives for their OB-GYN care. Some choice them out of lack of availability of OB-GYNs. And again, I practice in Omaha, so there's lots of OB-gynecologists available. In rural areas, I think it's even-- there's less opportunity. So I think having midwives available is really important for that. Again, I think they, when I see patients that are delivered by midwives, I think I see a higher incidence of breastfeeding, lower C-sections, lower inductions, and very good patient satisfaction. What my experience has been with our midwives, or the midwives in Omaha, all of them, is that they stay with the patients from beginning to end of labor, and so they're there to support them and help them, help them with breastfeeding when that's all-- after the baby is delivered. And so again, I think the available, availability of midwifery to these patients is very important. Again, I have lots of patients who ask for referrals. Many patients choose physicians, and I think that's important, too. And there are a lot of patients that really don't-- that would require the care of an MD and not a midwife. But, for the patients who are low-risk, I think it's a good option, and I think the people, the women in the state of Nebraska deserve that opportunity to have that care available to them. Midwives also take care of my patients, teenage girls. I think they do a really good job educating them. They take the time to talk them about birth control, and sexually transmitted diseases, and date rape, and those problems that kids encounter. And I think they do an excellent job taking care of them from that standpoint. So again, I support LB730 because I think it grants greater access of care to the midwiferies. Again-- and I've

seen firsthand the difficulties that midwives have had in the state, obtaining practice agreements. And I think-- I do see more and more patients in my practice looking for midwives, and I worry that, if midwives aren't available, some patients are seeking out home births. And in the, our state, that's not available under, or under licensed care, so I worry that, if these midwives aren't available, we might see more home births, which I feel are dangerous. So again, that's my request. Do you all have any questions?

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

WILLIAMS: Thank you, Senator Howard. And thank you, Doctor, for being here.

LISA WHITCOMB: Sure.

WILLIAMS: In, in your testimony and that of Jenda Stauffer before you, who works with you at, it appears, at Heartland Family First, you talked about improved outcomes and lower statistical numbers. What do you think is the primary reason for that?

LISA WHITCOMB: I think having the midwife there, you know, I think they do a lot of education for natural birth and they support it. Again, not that OB-GYNs don't, 'cause they do a very good job with that, too. But I think when you have your care provider, that's provided you all your prenatal care, with you from start to finish for a delivery, I think they have better techniques of helping moms make it through without having interventions like epidurals, which then can increase C-section rates and interventions like that.

WILLIAMS: Thank you.

LISA WHITCOMB: OK.

HOWARD: Other questions? Seeing none--.

LISA WHITCOMB: OK. Thank you very much.

HOWARD: --thank you for your testimony today. Our next proponent testifier. Good afternoon

GINGER BREEDLOVE: Good afternoon. I'll get my glasses so I can communicate with you effectively. I want to thank you for this opportunity. My name is Dr. Ginger Breedlove, G-i-n-g-e-r B-r-e-e-d-l-o-v-e. I am here on behalf of the Nebraska affiliate of

the American College of Nurse-Midwives, as past president of ACNM, and a practicing nurse midwife for 39 years in Kansas and Missouri. In addition to submitted testimony that I e-mailed all of you a couple days and is circulating again now, I really want to take this opportunity to highlight three numbers within those three pages that provide a balcony view of why nurse midwives should be regulated as other APRNs in your state. So the numbers are 64 years, 81 counties, and $7,000; so I want you to remember those as I proceed here. Nurse midwives are educated health professionals, formally integrated throughout the U.S. for 64 years, and they certainly existed for decades before that formal organization occurred. CNMs have comparative graduate educational training, are required to set a national certifying exam, and are licensed in all 50 states, as other APRNs. In fact, in some states CNMs attend over 35 percent of all vaginal births. It's astounding to many when I speak nationally about our counterparts of midwives in Europe and share that the U.K. has 36,000 practicing nurse midwives and 1,550 OB-GYNs. The adoption of equivalent regulations for nurse midwives in Nebraska is critical, and I want to share why. We may be fewer in number but we're not the new kids on the block. The U.S. is experiencing a rapidly growing women's health provider shortage combined with state maternity care deserts. So I want you to remember the number 81. In the U.S., 40 percent of all counties have no practicing obstetrician or midwife. According to the American College of OB-GYNs that I'll refer to as ACOG, 81 of 93 counties in Nebraska do not have an OB provider. What happens with unmet needs of childbearing women? I'm sure you know about recent media attention highlighting the rising rate of maternal mortality in the last 20 years. In 2015, more than 26 deaths were reported per 100,000 pregnant women, up from 17 in 1990. That means American women today are 50 percent more likely to die in childbirth than their own mother. Four out of five of these deaths happen in the weeks before and after birth, not while they're in the hospital. The latest data shows Nebraska maternal mortality rose 2 percent from 2016. If pregnant and postpartum women are required to travel great distances for a concerning health need before their labor and birth, we know their risks significantly increase for poorer outcomes. ACOG estimates a shortage up to 8,800 physicians next year and a shortfall approaching 22,000 by 2050. ACOG and ACNM have worked extremely close, and I've been part of most of those meetings over the last several years, to implement team-based models of care. And this includes ACOG endorsing CNMs with full practice authority in all states. So here's the good news. U.S. Congress passed a bill, signed by the president this past December, that a new definition of provider shortage area

called a maternal health care designation. This will fund CNMs and OBs to practice in unmet maternity care needs. Over 18 million reproductive-age women live in rural counties. In rural areas the number of hospitals offering obstetric services has fallen more than 16 percent since 2004. LB730 will unencumber CNMs to serve in maternity care designation areas in rural Nebraska, using the ACNM professional standards they practice to every day, in the exact same way that we practice around the country, but without a state-mandated contract. Seven thousand dollars-- someone asked this earlier: why are midwives less expensive? Reduced use of interventions and overall costs associated with CNM-led care is observed in medically low-risk women in multiple studies, both in hospital and birth centers, and many studies show a fee for service of midwifery-led care averaging half the cost: $7,000 compared to $15,000. Why is this relevant? I attended a Network for Excellence in Health Innovation meeting in DC in December. A highlighted report was from the director of prevention and population health, CMS-CMMI, speaking about the federal strong start four-year study that ended last year. The study evaluated midlife, midwife-led care for Medicaid-insured women in 43 accredited birth centers. Findings provide clear evidence that the models significantly improved almost every outcome measured, including preterm birth, low birth weight, and C-sections, when compared with similar risks. Study conclusions are profound. If progress could be made in addressing barriers to midwives, more Medicaid covered pregnant women could experience positive births on the Medicaid program. At the federal and state level you could recap a significance in savings. I urge this committee to understand how CNMs reach the triple aim of IOM: of improving experience of care, improving health of your populations, and reducing per capita costs of care. Thank you.

HOWARD: Thank you, Doctor. Are there questions?

ARCH: I have a question.

HOWARD: Senator Arch.

ARCH: Can you help me understand the training of a nurse midwife?

GINGER BREEDLOVE: Yes.

ARCH: And how does that, does it differ from other APRNs that are in this category here, both, both classroom, clinicals, all of that?

GINGER BREEDLOVE: I served as a University of Kansas nurse midwifery education program founder with about a $2 million HRSA grant. We introduced nurse midwifery education in Kansas at KU, and the graduate requirements for advanced practice nursing are essentially the same. The path of physiology, advanced pharmacology, and. advanced physical health assessment. And the competencies that then follow, that are required for nurse midwives, are, are accredited by a national accrediting body. Actually CRNAs and CNMs in our country were the first to have individual professional accreditation outside of AACN and other accrediting bodies. So we have equivalent hours, we have equivalent clinical experiences-- some would argue more because it's based on numbers, not hours-- and there is a national certifying exam that all midwives are required to sit and pass to practice.

ARCH: And has that been in place for some time?

GINGER BREEDLOVE: It's been in place-- oh my gosh-- for probably 50 years. We really are ahead of, ahead of most of the nurse practitioners alongside the CRNAs in academic education of our profession.

ARCH: So you don't have nurse midwives at this point practicing that have not gone through that educational program?

GINGER BREEDLOVE: That's correct. Now if there are states that are grandfathering in diploma-based nurse midwives, they are far and few. Most all require a graduate education degree and mandate that in order for you to practice in their state.

ARCH: Thank you.

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

GINGER BREEDLOVE: Thank you.

HOWARD: Our next proponent testifier. Seeing none, we do have some letters for the record: one from Tara Whitmire, from the Nebraska Nurse Practitioners; and one from Dr. Ginger Breedlove, certified nurse midwives from the Nebraska affiliate of the American College of Nurse-Midwives. We'll now invite any opposition testifiers to come up. Good afternoon.

TRAVIS TEETOR: Hello. My name is Travis Teetor, T-r-a-v-i-s Teetor, T-e-e-t-o-r. I'm a physician. I'm testifying on behalf of the Nebraska

Medical Association and the Nebraska Society of Anesthesiologists, in opposition to LB730. I'm also a member of the Nebraska State Board of Health; however, this testimony is not being done on their behalf, just to make that clear, as well. While the purpose of this bill may seem to be combine, to combine individual APRN and nursing role acts into an overarching act titled The Advanced Practice Registered Nurse Act [SIC], it allows for much more than simply cleaning up language. As physicians, patient safety is of the utmost concern, and there's many items buried within this piece of legislation which may unintentionally allow for unqualified providers to perform various diagnostic procedures, etcetera, for which they are not adequately trained to perform. On page 17, lines 22-31, pages 18, lines 1-18, in this 31-page bill, there's an attempt not only to provide cleanup language, as throughout other pages, but also to insert almost a full page of additional scope-of-practice language "as defined" and "as determined by the board." We feel that this would be an unlawful delegation of legislative authority to the newly formatted board of advanced practice registered nurses. All other healthcare profession scope-of-practice changes or revisions are accomplished through legislative format, many times after undergoing a thorough credentialing review or 407 process, under the guidance of the Nebraska State Board of Health. Another concern the Nebraska Medical, Medical Association has with this bill is in Section 24 on page 11, lines 22 and 23. It removes integrated practice agreements between collaborating physicians and certified nurse midwives. This is further reinforced, as well, by striking practice agreement language in Section 42 on pages 19, lines 14-28. Integrated practice agreements provide a further safety net for patients undergoing the birthing process during this critical time. Many deliveries can go awry in a very short amount of time and, by having practice agreements in place, it allows for all patients to be provided more critical care by a physician, if needed. Most hospitals, through their in-house hospital bylaws, as referenced by people that have testified earlier, still require practice agreements to be in place for certified nurse midwives to deliver babies in the hospital setting. There is also some confusion that LB730 would also grant prescriptive authority to certified registered nurse anesthetists and certified nurse midwives. Language found in Section 37 on pages 17, lines 29-30, and Section 38 on page 18, lines 12-14, both allude to this increase in prescriptive authority. These two nursing professions currently do not have prescriptive authority and, before allowing this to proceed without a scope of practice increase, it should likely be investigated further through a credentialing review process, as well. One aspect of this

bill that the Nebraska Medical Association is in favor of is Section 37 on page 18, lines 5-8, which discusses providers wearing identification that clearly identifies individuals, based upon the types of licenses they hold. I have attached a copy of the Nebraska-- or the American Medical Association's "Truth in Advertising" campaign, which has suggestions for further modification of language in this section to provide consumers with adequate knowledge of the credentials and licenses of providers who are providing them care. The other evening, while watching television, there was a commercial that I noticed, that was paid for the National Council of State Boards of Nursing, that was airing. There was a clinical nurse midwife, a nurse practitioner, a certified registered nurse anesthetist who appeared in the advertisement. During the advertisement they state that they are healthcare providers who need viewers' help because they can't-- they, with help they can provide more services to veterans, deliver more babies, and provide more services to seniors in rural areas. As the healthcare crisis in Nebraska grows, we're more important than ever in providing services but were being held back, and we're not being allowed to practice to the full extent of our abilities. If their purported claim of this bill is to simply be administrative only, clean up things, and streamline everything into one board, then why is the National Council of State Boards of Nursing, which is the parent organization of APRNs running this ad, claiming that they are being prevented from providing care in Nebraska? The Nebraska Medical Association and the Nebraska Society of Anesthesiologists would be happy to work with Senator Walz to amend and remove scope expansions in the current proposed version of LB730 and help accomplish the goal of simply an administrative, streamlining bill. Thank you very much for your time.

HOWARD: Thank you, Doctor. Are there questions? Senator Hansen.

B. HANSEN: So you reference, page 17 and 18, as it, as it is, as it is increasing their scope of practice, but in all those instances it says "within his or her scope of practice."

TRAVIS TEETOR: I don't have the bill in front of me, I'm sorry.

B. HANSEN: OK, certainly. But that's just, that's what I was wondering, 'cause that, that sounds like it's within their scope of practice, and I didn't think this was increasing anyone's scope of practice.

TRAVIS TEETOR: So the, are you referring to everything that's underlined on-.

B. HANSEN: Yeah, yeah.

TRAVIS TEETOR: --page 17 or 18?

B. HANSEN: But I, some of-- also, with some of the prescribing concerns you had. It said, "An advanced practice registered nurse may, within his or her scope of practice, assess the need for, prescribe or administer drugs," etcetera. This is within his or her scope of practice.

TRAVIS TEETOR: Yes.

B. HANSEN: Does that mean authority within their scope of practice? Or am I reading it wrong?

TRAVIS TEETOR: So Section 37: Is that what you're referring to?

B. HANSEN: Yes.

TRAVIS TEETOR: OK. As defined by the board. So essentially the board is defining what their scope of practice is.

B. HANSEN: OK.

TRAVIS TEETOR: The scope of practice needs to be defined by the legislative process, not by a board. The Board of Medicine and Surgery can't define what my scope of practice is; that has to be defined statutorily.

B. HANSEN: Sure, OK.

TRAVIS TEETOR: So this is, in essence, putting it in the board's hand to define what these providers' scope of practice is. It's not doing it through the legislative process.

B. HANSEN: OK, all right. Thank you.

HOWARD: Senator Cavanaugh.

CAVANAUGH: I think, to Senator Hansen's question, is not the scope of practice currently defined for nurses in Nebraska?

TRAVIS TEETOR: The scope of practice is currently defined.

CAVANAUGH: So advanced practice registered nurses may, within his or her scope of practice, and then conduct-- not their scope of practice, but line 1 [SIC] is "conduct an advanced assessment as defined by the board." That's not scope of practice; that's conducting an advanced assessment, which I don't know what an advanced assessment is, but that's not scope of practice. Their scope of practice is set. This is not changing what the scope of practice is; it's saying that they may practice within their scope.

TRAVIS TEETOR: Based on determination of the board.

CAVANAUGH: I guess that's not how I'm understanding it.

B. HANSEN: Now I'm confused.

CAVANAUGH: I'm understanding it is already defined, not that we're allowed, that we're giving the board the opportunity to change anything.

TRAVIS TEETOR: I'm not an attorney so I'm not gonna--

CAVANAUGH: OK.

TRAVIS TEETOR: I can't quote law, but the way that we read this, it looks like the board is defining what their scope of practice is.

CAVANAUGH: OK.

TRAVIS TEETOR: I would have to defer to legal people who can read that more in depth. I came from the operating room this morning, so--

HOWARD: Doctor, may I ask, if the language of "as determined by the board" was removed, with that assist with removing your opposition?

TRAVIS TEETOR: That would be, that would help a fair amount in removing our opposition to this, because then the board is not defining this; you guys are defining this, or the legislative process is defining this.

HOWARD: Sure. Other questions? Thank you so much for your testimony today.

TRAVIS TEETOR: Thank you.

HOWARD: Our next opponent testifier. Good afternoon.

KIM 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 both on behalf of the Nebraska Medical Association and Nebraska Methodist Health System, in, in opposition to this bill. But I want to start out by saying, first of all, both the Nebraska Medical Association and Nebraska Methodist support APRNs. They are an essential part of the healthcare team, and, and they should continue to be a part of the healthcare team. This in, this testimony in no way is, is in opposition to what they do. What we are in opposition to is the language of the bill, which is confusing at, at best; and so I want to talk a little bit about the bill. I also need to say-- and it was made very clear to me that if I was testifying on behalf of Methodist, I needed to say, because Methodist feels very strongly-- that nurse mid, midwives are an important part of their program at the Women's Hospital. They work with them regularly and have had a wonderful experience with them. So Senator Cavanaugh, you are a prime example of how well that works at Methodist. But we have been told several times today that this bill just consolidates five practice acts into one to avoid duplication and red tape, and in order to prevent confusion. If anything, this has caused substantial confusion, at least to the medical community. In Nebraska the process right now is that you get licensed as an, as a registered nurse. And then you need to go on after that, after you get your initial license, to get a second credential in one of those four areas, in order to become an APRN. And when you become one of those four areas, when you're credentialed in one of those areas, the Department of Health and Human Services will give you an APRN license. That's the way it works today. What this bill does is it strikes four practice acts. Just, if you look at the first page of the bill, page three, they're stricken completely: the Certified Nurse Midwife, Midwifery Practice Act, the Certified Registered Nurse Anesthetist Practice Act, the Clinical Nurse Specialist Practice Act-- they're stricken. So the question is, what now is the practice act for them? So when we talk about scope of practice, the scope would be under that act. And so when that act is gone, does that individual scope remain? If that's the case, then that may be OK, but it's unclear. And part of the reason it's unclear is because when the bill was drafted, we have a APRN Practice Act, but much of the language of this bill was not put in the APRN Practice Act; it was put in the Nurse Practitioner Act [SIC]. So they struck the words "nurse practitioner" and put in "APRN." So the question now becomes, are we now giving all of the scope of an APRN, which is in

the current APR, Nurse Practitioner Act [SIC], are we giving all of the scope of a nurse practitioner to an APRN? I don't think that's the intent, but that's the way it's drafted; so it's confusing. To the question of scope of practice, if you look on page 20 of the bill, if you have it in front of you, you will see that, under the section of nurse anesthetists, from line 17 on, there is, in excruciating detail, the scope of a nurse anesthetist. And any of you who were around previously dealing with dentists, dental assistants, and dental hygienists, you read massive amounts of scope-of-practice detail about what each one of those entities can do. So the state sets out, in statute, what someone can do. What this bill does is say, within a scope of practice, but now we've changed those scopes and we stricken the acts altogether, and now we're saying that the board, the APRN Board gets to determine that scope. So it's confusing. We, we've, we've spoken with Senator Walz. If this bill is to simply streamline the process and to make it clearer, we have no objection. What we do have objection to, however, is, is an accidental scope change or an, an inadvertent scope change or even an intentional scope change, in order to make sure that we all understand what's happening as a result of this bill. My last comment is-- I think, Senator Howard, you asked if the CRNAs had gone through a scope change when they went to independent practice; and yes, they did. I double checked and they did go through that at the time of the statutory change. So with that, I'd be happy to answer any questions.

HOWARD: Any questions? Senator Cavanaugh.

CAVANAUGH: I'd just like to say thank you, Ms. Robak, for clarifying and confusing me further [LAUGHTER]. But I do appreciate you highlighting the, on page 3 versus page 17. I can see why we were speaking different, differently and the same at the same time. So thank you for that.

KIM ROBAK: All right, thank you.

HOWARD: Any other questions? Seeing none, thank you. Our next opponent testifier. Anyone wishing to testify in opposition? Seeing none, we do have some letters for the record: Dr. Aaron Lanik from the Nebraska Academy of Family Physicians; Angela-- hmm, we're-- Cyza, the Nebraska Society of Radiologic Technologists; and Greg Morrison from the American Society of Radiologic Technologists. Is there anyone wishing to testify in a neutral capacity? Seeing none, Senator Walz, you are welcome to close.

WALZ: Thank you. Well, I believe the intent behind this is good and we should continue working on this in order to help facilitate recipro-- I can't say this word--

B. HANSEN: "Reciprocality."

WALZ: --reciprocity for APRNs across the state lines and help create uniformity between Nebraska and other states in order to bring us in line with the interstate licensure compact for APRNs. We do have an amendment, but we did not bring it in to the committee at this time because it did not satisfy both sides. Therefore, we will bring a more complete amendment at a later date. At this time, I would like to respectfully request the committee to hold it until we have everything worked out and everybody is satisfied with this content. So with that. I'd like to thank you.

HOWARD: Great. Are there any questions? Seeing none, thank you, Senator Walz. This will close the hearing for LB730. And we will be staying to Exec. So we'll ask everybody to clear the room.