**HOWARD** [00:00:02] [RECORDER MALFUNCTION] Committee. My name is Senator Sara Howard and I represent the 9th Legislative District in Omaha and I serve as 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** [00:00:14] I'm Senator-- hello. I'm Senator Dave Murman, District 38, from Glenville, Clay, Webster, Nuckolls, Franklin, Kearney, Phelps, and southwest Buffalo County.

**ARCH** [00:00:23] John Arch with District 14, Papillion, La Vista, and Sarpy County.

**WILLIAMS** [00:00:28] Matt Williams from Gothenburg, Legislative District 36, Dawson, Custer, and the north portion of Buffalo Counties.

**B. HANSEN** [00:00:34] Senator Ben Hansen, District 16, Washington, Burt, and the flooded Cuming County.

**HOWARD** [00:00:41] Also assisting the committee is our legal counsel, Jennifer Carter, our committee clerk, Sherry Shaffer, and our committee pages, Maddy and Erika. A few notes about our policies and procedures. Please turn off or silence your cell phones. This afternoon we'll be hearing three bills-- well, two bills and an amendment, and we'll be taking them in the order listed on the agenda outside the room. On each of the tables near the doors to the hearing room you will find green testifier sheets. If you are planning to testify today, please fill one out and hand it to Sherry when you come up to testify. This will help us keep an accurate record of the hearing. If you are not testifying at the microphone but want to go on record as having a position on a bill being heard today, there are white sign-in sheets at each entrance where you may leave your name and other pertinent information. Also I would note, if you are not testifying but have written testimony to submit, the Legislature's policy is that all letters for the record must be received by the committee by 5:00 p.m. the day prior to the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. We would ask that if you do have any handouts, that you please bring ten copies and give them to a page when you come up to testify. We do use a light system in this committee. Each testifier will have five minutes to testify. When you begin, the light will be green. When the light turns yellow, that means you have one minute left. When the light turns red, it is time to end your testimony and we will ask you to wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone and then 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 of the bill, then from those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given the opportunity to make closing statements if they wish to do so. We have a very strict no-prop policy in this committee. And with that, we'll begin today's hearing with the gubernatorial appointment of Rebecca Schroeder to the Nebraska Rural Health Advisory Commission. Welcome, Ms. Schroeder.

**REBECCA SCHROEDER** [00:02:32] Thank you. Good afternoon.

**HOWARD** [00:02:32] Good afternoon. So we were hoping you could just tell us a little bit about yourself. And I know you've been on the commission for a while, and so tell us a little bit about your work there.

**REBECCA SCHROEDER** [00:02:41] Sure, sure. Well, I am a clinical psychologist in Curtis, Nebraska. I practice in Curtis, North Platte, McCook, Dawson County, kind of all in that area. I have been on the commission since-- I-- I looked this up today-- since 2003, and I was kind of shocked that it's been that long. But years do go by fast, but it's been-- it's been a great experience; it's been a growing experience. I live and work with rural issues on a daily basis, being from Frontier County, and I feel that it's been really beneficial for me, and hopefully for rural psychology, to have the commission and to have the health issues addressed as we do. We are working really hard right now on our two incentive programs. One is the student loan program. One is the loan repayment program. And I was-- I was kind of amazed at our last commission meeting. We were told that there was a graduate student from-- I think it was the Office of Rural Health who did a study that showed that 40 percent of all family practice doctors in rural Nebraska went through our program. Isn't that amazing? I was just astonished by that and what a great thing that we can offer those medical students who are coming out of prac-- coming out of school and ready to go to practice.

**HOWARD** [00:04:01] It's wonderful. So you've specifically been working on the student loan and the loan repayment program, but your background is in mental health. Would you care to speak to our challenges in terms of mental health coverage and availability in Nebraska?

**REBECCA SCHROEDER** [00:04:15] Sure. As I'm certain you are all aware, there-- there is definitely a behavioral health shortage, especially in rural Nebraska. We struggle with number of psychiatrists, number of psychologists. You heard me mention the wide area that-- that I cover. There just aren't very many Ph.D.-level practitioners or M.D. practitioners in our part of the state. We are starting to get some APRNs coming in, some nurse practitioners, who are specializing, which is very helpful, but we still have a big gap between what we have and what we need in the future. For example, I had somebody call me just a couple days ago and say, well, we-- I really need my son in counseling, and they live in or around Curtis. It's like, where can we go? It's like, well, McCook, North Platte. Either way, it's a 45-minute drive, which is just prohibitive for a lot of people. So we deal with the access of care. We deal with the shortage of workers. In North Platte we especially have a shortage of workers who are willing and able to deal with children. I think that's a real big area right now that needs to be addressed.

**HOWARD** [00:05:16] Thank you. Are there questions from the committee? Senator Williams.

**WILLIAMS** [00:05:21] Thank you, Chairwoman Howard. And thank you, Ms. Schroeder, and especially thank you for your long-term commitment, I think, that continuation of bringing those visions. Senator Howard asked you about the continuation of care. Are-- are you seeing that the-- the loan program would be something that we should try to figure out a way to not just continue but expand into some other disciplines besides just the medical doctors?

**REBECCA SCHROEDER** [00:05:50] One of our-- our main challenges right now is on our loan repayment program is we're just running out of money. We have 14 people on waiting list and as of the middle of February, we had 12 more applications and I'm guessing there's probably been more that have come into the office since then. So these individuals are having to wait an average of one-and-a-half years right now to even get on the loan repayment program. So as you can see, that would be a big issue. I would definitely be in favor of including as many professions as we can, but we are certainly limited by funds right now.

**WILLIAMS** [00:06:29] Yep. Thank you.

**HOWARD** [00:06:29] Any other questions? Seeing none, thank you for your willingness to serve on the Rural Health Advisory Commission. We're very grateful. The committee will meet in Executive Session and make a decision about whether to recommend your appointment to the full Legislature and then we'll-- we'll hear it on the floor. So we do appreciate your willingness to serve.

**REBECCA SCHROEDER** [00:06:48] All right. Thank you. Thank you all.

**HOWARD** [00:06:50] Thank you. This will close the gubernatorial appointment for Rebecca Schroeder to the Nebraska Rural Health Advisory Commission and open the hearing for LB653, Senator Wayne's bill to adopt the Healthy Kids Act and require tests for lead-based hazards in housing. Welcome, Senator Wayne.

**WAYNE** [00:07:06] Thank you. Thank you, Chairwoman Howard. How are you doing today, and how is everybody? Great. My name is Justin Wayne, J-u-s-t-i-n W-a-y-n-e, and I represent the Legislative District number 13 which is north Omaha and northeast Douglas County. I'm here today to introduce Healthy Kids Act. This bill require lead-- lead swipe tests paid for by the landlords and sellers within 90 days-- in 90-day windows preceding the sale or rental of property built before 1978, when lead-based paint was banned. There are a number of states that have implemented similar protections. And this, given the age and the great deal of homes in this state, if you look at the fiscal note, it does a pretty good job of outlining how many homes are in the state that potentially were built before that time for you. And just for the record, it-- they estimate it around 522,000 house-- housing units. That's a significant number. And in fact, one county had-- Deuel County had roughly 89.44 percent of their housing structures built before 1980. So when you look at the amount of people, and particularly kids who can grow up in this area, this is an extremely important issue because, as this committee knows, and if not, there

will be people testifying behind me about the importance and the toxicity of lead when it comes to kids. I won't-- like I said, I won't go in all the details about this, but many of you have known that affordable, safe housing is a huge issue, not just for this year as we've talked about LB85 and other concepts, but just overall I truly believe that Americans-- the American dream is built on the-- of homeownership and having safe, affordable housing is critical to Nebraska. And the keyword in that is also "safe," not just affordable. Prolonged exposure to lead damages brain, kidneys, and the nervous systems, and also the bloodstreams and anything that interacts with those. Lead can create learning disabilities, seizures, and major behavior problems. This bill will just help us to start get a grip on the widespread issue of lead-based paint throughout our state by requiring DHHS to maintain a registry. And remember, over 60 percent of the housing block in this state probably has lead in it, one way or another. All this does is require a lead paint or a lead wipe that will identify the problems and make people aware of those issues before or after they move in when they decide to live there. Chairwoman Howard and members of this committee, please allow this bill to move forward. And I am open to any committee amendments that will make this bill better. And I also appreciate your time and your consideration. Thank you. I'll answer any questions.

**HOWARD** [00:09:45] Thank you. Are there questions? Senator Williams.

**WILLIAMS** [00:09:47] Thank you, Chairwoman Howard. And thank you, Senator Wayne, for bringing this bill again this year. Can you-- just so that I clearly understand on the rental property side, can you take me through the available-- the use of the program on the rentals?

**WAYNE** [00:10:00] So what would happen is-- when this would be implemented, let's say it's the first time the rental program-- the house comes up for rent. There would be a lead-- a lead swipe. But overall, if the building, if it's multiple units and there's swipes that continue to occur, if it's just a single person, single family, and it's a swipe, they would go on a registry and they would be certified as lead free if there's no lead, no issues.

**WILLIAMS** [00:10:21] So it's not something when-- when that renter leaves and a new renter rents that property, they would have to do it again if it's already taken care of once?

**WAYNE** [00:10:31] If it's already taken care of once, that's my intention, and if-- the language sometimes, as we all know, we write a bill hoping that it's there. If it needs to be clarified, we can-- I'm willing to amend it.

**WILLIAMS** [00:10:38] I just wanted to be sure that I understood that correctly.

**WAYNE** [00:10:41] Yes.

**WILLIAMS** [00:10:41] Thank you, Senator Wayne.

**HOWARD** [00:10:44] Thank you. Any other questions? Seeing none, will you be staying to close?

**WAYNE** [00:10:47] No, I have a Revenue and Judiciary today, so thank you..

**HOWARD** [00:10:51] All right. Well, good luck. Thank you, Senator Wayne.

**WAYNE** [00:10:54] Thank you.

**HOWARD** [00:10:54] Our first proponent testifying for LB653. Good afternoon.

**MADDIE FENNELL** [00:11:09] Good afternoon, Chairman Howard and members of the committee. For the record, I am Maddie Fennell, M-a-d-d-i-e F-e-n-n-e-l-l, and I am here representing the 28,000 members of the Nebraska State Education Association. The NSEA stands in support of LB653, the Healthy Kids Act, and thanks Senator Wayne for sponsoring this bill. The bill requires sellers of residential property constructed prior to 1978 to perform a lead dust-wipe assessment prior to the sale or, for rental properties, prior to a rental agreement unless the dwelling has a lead-free certification. Most commonly, kids get lead poisoning from lead-based paint, which was used in many U.S. homes until the 1970s when the government banned the manufacture. That's why kids who live in older homes are at greater risk for lead poisoning. It comes from indoor sources such as old lead paint on surfaces that are frequently in motion that bump and rub together, such as window frames, deteriorating old lead paint on any surface home repair, tracking lead contaminated from soil outdoors into the indoor environment, or even from lead dust on clothing worn at a job site. Long-term exposure to lead can cause serious health problems, particularly in young kids. Lead is toxic to everyone, but unborn babies and young children are at greatest risk for health problems from lead poisoning. Their smaller, growing bodies make them more susceptible to absorbing and retaining lead. Each year in the United States, 310,000 one- to five-year-old kids are found to have unsafe levels of lead in their blood which can lead to a wide range of symptoms from headaches and stomach pain to behavioral problems and anemia, meaning not enough healthy red blood cells. Even low levels of lead in the blood of children can result in behavior and learning problems, lower IQ and hyperactivity, slowed growth, hearing problems, and anemia. Lead can also affect a child's developing brain. Lead poisoning is entirely preventable. I have taught children who have suffered from lead poisoning and it was heartbreaking to see them struggle from something that can easily be prevented. I also owned a home in north Omaha and the soil around my home was found to contain too much lead, as that of my neighbors, and we all had to have the lead abatement soil work done. The benefits of requiring this assessment can protect the lives and health of many children going forward. For those who also seek financial accountability, preventing lead poisoning will also reduce costs for medical intervention and special education services in our schools. For these reasons we urge the committee to support LB653 and advance it for General File debate.

**HOWARD** [00:13:29] Thank you. Are there questions? Seeing none--

**MADDIE FENNELL** [00:13:34] Thank you.

**HOWARD** [00:13:36] --thank you for your testimony today. Our next proponent testifier for LB653. Good afternoon.

**IAN SHEETS** [00:14:02] Good afternoon. Good afternoon, Chairwoman Howard and the members of the Health and Human Services Committee. My name is Ian Sheets, I-a-n S-h-e-e-t-s. I work for and represent Omaha Healthy Kids Alliance, a Children's environmental health organization. The mission of Omaha Healthy Kids alliance is to improve children's health through healthy homes. Its vision is a healthy home for every child. I've worked for the organization for three years and I'm a state-licensed lead risk assessor. Omaha Healthy Kids Alliance was founded in 2006 as a response to the high levels of lead contamination in the city. Since then, we've expanded our services to include construction, supplies, and education to Omaha's residents about hazards in their homes, including lead. Last year we provided over $300,000 of free construction upgrades to homes in order to give the children in those homes the best possible chance at a healthy and safe future. We reached over 6,500 Omaha residents, educating many of them about lead poisoning and other health and safety hazards. Five hundred and thirty of these residents were direct clients of ours, meaning we were in their homes with them, walking them through the issues we found and how to fix them. I'd like to focus on one of these 530 clients in my testimony today. Her name is Norma and she's two years old. Norma has jet-black hair, bright eyes, and is very good at repeatedly turning the TV in the living room off and on. She's at the age where the entire world is new and exciting and she's more than willing to explore every part of it. She's also about three feet tall, which is the perfect height to get on her tiptoes and look out at her front yard through her window. Lastly, she's getting done teething, which means a lot of chewing, including on window sills. The issue is that when I did my lead dust test on one of their window sills, our lab returned a result of 26,000 micrograms per square foot, 260 times the action level put forth-- sorry about that-- by the Department of Housing and Urban Development and a little over 100 times the action level put forth by the Environmental Protection Agency. This window sill was the perfect height for her to look out and the paint on it was severely deteriorated. We educated Norma's mom and dad on the hazard and how to protect Norma, despite her curiosity, but her parents and brother moved in ten years ago when her brother was her age. Imagine if they had received that information when they moved in. If they had, Norma's big brother may have not been exposed and she certainly would not have been. I'm not sharing Norma's story because it's atypical. I'm sharing it because it's the norm for many of the families we serve every day. These are families who have young children or who may be-- who may be planning to have children soon, families who live without knowing where lead paint might be present in their homes or what to do about it. They're families who are willing and capable to take care of the lead paint but just need a little bit of education about it and don't know where to start. LB653 would be a step towards ensuring every family getting that education at the outset of renting or owning a property. I'd also like to briefly

clear up some misconceptions about the cost and feasibility of taking a single lead dust wipe. Our organization works with a laboratory out of New Jersey. These lead dust tests cost us about $25 per wipe with postage costing $3.50. We generally send our wipes six at a time, which reduces the cost per wipe due to postage. A single wipe takes at most three minutes to collect. Results are usually returned within seven days. As someone who has taken hundreds of dust-wipe samples and interpreted their results, I can confidently say that the cost of the wipe itself is not prohibitive. Many studies have been done on the return on investment in terms of lead poisoning prevention. The industry-accepted figure is that for every $1 invested into lead poisoning prevention efforts there is a $17 to $221 return. This return comes to taxpayers through reduced stress on our education system, our juvenile justice system, and our healthcare system. This return also comes to the parents that have to pay for treatment and to future generations whose ability to contribute to society isn't hindered by lead poisoning. I would urge you to think of this ROI in a different way. These are costs that we are already shackled with and for every dollar we don't invest into lead poisoning prevention efforts, this is the financial load we're choosing to take on. One of my favorite things to show people when I talk about lead poisoning, which as you might imagine is pretty often, is a graph. On the graph's horizontal axis is a time line starting at 1971 when the Lead-Based Paint Poisoning Prevention Act was put into effect. On the vertical axis is the average blood-lead level in the United States' children as collected by the National Health and Nutrition Examination Survey every year. Along the time line lie several legislative acts and standards for lead poisoning prevention, things like the ban on residential lead paint, the ban of lead in gasoline, lead, dust, and soil health standards, and things like that. What you can see on the graph is that with each-- each piece of legislation, no matter how small, the average blood-lead level decreases. Think you have an opportunity here and now to add to that time line. More importantly, you have an opportunity to take a step towards making sure that kids like Norma can explore their world without danger of being poisoned by lead paint. I'd also like to add that our organization feels it is a best practice to amend the bill on page 3, lines 26 to 30. We'd be more than willing to work with Senator Wayne on that amendment basically removing any wording about a lead-free certification in a home. That's just not in line with the best practices that we see every day. It's really hard to say that a home is completely free of lead. It takes a ton of testing and it's not-- it's misleading or potentially misleading. So thank you for your time. And thank you, Senator Wayne, for introducing this bill. We work-- look-- we look forward to working with Senator Wayne on that amendment.

**HOWARD** [00:19:03] Thank you. Are there questions? Senator Hansen.

**B. HANSEN** [00:19:07] Thank you, Chairwoman Howard. Thank you for coming. Is there a certain type of test that's certifiable? Like I know there's all kinds of test-- you can go to Walmart and buy a lead test--

**IAN SHEETS** [00:19:16] For sure.

**B. HANSEN** [00:19:16] --you know, it changes colors when you do something.

**IAN SHEETS** [00:19:18] Yeah.

**B. HANSEN** [00:19:19] So is there a certain type? And-- and I didn't see anything in the bill that requires, you know, certified lead testing company that comes in or something?

**IAN SHEETS** [00:19:27] Right.

**B. HANSEN** [00:19:27] So is there something that you recommend or is there differences between them?

**IAN SHEETS** [00:19:31] Yeah, there are different-- bunch of different tests. We primarily use lead dust wipes, which are basically just cotton wipes, that we send off to a lab. And then they use a process called flame absorption which destroys the wipe and leaves the lead behind. We also use an x-ray fluorescence gun, which is definitely a more high-tech method. You point it at a wall or a surface, any kind of painted surface, or even soil or water, and you basically pull the trigger and a small amount of radiation comes out, bounces back, and that tells us a pretty exact amount of lead in that surface behind, you know, certain layers of what we call substrate, so--

**B. HANSEN** [00:20:15] So it probably is a difference between companies that--

**IAN SHEETS** [00:20:16] Oh, yeah, to--

**B. HANSEN** [00:20:17] There are a whole bunch of companies that do it or--

**IAN SHEETS** [00:20:18] Yeah, for sure. I mean basically any lead risk assessor has the ability to do that, and any homeowner technically has the ability to do it in their own home with a lead dust wipe. I would say that a lead dust wipe is, for the purposes here, the most appropriate and least cost-prohibitive and also, yeah, just simplest. But as long as you follow the EPA's protocols, which we do, the test is fairly accurate in terms of giving you an understanding of how much lead is in a certain area.

**B. HANSEN** [00:20:49] That's good. I'm just thinking I just didn't know if we need some kind of resource for-- to the owners of the property to access-- to know which kind of test you use because there might be a whole bunch of different kinds they--

**IAN SHEETS** [00:21:00] Right.

**B. HANSEN** [00:21:00] And so it's not very particular in the bill.

**IAN SHEETS** [00:21:03] For sure.

**B. HANSEN** [00:21:04] If there's some research maybe the state can provide that says, oh, go to the EPA Web site, they'll-- they have a list of all these people you could send them to, here's-- here's test kits, here are-- here's our Web site.

**IAN SHEETS** [00:21:10] Yeah, definitely. And I think that's been a lot of the work that we've been trying to do and Omaha is becoming that resource for our community, you know, creating educational materials and Web sites and things like that, but I think that that's a great idea, definitely creating a resource for statewide kind of education about that, especially in the context of this bill.

**B. HANSEN** [00:21:29] OK. Thank you.

**IAN SHEETS** [00:21:29] Thank you.

**HOWARD** [00:21:31] Any other questions?. Did you speak with Senator Wayne about your amendment proposal?

**IAN SHEETS** [00:21:35] Yeah, we have spoken with him.

**HOWARD** [00:21:37] OK. Great. All right, seeing none, thank you for your testimony today.

**IAN SHEETS** [00:21:40] Thank you.

**HOWARD** [00:21:40] Our next opponent testifier for LB653. Seeing no one wishing to speak, we do have one letter in support, Sarah Hanify from the National Association of Social Workers-Nebraska Chapter. Is there anyone wishing to speak in opposition to LB653? Seeing no one wishing to speak, we have one letter in oppose-- oh.

**JOHN CHATELAIN** [00:22:07] Opposition?

**HOWARD** [00:22:08] Opposition, yes.

**JOHN CHATELAIN** [00:22:31] Yes.

**HOWARD** [00:22:31] Good afternoon.

**JOHN CHATELAIN** [00:22:32] Chairman Howard and the remaining members of the committee, my name is John Chatelain, and I'm president of the Metro Omaha Property Owners Association. And we are an association of property investors and landlords in Omaha--

**HOWARD** [00:22:46] Oh, I'm so sorry. Would you spell your name for the record?

**JOHN CHATELAIN** [00:22:48] Oh, certainly. J-o-h-n, last name C-h-a-t-e-l-a-i-n. And we also work through the Statewide Property Owners Association, which is an affiliation of different landlord groups in Lincoln and Beatrice and elsewhere around the state. Our association opposes LB653. It's kind of unfortunate that it's called the Healthy Kids Act because we certainly support the concept of healthy kids, but we just oppose the wording of this bill. It would require a lead dust wipe assessment of any residential property before it could be sold or rented. And the lead dust wipe assessment is an investigation to determine the presence of lead-based paint conducted by a firm or individual licensed in accordance with the Residential Lead-Based Paint Professional [SIC] Practice Act. I'm not quite sure what that is, but if it-- if it creates some kind of a small group of people only that can do the lead testing, then I think that's a problem. Also, the-- the way in which the test is done is not very clear to the-- the average layperson as to know how they would be in compliance or not. What does "in accordance with the Residential Lead-Based Paint Professions Practice Act" mean? It's-- it's kind of difficult to understand. I don't think that lead-based paint hazard is as much of a problem as it was years ago. A recent Omaha World-Herald article reported that the percentage of children testing high for lead has dropped dramatically since the 1990s because more kids are being tested and lead risks have been reduced. This is a twentyfold drop in Douglas County of children requiring lead tests. LB653 would require the landlord to perform the lead assessment more-- not more than 30-- 90 days before renting. As I read it, it's every time that a property would be rented. I know there is some reference there to a lead-free certification, but homes that were built before '78 could probably be expected to have some lead-based-paint hazard in them. Now that doesn't mean that it's dangerous or it doesn't mean that it's not encapsulated or-- or taken care of in some way. But I don't know how you would get a lead-- a lead-free certification under-- under the wording of this statute, which would mean that it would have to be tested every time it's rented. We're concerned also about creating a monopoly of those people who could do the tests and that the cost of doing the tests would be uncertain. It could be very high. And how quickly could the landlord get the test back? It might-- it might interfere with the process of getting a property rented quickly. How-- how is a landlord supposed to know if they've been in compliance with the act? Now if-- if the landlord is not in compliance, then there's-- a tenant has a cause of action against the landlord to recover actual damages, court costs, and attorney fees. I'm always very concerned as a lawyer about those cases where attorney fees are awarded because if you're defending a case like that, it means that you not only have to pay your own attorney's fees but you could potentially have to pay the plaintiff's attorney fees, which is a huge incentive or-- or a huge pressure on the defendant to settle the case and maybe not go to court on a-- when they have a legitimate defense, there's a pressure there to settle the case. And also, LB653 allows a tenant to get out of paying the rent and guarantees a return of the deposit, and this could be a major incentive for the tenant to-- to apply under the remedies of this statute to get out of paying the rent. Now actually this issue has been addressed quite successfully I believe by the landlords in-- in-- for a number of years. The EPA has a disclosure of information on lead-based paint, lead-based paint hazards, which is signed by the landlord and also by the-- the tenant. If the tenant wants to have an inspection, they may do so. Also, the landlord provides the tenant

with a pamphlet from the EPA called Protect Your Family From Lead in the Home which explains all the hazards that could come from lead-based paint. And so I think the issue is already taken care of. If the tenant wishes to have an inspection and to find out about the-- the-- the level of severity in the home, they can do so. There is always-- do I need to quit?

**HOWARD** [00:27:44] Would you like to wrap up your final thoughts?

**JOHN CHATELAIN** [00:27:46] Well, I was going to say that there's always unintended consequences with bills like this. And if you make it more expensive, and we don't know how much this would make it more expensive for the landlord to operate their business, then those costs get passed onto the tenant in the form of higher rents. There's also a substantial cost to the state for operating this plan, as I understand it, just for the Health and Human Services Department to absorb the cost of doing the registry and-- and the other things here, so we would urge that the committee not advance this bill.

**HOWARD** [00:28:22] Thank you.

**JOHN CHATELAIN** [00:28:23] OK?

**HOWARD** [00:28:26] Are there questions? Seeing none, thank you for your testimony today.

**JOHN CHATELAIN** [00:28:28] And thank you very much.

**HOWARD** [00:28:30] Our next testifier in opposition to LB653. Good afternoon.

**GENE ECKEL** [00:28:47] Good afternoon, Senator Howard, members of the Health and Human Services Committee. My name is Gene Eckel, that's G-e-n-e E-c-k-e-l, and I am a board member of the Nebraska Association of Commercial Property Owners and the Apartment Association of Nebraska. The Nebraska Association of Commercial Property Owners and the Apartment Association Nebraska oppose LB653 for the following reasons. First of all, there's a large number of homes in Nebraska, including greater Nebraska, that were built before 1978. Many of the testing methods, including lead-dust testing, provide misleading results and are not appropriate for local inspection proposals. The dust tested at a property could originate and be carried into the property from other locations, such as through an open window. Lead is still prevalent in soil, buildings outside of residential multifamily housing, and it could also be found in drinking water, cookery, candy, and toys. A peer-reviewed study that was published in 2007, which I have passed out, concluded that one particular lead-dust test produced a false negative rate of 64 percent. The EPA, which I've also passed out, stated that no lead test kits to date has met both of the performance criteria set forth in its 2008 lead renovation, repair, and paint rule. The costs of remediation may be higher than a property's value, and this type of inspection program would hurt affordable housing since it would result in removing affordable housing from the market, especially if it is based on inaccurate testing methods. It may also lead to more local

abandoned properties with lead paint issues, which would create a local-- or a liability for local governments and neighbors. Although this bill is titled the Healthy Kids Act, it appears to apply to all rent-- rental properties, not just properties with children, including six and under, may reside. Public education we believe is going to continue to play a role in mitigating lead exposure risks. In addition, the importance of cleaning practices and controlling lead exposure from lead paint dust should be incorporated in any informational effort to reduce exposure. And I believe there's always been-- there's already been a mention of the fiscal note on this particular bill. So for the reasons that I've laid out, we would ask the committee to vote not to advance LB653 to General File.

**HOWARD** [00:31:22] Thank you. Are there questions?

**ARCH** [00:31:28] I have a question.

**HOWARD** [00:31:29] Oh. Senator Arch.

**ARCH** [00:31:29] You may not be the one that's able to answer this, but if-- if you could, do you happen to know what's involved in remediation? And I-- and I ask specifically if-- if lead paint is identified as the source, lead-based paint is identified as the source, do you know what remediation would be required for something like that--

**GENE ECKEL** [00:31:49] I mean I actually--

**ARCH** [00:31:49] --if you really wanted to get rid of it?

**GENE ECKEL** [00:31:51] I'm going to be honest with you, Senator. I would not know.

**ARCH** [00:31:52] OK. All right. I'll-- I'll find out. Thank you.

**HOWARD** [00:31:56] Any other questions? Seeing none, thank you for your testimony today.

**GENE ECKEL** [00:31:58] Thank you, Senator.

**HOWARD** [00:32:00] Our next opponent testifier for LB653. Going once. All right. We do have one letter in opposition from Korby Gilbertson representing the Nebraska Realtors Association. Is anyone wishing to testify in a neutral capacity on LB653? Seeing none, Senator Wayne has waived his hearing and this will-- waived his closing and we will-- this will close the hearing for LB653 and opening-- open the hearing for LB716 and AM524, Senator Hilkemann's amendment to AM716 [SIC]. All right. Good afternoon, Senator Hilkemann.

**HILKEMANN** [00:32:58] Good afternoon, Chairwoman Howard and members of the committee. I am Senator Robert Hilkemann, R-o-b-e-r-t H-i-l-k-e-m-a-n-n, and I represent Legislative District

4. I am here to introduce AM524 to LB716. To begin with, I have shared with all of you AM715, intended to be a white-copy amendment to AM524 and LB716 which contains minor technical changes to AM524 that were brought to my attention by Bill Drafters. It also strikes Section 8 from the amendment due to concerns from the Legislative Fiscal Office. As I'm sure you recall, we first visited about LB716 a few weeks ago and I shared with you my view on the importance of timely, accurate, and quality data analysis. Since that time there have been compromises reached regarding the idea of a Medicaid cost and quality data analysis center that was included in the green copy of LB716. I am grateful for the effort put forth between the Department of Health and Human Services, UNMC regarding access to data; however, there remains the need for complete, timely, accurate, and quality data analysis, which was the heart of the bill which you have had handed out to you. This maintains the intent and the heart of what I sought to achieve with LB716: data, data, data that we can use as legislators to inform good public policy. When the statewide health information exchange was put into place in Nebraska, I was a practicing podiatrist. As you can imagine, the concept of it involved teaching an old dog new tricks. Technology today affords us an excellent opportunity for data collection and analysis like we've never had before. I'm glad that the statewide health information exchange exists and I want to do what I can as a legislator to make sure that it is being utilized to its fullest capabilities and that we as appropriators can use that data to help cut costs or to control costs. It is crucial for us, all of us, to support the statewide health information exchange so that patients have access to their own health records and so doctors and clinicians have timely access to deliver safe and effective patient care. Now if I had my Dr. Hilkemann hat on today, I would speak to you about just that; however, as Senator Hilkemann sitting before you, representing Nebraska taxpayers, I want to em-- emphasize the need for accountability. State spending on Medicaid is growing every year and with the imminent addition of Medicaid expansion we will be committing even more resources. I want to know, are those dollars being spent as effectively and efficiently as possible? Where is there room for improvement? How can the state do better? We owe it to our constituents, those whose tax dollars we collect and put to work for the greater good of society, to be able to answer those questions. I truly believe that until we are working in a fully collaborative fashion when it comes to collecting and analyzing that healthcare spending data, we cannot honestly answer those questions. I had a meeting earlier this year with Director Van Patton. He laid out for me his vision to get us to the place where we're able to have those answers and more about our Medicaid spending. I believe he's on the right track and this amendment is an important step in that direction. Thank you for your time and consideration. I'll be happy to answer any questions.

**HOWARD** [00:37:35] Thank you. Are there questions? Senator Arch.

**ARCH** [00:37:36] Did I-- did I understand you correctly that AM715 is now the amendment we're to be looking at?

**HILKEMANN** [00:37:48] That's correct. Yes.

**ARCH** [00:37:50] Not AM524 and not the original green copy?

**HILKEMANN** [00:37:53] That's correct.

**ARCH** [00:37:55] OK. Thank you.

**HOWARD** [00:37:57] Senator Williams.

**WILLIAMS** [00:37:59] Thank you, Chairwoman Howard. And thank you, Senator Hilkemann. I want to be sure that I understand a couple of things in here because of the change of-- of nature of this that we are directing NeHII-- they will be the gatherer of this information. And we know that we have some people in our state, some providers in our state that are not members of NeHII, have chosen not to be, some of them, because of very small size, and this covers healthcare facilities or, you know, home health services, medical labs, managed care organizations, federally qualified health centers, rural health clinics, all of those kind of things. How do we get around this being a mandate to them that they have to join NeHII and participate in that?

**HILKEMANN** [00:38:55] As I understand it, Senator, they don't necessarily have to join; they just have to provide the information.

**WILLIAMS** [00:39:01] So we are [INAUDIBLE]

**HILKEMANN** [00:39:03] So there's no cost-- there's no cost for them to provide the information. But if we don't have everybody putting in information, the data, then we're not getting out what we want. It's-- it's important that we have the complete data.

**WILLIAMS** [00:39:17] I-- I agree with that but I-- there-- there is-- there is no direct cost to them from NeHII for providing it, but they do have the cost, their own internal cost of submitting that information, correct?

**HILKEMANN** [00:39:32] You know, I think that most facilities at this point have-- have the-- have the capabilities for that.

**WILLIAMS** [00:39:40] I agree. I agree they have the capability. Thank you.

**HOWARD** [00:39:44] Other questions? Senator Hansen.

**B. HANSEN** [00:39:44] Thank you. This-- is information collected through electronic purposes primarily, like--

**HILKEMANN** [00:39:55] That's correct.

**B. HANSEN** [00:39:55] OK. And so maybe some facilities that do not have electronic health records or the ability, do they do that through paper then or-- or they have to update their system somehow?

**HILKEMANN** [00:40:05] Well, I think they can do it-- I think they can go either route. But again, it's-- we know most facilities are being-- are going to electronic systems.

**B. HANSEN** [00:40:13] OK. But the ones that don't have electronic--

**HILKEMANN** [00:40:17] I believe that that's correct.

**B. HANSEN** [00:40:19] OK. But if they don't and they have to update their system or they have to file-- are they allowed to file through paper means?

**HILKEMANN** [00:40:25] As I understand it, they can.

**B. HANSEN** [00:40:26] OK, cool. Thanks.

**HOWARD** [00:40:29] Any other questions? Seeing none, you'll be staying to close?

**HILKEMANN** [00:40:32] I'll be here.

**HOWARD** [00:40:34] It's-- the rest of the day is yours.

**HILKEMANN** [00:40:37] All right. Let's go to the next one-- no.

**HOWARD** [00:40:43] Our first proponent testifier. Good afternoon.

**JAIME BLAND** [00:40:52] Good afternoon, Senator Howard and members of the Health and Human Services Committee. My name is Jaime Bland, J-a-i-m-e B-l-a-n-d, and I am testifying in support of the circulated AM715 to LB716. NeHII and the department and Senator Hilkemann have been collaborating extensively on the language that was circulated in AM715. I am testifying today as the CEO of the Nebraska Health Information Initiative, or NeHII, which was designated as the statewide health information exchange by Governor Heineman in 2009. As a neutral collaborator, NeHII is well positioned to house population health tools and represents a true path forward for cost containment of rising health expenditures by citizens, business, and government. Nebraska has been first in many innovations in healthcare, most recently the notable success of the Prescription Drug Monitoring Program, or PDMP. Our PDMP is the envy of many states and our inclusion of all prescription drugs is now-- is now considered model policy for states looking to adopt or enhance a prescription drug monitoring program. Thank you to Senator Howard and the Legislature for the tools to create and be the best. Now imagine if

we are able to do the same with clinical data, the ability to examine the clinical "why" behind the prescription. By coupling that information together, this will not only ease the burden of clinicians' experience, but will result in better and more efficient and less costly care for patients. The state has made a sound investment in NeHII over the years, resulting in improved communication, coordination, and healthcare outcomes for all of Nebraskans. AM715 offers a way for this committee to continue to support and improve public health and population health well into the future. From its origins in 2008, NeHII has operated as a nonprofit partnership of healthcare organizations and government for the purposes of sharing health data for the benefit of the citizens of Nebraska. CHI Health Nebraska, Nebraska Medicine, Methodist Health Systems, Regional West, Children's Hospital, and Blue Cross Blue Shield are founding members of NeHII and continue as strong advocates today. In addition to the founding members, numerous hospitals, clinics, county health departments, and other entities like WellCare Nebraska currently participate in NeHII. I speak to you today as a registered nurse having been directly responsible for coordinating care for patients, my family, friends, and neighbors for over 20 years. The hunting for data, information, and test results are labor- and time-intensive tasks that nurses, providers, clinicians, and administrative teams perform every day, taking time away from the clinical work, the patient-centered work. The lack of interoperability is an expensive inefficiency and one we all pay for. Patients need their data in one place. Doctors and clinicians need easily accessible information to support the very best care that Nebraska facilities provide. As part of my work with NeHII, I travel the state speaking with clinicians, providers, and healthcare executives and hear similar stories wherever I go. Nebraska is a state full of healthcare professionals who are striving to provide better healthcare and decrease costs but often lack the data and tools necessary to accomplish this goal. I am often presented with personal stories about waiting for records, not getting the information, or having it lost in facsimile purgatory. We can do better and we should do better. Healthcare is challenging and complex. AM715 is an integral part of the effort to make sense of the complexity and to unravel some very tough issues to promote the health of Nebraskans to a better place, one where individual's data to the-- one where an individual's data is accessible to a person and the commission. You may hear today from opponents that they are already sharing data with an exchange framework. The difference, however, between a statewide health information exchange, or an HIE, and a national network like a commercial or vendor system is that the statewide HIE, like NeHII is an organization built not by Nebraskans for Nebraskans. The continuous improvement at NeHII benefit Nebraskans first. If the goal is patient accessibility to data, which we at NeHII believe it should be, participation in the vendor-focused exchanges or vendor-to-vendor networks that require a push, not a pull, of data will not get us there. These vendor approaches result in data that is excluded or not available. What's more, these networks are not accountable to Nebraskans. You may also hear that fees are cost-prohibitive for participation. Today, if the only services an organization accesses through NeHII is data sharing, there are no fees. You may hear several counterarguments; however, I will tell you, I know we are providing resources and services that are the envy of the country, supporting value-based care at every opportunity that we align, link, and support providers. You may hear today from opponents-- I'm sorry. We are saving healthcare dollars for the taxpayers of

Nebraska, your constituents. In the literature I provided in the exhibit, HIEs are saving federal tax dollars across the country. Also in the exhibits is the definition of data and information blocking. If an organization interferes knowingly, causes interference, or cannot reasonably justify the act of information blocking, there are proposed consequences by CMS. Secretary Verma and the ONC have stated clearly patients own the data. Clinicians and health systems have rights to the data for care. But not participating in HIE, especially when it has the participation that NeHII has built, may be creating scenarios where availability of data is contributing to harm, both medical and financial, for patients and for our healthcare system in general. We applaud the vision of Senator Hilkemann and other stakeholders around the table in imagining a population health tool that helps policymakers and researchers answer the pressing public questions of our time. As I close, I want to thank the committee, the Department of Health and Human Services, and Senator Hilkemann. For these reasons, I strongly encourage the committee to adopt AM715 in-- as a committee amend-- amendment and advance the amended bill to the floor for the body's consideration. Thank you. I'll answer any questions.

**HOWARD** [00:46:41] Thank you. Are there questions? Senator Williams.

**WILLIAMS** [00:46:45] Thank you, Chairwoman Howard, and thank you, Ms. Bland, for being here again on this. And as you made clear in-- in your opening statement, if a person is just inserting or gathering information, there is no cost, right?

**JAIME BLAND** [00:46:59] Yes, Senator, that's correct.

**WILLIAMS** [00:47:01] I-- I-- I question or-- or my concern that I'd like you to address is it appears based on the information that you've submitted to us that we have 23 critical access hospitals in our state that are not data sharing at this point.

**JAIME BLAND** [00:47:15] That's correct, Senator.

**WILLIAMS** [00:47:17] Why have they chosen not to data share if there's no--

**JAIME BLAND** [00:47:19] So--

**WILLIAMS** [00:47:20] --cost associated with it?

**JAIME BLAND** [00:47:20] Great. Thank you. There's a number of scenarios. They may participate in a health information exchange like the vendor-to-vendor networks I described. It may be a financial burden that they've experienced that they're not able to participate in or they just don't want to participate.

**WILLIAMS** [00:47:39] Would that same financial burden, if that is the case, be there under the-- the question of the LB716 that we're asked to advance?

**JAIME BLAND** [00:47:50] So between now and September 30 of 2021, working closely with the department and Director Van Patton, we've actually submitted an application to CMS, which has been approved, to cover all fees for connection for Medicaid-eligible providers. So all the critical-access hospitals would not incur costs, both from their EHR vendor as well as to connect to NeHII.

**WILLIAMS** [00:48:11] Thank you.

**JAIME BLAND** [00:48:14] Yep.

**HOWARD** [00:48:15] Senator Arch.

**ARCH** [00:48:15] Thank you. What-- what data do you currently collect and how do you determine what you are asking to receive?

**JAIME BLAND** [00:48:27] So we collect data that certified EHR technology is architected to submit to us. So admission, discharge, and transfer, or what we call an ADT, which includes demographic data, includes payer information, may include a couple of different data elements, that is in an ADT message. HL7 architecture, which is a worldwide standard for communication in EHRs, we collect the lab information, the-- what we call an O-- ORU, which includes radiology and other reports, a VXU which is the immunizations data, and then we collect V3, or Version 3, which is a continuity-of-care document which we are able to parse. It's essentially a PDF we are able to parse data elements out of, but we follow the U.S. CDI and HL7 standards for connection and then extraction of data.

**ARCH** [00:49:31] And-- and how are those, and this is probably a broader question, but how are-- how are those decisions made as to what data that you would ask of your, at this particular time, members, correct?

**JAIME BLAND** [00:49:45] Um-hum. So we-- so based upon the vendor type, they're certified in certain categories under the certified EHR technology definitions, and that's determined by the Office of the National Chairman, or the ONC. They certify against those reporting requirements. We take that data. We ask them to submit that information. We take the ADTs, the labs, the reports, the immunizations, syndromic surveillance, take that information, so we-- we do request that and working with Public Health, we've worked to reduce burden of number of data feeds an organization is required to submit. So the organization submits to us. We then point that to Public Health so they don't have to manage another data feed. So we are actually reducing the administrative burden for a number of critical-access hospitals and clinics which report-- we report the data to Public Health as a pass-through information versus managing another data

feed. So what's mandatory reporting and what is HL7 standard for reporting is what we abide by.

**ARCH** [00:50:55] So could you-- could you please also explain your governance structure?

**JAIME BLAND** [00:51:00] Sure. So NeHII has a board which is an elected board by-- every annual committee we elect a board. It's pretty much made up of our committee members, so we have a finance committee, an executive committee, a professional advisory council, a value-based care and quality reporting council, and a number of work groups and sub-work groups underneath that. We also have a data governance council. All of those committee members are represented, and then those committee members elect the board members. We have board members from Blue Cross-- Blue Cross Blue Shield, Methodist, CHI, Nebraska Hospital Association, a wide representation of stakeholders.

**ARCH** [00:51:50] I just have one other follow-up question.

**JAIME BLAND** [00:51:52] Sure.

**ARCH** [00:51:52] It-- it relates to something Senator Williams asked regarding-- regarding cost. So if I understand what you said, the uploading, if you simply-- if-- if a mandate is there and you're required to send the information, no cost.

**JAIME BLAND** [00:52:07] Yes.

**ARCH** [00:52:08] It's if you want to receive information, is that where cost is incurred?

**JAIME BLAND** [00:52:12] That's-- that's correct, Senator.

**ARCH** [00:52:13] OK. So if you want to, you-- you're sending information about your patients and who you're caring for. But if you want to then-- somebody shows up at a hospital, shows up in the emergency room and you want to query, you would have to be a-- a--

**JAIME BLAND** [00:52:27] A participant.

**ARCH** [00:52:27] --a participant--

**JAIME BLAND** [00:52:28] Correct, sir.

**ARCH** [00:52:28] --in order to-- in order to query.

**JAIME BLAND** [00:52:31] Yes, Senator.

**ARCH** [00:52:31] OK, thank you.

**JAIME BLAND** [00:52:33] Yep.

**HOWARD** [00:52:35] Other questions? Senator Hansen.

**B. HANSEN** [00:52:35] I've just got to follow-up with what they're both mentioning, too, is you were talking about a grant that you guys might have available--

**JAIME BLAND** [00:52:42] Yes.

**B. HANSEN** [00:52:42] --to help take care of some of that-- some of the fees or costs that are associated with the--

**JAIME BLAND** [00:52:46] Yes, um-hum.

**B. HANSEN** [00:52:46] --administration of this service. Is that just for critical-care hospitals or is that for everybody who--

**JAIME BLAND** [00:52:50] That's any Medicaid-eligible provider.

**B. HANSEN** [00:52:51] OK, anyone, OK. Good. Right.

**JAIME BLAND** [00:52:51] Any Medicaid-eligible provider.

**B. HANSEN** [00:52:55] Right.

**JAIME BLAND** [00:52:55] And that's the high-tech 90/10, Senator. And to answer your question from earlier around if they don't have an electronic health record and could they report by a paper, it-- so we wouldn't have a paper conduit but we would have a way for scanned documents or electronic-- or Excel document that could be reported to us should that provider's office or small practice want to submit information. That could be a possibility but there, again, would be no cost to-- to submitting data in that way.

**B. HANSEN** [00:53:24] And what is the fee then to extract the data like-- or the query that Senator Arch was talking about, what-- you said there's a cost with that. Like what-- what-- what is the cost for that?

**JAIME BLAND** [00:53:32] So depending upon the hospital, so we have a fee set for PPS hospitals, we have a fee set for critical-access hospitals, we have a fee set for long-term postacute. It's a-- it's a gradient scale. And for the most part, through the high-tech 90/10, we kept-- keep those at fairly nominal cost. I will say that the fees are not only for supporting a

query access. We actually for critical access hospitals have partnered with the Office of Rural Health to support initiatives like reducing the administrative burden and reporting for the Medicare beneficiary quality improvement program, which clinical FTE are assigned to; several clinical FTE in a critical-access hospital could be assigned to that for reporting. We're automating that for a critical-access hospital. We have three participants at this time and we'll be submitting that data to the Office of Rural Health on behalf of the critical-access hospitals. We also submit data for MIPS reporting to CMS. We also are a qualified entity. We recently are NCQA certified, so HEDIS measures can be submitted and act-- we actually enhance performance for providers so they can get a little bit more return on investment in the HIE. So we look-- we take the wide span of information and say, actually, these-- these activities in the HEDIS measures have been done so there's not duplicative testing. In an era of high-deductible healthcare plans, Senator, that-- that's impactful for an individual citizen. If we can prevent a $300 lab test or a $1,000 MRI-- MRI or a-- that's real economic value for the citizens of Nebraska.

**B. HANSEN** [00:55:18] Um-hum. OK. Do you guys see your costs going up at all anytime soon, like especially the implement-- implementation of this bill, because--

**JAIME BLAND** [00:55:22] We are a nonprofit. We actively work with our stakeholders and actually the board sets the-- the pricing.

**B. HANSEN** [00:55:30] OK.

**JAIME BLAND** [00:55:30] So if they are raising fees, they're raising fees on themselves.

**B. HANSEN** [00:55:33] OK. Good. Thanks.

**JAIME BLAND** [00:55:36] Yeah.

**HOWARD** [00:55:37] Any other questions? Seeing none, thank you for your testimony today.

**JAIME BLAND** [00:55:39] Yes. Thank you.

**HOWARD** [00:55:40] Our next proponent testifier. Anyone else wishing to testify as a proponent? Good afternoon.

**ANN POLICH** [00:56:06] Good afternoon. Good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. My name is Ann-- Dr. Ann Polich, A-n-n P-o-l-i-c-h, and I am testifying in support of the circulated amendment to LB716. I am testifying today as the vice president for quality, patient safety, and population health for the Methodist Healthcare System. We are founding members of NeHII and actively support their mission to bring trust and value to health information technology by creating solutions for moving health

data forward, and indeed that is what we were discussing today. By amending this legislation, we will have the opportunity to have our patients complete electronic health history located in a common data repository. This will be the first time in my 20-plus years practicing as a physician that I will be able to find all patient data in a single location. What a momentous occasion. The impact of this legislation will significantly and positively-- positively impact the care of our patients in many ways. First and foremost, the safety of our patients will be improved. Historically, medical decisions and treatment plans have been made without all pertinent data, as a clinician was not aware that prior testing had occurred. Other times, the data cannot be obtained in a timely manner and tests have to be repeated, increasing the time to diagnosis and treatment as well as the cost. Efficiency is compromised tracking down procedures and tests. Frustrations arise on both the side of the provider and patients when several days to weeks can pass trying to find data and connecting back to patients so that their problems can be addressed. The time lost and the expense incurred hunting for data and repeating tests is a drag on both the consumer and provider of healthcare and contributes to the uncontrolled cost of medicine. The problem of fragmented data is compounded when we seek to understand the health of the populations that we serve. Attempting to make decisions on healthcare delivery for several thousand patients with missing data can lead to operational plans which do not address the true needs of the population. By requiring healthcare entities within our state to participate in our health information exchange, we will be able to improve the integrity of the data, leading to better decision making, thus improving the quality of healthcare and outcomes for Nebraskans. In closing, I would like to thank the committee members for allowing me to testify today on behalf of the AM715 to LB716. I am happy to answer any questions you may have.

**HOWARD** [00:58:46] Thank you. Are there questions? Senator Hansen.

**B. HANSEN** [00:58:52] Thank you. I probably should have asked this earlier of Ms. Bland, but are we seeing like a growing trend of providers or hospitals joining or-- or-- or-- joining the data sharing or has it all been kind of stagnant like--

**ANN POLICH** [00:59:11] That would have to be a question-- you mean in-- in relationship to NeHII?

**B. HANSEN** [00:59:15] Yeah.

**ANN POLICH** [00:59:16] That would be-- have to be-- Jaime Bland would be best to-- to tell you the numbers. I will tell you, data-- data systems, data integrity, data analytics is now the accepted way to do business in medicine. Really, you are very handicapped if you cannot share data and your patients really deserve the portability of the data anywhere that they may reside in the state. Over time, we have seen that patient safety is severely impacted by not having that data. So I would tell you that this does not replace our electronic medical record. Our records are the internal way that we take care of patients, but what we really need is a way to connect patients who, as you know, travel time and distance and go to many different specialists and

that they are not contained in one system. Our IT department has many different commitments to transfer data to CMS, to Medicaid, and to entities like that, so we have to develop the infrastructures to make sure that we are capable to communicate with others.

**B. HANSEN** [01:00:42] Thank you.

**ANN POLICH** [01:00:44] Um-hum.

**HOWARD** [01:00:44] Any other questions? Seeing none, thank you for your testimony today.

**ANN POLICH** [01:00:48] Thank you.

**HOWARD** [01:00:49] Our next proponent testifier. All right, seeing none, we do have two letters for the record, Dr. Michael White from CHI Health, and Dr.-- and Carey Potter from WellCare of Nebraska. Is there anyone wishing to testify in opposition? Good afternoon.

**JENIFER ACIERNO** [01:01:25] Good afternoon. Good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. My name is Jenifer Acierno, J-e-n-i-f-e-r A-c-i-e-r-n-o, and I'm the president and CEO of LeadingAge Nebraska. Thank you for the opportunity to testify in regard to LB716 and the associated amendments, the last of which I have not yet seen. LeadingAge Nebraska is an association that represents over 70 nonprofit providers of long-term care services, including nursing facility, assisted living, independent living, and adult day services across Nebraska, members who will be impacted by this bill. While I understand that this bill attempts to cover healthcare facilities as defined in Nebraska Revised Statute 7-- 71-413 and more, my comments below are specific to nursing facilities and assisted living facilities. While our members understand and appreciate the availability of medical information for patient care, we also understand and appreciate the cost to our members of implementing this type of reporting. We have been in a number of hearings and talked to many of you about the challenges that are being faced in long-term care and by the providers across the state. Challenge is largely driven by unrealistically low Medicaid reimbursement. As a former deputy director of Medicaid and Long-Term Care, I can tell you that there are three major ways to reduce or constrict a Medicaid budget: (1) reduce the number of beneficiaries involved in the program; (2) reduce the types of services covered under the program; and (3) reduce provider rates. In the long-term care space, providers have been shouldering the burdens of these reductions, reductions that have left many of them on the verge of being unable to operate in areas where there are limited or no other long-term care providers. While I have heard that there is an intent to cover the cost of connecting systems and access to the state-designated health information exchange, this bill is silent as to how those costs will be covered, which essentially defers the cost to the provider by including the "shall report" language. That makes this reporting mandatory for our members. We cannot support any requirement that causes a fiscal impact to our members during a time when many do not have the financial or human resources to implement reporting. Perhaps an alternative would be

to make reporting for nursing facilities and assisted livings permissive or voluntary. Including the words "may report" would be helpful. In regard to assisted living facilities, many of these providers keep paper files and are not required to keep detailed medical records like other types of providers, based on the sheer function of assisted living. They should be exempted from this bill. In regard to the waiver process in Section 6, the waiver only speaks to technical inability of a facility to connect but makes no reference to a financial or resource waiver. This waiver should not be limited to technical issues only. As you're aware, there-- Long-Term Care has been tumultuous in the last few years in Nebraska with a number of facilities closing and many going into receivership during that time. These facilities are in the midst of a crisis. As written, this bill would require time and money for them for this reporting, time and money that many of them do not have. For this-- for these reasons, we oppose this bill. Thank you, and I am happy to answer any questions.

**HOWARD** [01:04:44] Thank you. Are there questions? Would it help if there was language that specifically said that-- that there couldn't be any fees associated with-- with the reporting of the data?

**JENIFER ACIERNO** [01:05:00] I believe that it would be helpful to have language included regarding the reporting of the data, but also in regard to the interface and the work that the providers would have to do, those who have electronic health records or systems in order to implement the work with their vendor and also to connect to NeHII. So while the reporting itself at no fee is fine, you have to be able to do that reporting first, and that's a capa-- a capability that many of our provid-- providers would not have.

**HOWARD** [01:05:31] And then you've spoken with Senator Hilkemann about these changes?

**JENIFER ACIERNO** [01:05:34] I have not spoken with Senator Hilkemann yet about these changes.

**HOWARD** [01:05:37] OK. All right. Thank you.

**JENIFER ACIERNO** [01:05:39] OK. Thank you.

**HOWARD** [01:05:40] Any other questions? Seeing none, thank you for your testimony today.

**JENIFER ACIERNO** [01:05:42] OK, thank you.

**HOWARD** [01:05:43] Our next opponent testifier. Good afternoon.

**HEATH BODDY** [01:06:00] Good afternoon, Chairwoman Howard. Members of the committee, my name is Heath Boddy, that's H-e-a-t-h B-o-d-d-y. I'm the president and CEO of the Nebraska Health Care Association. And on behalf of our nearly 400 nonprofit and proprietary skilled

nursing, assisted living members across the state, I'm here today to speak in opposition to AM715 as it's currently drafted, In an effort not to repeat what Ms. Acierno has just went through, I thought I would just focus on a few things. We feel like the-- the nursing-- maybe-- and I'll separate it in two ways, nursing facilities versus assisted living. In the nursing facility space, there's a tremendous amount of data that's already required to be submitted to the Centers for Medicare and Medicaid Services. That, in return, then comes back to the state Medicaid department and it would seem that there would be an opportunity to harness that data. Now not an expert on the exacts of what NeHII collects, it makes me wonder if there's some synergies in that data collection that wouldn't be put on into redundant reporting from-- from the providers. Our members are willing and have been willing participants in starting some pilot things with NeHII, especially on the nursing facility side. It would seem unneeded to mandate that they do something that they're already willing to start-- start working through. I've been working with NeHII prior to Ms. Bland joining them and frankly the issue even nine years ago, or eight years ago, was that it-- there just wasn't a-- a real sort of carrot, if you will, there wasn't a real reason for the long-term care space to be in the system back then. Many of the people that are in NeHII now had financial incentives and things through federal funding to get and the long-term care space did not have that. So when Ms. Acierno talks about, you know, there's this-- there's this-- I would call it a bridge, the ability for NeHII to talk to the EMRs, the electronic medical records or health records in the facilities. That's one cost, the-- the cost to-- we've already talked that NeHII has said there would be no cost to input; it would only be to take out information. But there's also that infrastructure cost and if the-- if a facility is not-- does not have an EHR or electronic medical record that would work with NeHII, that would be a substantial financial implication for them. My understanding is NeHII is going to start with the top three systems in the state and then work their way-- as far as building that bridge between them and the provider, and then work their way forward. And so I think there is some real-- we support the idea of NeHII. I think there's some-- some great things in the future that could happen in that way, but it seems like putting that burden on those facility providers on the nursing facility side, especially, as Ms. Acierno laid out, at this time could be a real problem depending on the size of the financial implication. On the assisted living facility side, Nebraska is a social model in assisted living. There's very limited requirements for the resident record. And so we-- we in essence would be asking them (1) to collect much more information than the Nebraskan that resides in those has to give now. The Nebraskan in an assisted living center in Nebraska can direct their own care. They would tell the team if they would choose to have medicines given or if they would choose to do that themselves. They may just maybe would ask for food or for housekeeping services. And so it would seem that we're sort of changing the model from a social model, which is what Nebraska's design is, into a medical model by forcing this upon-- upon those entities. So again I just want to reiterate we support the goal of the electronic health information exchange. We do not believe there is a need to force the timetable and a potential unfunded mandate onto the operations. And I would just point out-- Senator Howard, you'd asked about our work-- we have visited with Senator Hilkemann, we visited with Senator Howard, we've talked with Ms. Bland, we've expressed those concerns, and there's been encouragement in that for us to work with other parts of the healthcare community to develop

some language that makes-- makes sense and we're working on that now. With that, I'd be happy to answer any questions just in an effort not to be redundant in information.

**HOWARD** [01:09:59] Thank you. Are there questions? Seeing none, thank you for your testimony today.

**HEATH BODDY** [01:10:04] Thank you.

**HOWARD** [01:10:05] Our next opponent testifier. Good afternoon.

**THOMAS "ROCKY" THOMPSON** [01:10:17] Good afternoon. Madam Chair, members of Health and Human Services Committee, my name is Thomas "Rocky" Thompson, T-h-o-m-a-s R-o-c-k-y T-h-o-m-p-s-o-n, and I serve as deputy director of Division of Medicaid and Long-Term Care at Department of Health and Human Services. I'm here to testify in opposition to some technical concerns with the AM524. And just to clarify, I have not yet seen AM715. And AM524 would amend the existing LB716 by reducing the scope of data that we provided to Medicaid Cost and Quality Data Analysis Center and by making reference to applicable law that restricts the data's use. This amendment also replaces the bill's original designation of UNMC as home to the center with an entity of the Department of Health Human Services CEO's choosing. A great deal of progress has been made in making this bill agreeable to a variety of stakeholders, and we would like to thank those involved in the conversations thus far, especially Senator Hilkemann. While AM524 addresses many of the department's concerns with underlying bill, this amendment fails to address all of our concerns regarding data privacy. The amendment had-- has a proposed amendment to AM524 that if adopted would alleviate the department's concerns. The proposed amendment would also alleviate any fiscal impact LB716 would have to the department. And we would ask the committee to take up the department's version of the amendment. Without all the changes required-- requested by the department, we cannot support this legislation. I have not yet seen the new amendment or reviewed it to ensure that all the changes requested by the department are in it. So for that reason, I oppose AM524 and thank you for the opportunity to testify.

**HOWARD** [01:11:59] Director Thompson, do we have a copy of the department's preferred amendment?

**THOMAS "ROCKY" THOMPSON** [01:12:04] I'm not sure. It is labeled AM648.

**HOWARD** [01:12:11] OK.

**THOMAS "ROCKY" THOMPSON** [01:12:12] So that's what's been--

**HOWARD** [01:12:13] Would you mind sharing a copy of that?

**THOMAS "ROCKY" THOMPSON** [01:12:15] We can-- I can share it with you. Mine is marked up with the changes--

**HOWARD** [01:12:17] Right.

**THOMAS "ROCKY" THOMPSON** [01:12:17] --and the changes are basically-- there are some changes and this is an amendment to the amendment that the hearing is on, not AM715 which we haven't seen.

**HOWARD** [01:12:28] OK. OK.

**THOMAS "ROCKY" THOMPSON** [01:12:29] So the-- Section 2 there's some language taken out there. In Section 4 there's reference to privacy laws and making sure it's confidential. Section 5, it has more with privacy laws, and then there's a definition of laboratory in Section 6. And then there's some additional language in Section 7.

**HOWARD** [01:12:47] OK. Thank you. We'll-- you're going to get us a copy of that.

**THOMAS "ROCKY" THOMPSON** [01:12:51] Yes, ma'am.

**HOWARD** [01:12:51] OK. All right. What questions? Seeing none--

**THOMAS "ROCKY" THOMPSON** [01:12:52] OK.

**HOWARD** [01:12:56] --thank you for your testimony today.

**THOMAS "ROCKY" THOMPSON** [01:12:56] Thank you, Madam Chair.

**HOWARD** [01:12:59] Our next opponent testifier. Seeing none, is there anyone wishing to testify in a neutral capacity? Good afternoon.

**KATIE ZULKOSKI** [01:13:18] Good afternoon, members of the Health and Human Services Committee. My name is Katie Zulkoski, Z-u-l-k-o-s-k-i, testifying on behalf of the Nebraska Hospital Association. We are testifying today neutrally to point out some language that we would like to see in an amendment that the committee would consider. And this is the same to both AM648 that the department is mentioning and AM715, which we understand is in front of you, has to do specifically with Section 6, and it matches what we are hearing from the testimony today and from the conversations that we've been in with the proponents and opponents of the bill over the last couple of weeks, the intent of the bill to have participants in the program be inputting information. And we would like to see language that specifically states that the requirement would be to input the information, and we think that would fit in Section 6, starting on line 18. Rather than where it says, "participate in and connect," we would like language that

says something similar to "provide information." And then on 19, striking the word "share" and instead put the word "input," we think that would more clearly line up with what we are hearing the intent of that required participation and input to be. And then similarly to what you heard from some of the opponent testimony, but again we're sharing this in a neutral capacity, would be that there would be some additional language, perhaps even a new subsection, that would say a fee shall not be imposed on the healthcare facility for compliance with this section. So if you are indeed only inputting the information, there would not be a fee imposed. Again, we understand that is the intent of those working on this bill, but we would like some language that would clearly state that. And with that, I'm happy to answer any questions.

**HOWARD** [01:15:02] Thank you. Are there questions? Seeing none, thank you for your testimony today.

**KATIE ZULKOSKI** [01:15:05] Thank you.

**HOWARD** [01:15:07] Our next neutral testifier. Good afternoon.

**ANNETTE DUBAS** [01:15:18] Good afternoon, Senator Howard and members of the Health and Human Services Committee. My name is Annette Dubas, A-n-n-e-t-t-e D-u-b-a-s, and I am the executive director for the Nebraska Association of Behavioral Health Organizations, otherwise known as NABHO. We are a statewide organization advocating for the behavioral health providers, hospitals, regional behavioral health authorities, and consumers. Our mission is to build strong alliances that will ensure behavioral health services, including mental health and substance use disorders, are accessible to everyone in our state. We had the original bill, LB716, on our monitor list, but with the amendment and the new hearing we felt maybe this was an opportunity for us to weigh in. So we may be a little bit late to the dance but realize that this is an important piece of legislation. Our members do appreciate the importance of understanding business trends and what it actually costs to deliver services. We are business people, too, and need to be able to analyze our own data, as well as how it fits into the global picture. Because behavioral health providers rely so heavily on public payers for our revenues, we intend to be good stewards of those dollars and work very hard to make sure that they are used in the most efficient and effective manner. And we want to be sure that we fully understand the intent and the goals of this legislation and any associated costs. We're certainly not strangers to submitting data to various government agencies, but just collecting data for data's sake doesn't result in positive changes, necessarily. We also understand the need to evaluate that data and to determine if there are better ways to manage resources and then how that data can be used to inform healthcare delivery. We see value in this type of an exchange, but setting up a system like this will require an investment and we're just not exactly sure what those costs will be associated with any kind of an IT infrastructure that will be required either from our members or any outside entities. A recent cost model study done by the Division of Behavioral Health demonstrates that behavioral health providers are already being paid below the cost of providing their services. Many of our-- our members had to hire additional staff to deal with the

administrative requirements related to Heritage Health. So taking on any additional costs at this time really would be a difficult burden for them to endure and could be very, very cost-prohibitive. So we do want to let Senator Hilkemann know we appreciate his leadership on this and understand the importance of this debate and this legislation and would appreciate being a part of any future discussions to bring what we-- to bring our questions in, to bring any possible additional language to the bill. So I thank you for your time and attention and would be happy to answer any questions if I'm able.

**HOWARD** [01:18:22] Thank you. Are there questions? Senator Arch.

**ARCH** [01:18:23] Thank you for coming, for testifying. Do you have any estimate as to how many of your members collect data electronically?

**ANNETTE DUBAS** [01:18:36] As I was sitting there listening to this, I'm like, this is something that we're in the process of trying to collect that information for our members, so I don't have an accurate number. I know that some do, but I also know that there are some that probably don't have a real sophisticated model yet.

**ARCH** [01:18:53] I guess my understanding of behavioral health would be that collection of data with behavioral health maybe doesn't lend itself as-- as much to medical, to the medical field for a lot of dictated reports, not easily extractable electronically. Would you-- would you agree with that?

**ANNETTE DUBAS** [01:19:13] I would absolutely agree with that, and that's-- you know, one of the things we struggle with is we want to be able to come forward when we're talking to you and really put that data on the table. But behavioral health is not like diabetes or cancer or anything like that. So really being able to get those hard numbers and demonstrate that in a, you know, a fact and figure, I mean, I think there are ways of doing it, but we certainly are-- are not in the same place that physical health is. Again, we understand the importance of it and demonstrating what it takes to provide our services and-- and be able to prove that to our payers. But it's just a different kind of field than other healthcare services.

**ARCH** [01:19:51] Thank you.

**HOWARD** [01:19:54] Any other? Senator Williams.

**WILLIAMS** [01:19:54] Thank you, Chairperson Howard. And thank you, Senator, for being here. You-- you have the opportunity to represent some large providers and also some very small providers. There-- there's a provision in the amendment that talks about a waiver based simply on technical inability. Would it make a difference to you in your thoughts on this if there-- if the waiver were expanded to include lack of resources or something like that?

**ANNETTE DUBAS** [01:20:28] I think that definitely would-- would help, especially for-- you know, we're a very diverse organization, so we represent some very, very small, what you would call a mom-and-pop type of operation all the way up to the largest hospitals and facilities in the state. So for especially some of those smaller, and even some of our midsized operators, you know, what's-- I guess the question is, what is it that's really going to be required of them? And if it is financially impossible for them to do, if we could have that waiver in place, I think that would help.

**WILLIAMS** [01:20:58] Thank you.

**HOWARD** [01:21:02] Any other questions? Seeing none, thank you for your testimony today.

**ANNETTE DUBAS** [01:21:04] Thank you.

**HOWARD** [01:21:06] Our next neutral testifier. Seeing none, we do have one letter in the neutral capacity, Pat Lopez from the Friends of Public Health of Nebraska. Senator Hilkemann, you are welcome to close.

**HILKEMANN** [01:21:24] OK. Well, we have this big table up in my office, and we have lots of chairs around it, and it looks like we're going to be using them a little bit more. But let me just follow this paper trail. AM524 was drafted and based on an e-mail that we received from Dr. Van Patton dated February 25, and it was sent to all the committee members. AM648 was drafted to address the concern from Bill Drafters. And when you get to AM715 it strikes-- the only thing it does is it strikes Section 8 from the AM648 so-- and so it was interesting for us that the department came in today to oppose their own draft that they had done on AM524. So at either rate, we'll continue. There's obviously some more work that needs to be done. We'll continue to keep working with-- I think this is that-- I think this is an extremely worthy goal and is worth our time and energy and effort. So I would ask that we continue to keep the conversations going and keep moving this forward and try to work out, get everybody on board. Not everybody's going to be happy. As I've been-- as I told about the two hats, I wasn't always happy to have to provide things either, but we did it. And I hope, Senator Hansen, that-- that Jaime was able to answer your question a little bit about the paper records. And we don't like to be stretching it, but at the same time, medicine is changing and we need to be on top of it and we need to share data and we know that that will help in cutting down costs. As I shared in our testimony, we've found some of the collaborative efforts already in Omaha that are happening that are cutting down the healthcare costs. We need to do everything we can. I used to-- when I would get-- in my days when I was not anti-medical records, and I said, someday you're going to go to a doctor, you're going to pull out a credit card, and it's going to contain your entire history on it. And I believe that someday that that's where we'll be. This is just one step in moving us closer so that we've got it. And we've got a long ways to go, but if we don't take these steps, nothing's going to happen. So I would ask you to keep on working with us on this.

**HOWARD** [01:24:13] Questions? Senator Arch.

**ARCH** [01:24:15] One more, and-- and this isn't something you can answer right here. I would just add-- I would add one other question to the question of cost. So providers are required to input, would be required to input, but there would be many people that would be interested in-- in accessing that data, whether it be the Department of Health and Human Services for the Medicaid population or insurance company or an accountable care organization that's trying to manage their population of patients, whoever-- whomever it might be. And I guess the question there is, is there a-- is there an anticipated cost for the accessing of data independent of the anticipated cost for a provider retrieving data who is already inputting and required to input that data? And I-- for that large table you have in your office--

**HILKEMANN** [01:25:11] Um-hum.

**ARCH** [01:25:11] --you could throw that into the questions there too, so.

**HILKEMANN** [01:25:14] OK. One more question to ask, right.

**HOWARD** [01:25:18] Any other questions? Seeing none, thank you, Senator Hilkemann. This will close the hearing for AM524 to LB716, and the committee will take a ten-minute break before we start next one.

**HILKEMANN** [01:25:31] Oh, thank you.

[01:25:31] [BREAK]

**HOWARD** [01:39:24] [RECORDER MALFUNCTION] and open the hearing for LB528, Senator Hilkemann's bill to change provisions relating to use of pharmaceutical agents and the use of certain treatments and procedures by optometrists. Welcome, Senator Hilkemann.

**HILKEMANN** [01:39:50] Good afternoon, Chairwoman Howard and members of the committee. I'm Senator Robert Hilkemann, that's R-o-b-e-r-t H-i-l-k-e-m-a-n-n, and I represent Legislative District 4. I'm here to introduce LB528 which is a bill that would require approval by both the Nebraska Board of Optometry and the Nebraska State Board of Health for expanded authority for licenses of doctors of optometry. I wanted to begin by stressing an important factor in this legislation. This bill does not increase the scope of practice for the profession. If this bill were passed tomorrow, Nebraska doctors of optometry would not be able to do anything different than they can do today. This is an important distinction, and I'm emphasizing it in large part due to a couple of e-mails that I received from people who were grossly misinformed about the intent and function of this bill. It is my hope that we can have a positive discussion about what this bill serves to accomplish and not get off track. Even though the bill does not change the scope of practice for the doctors of optometry, the bill does accomplish something significant, needed,

and safe. It creates an alternative pathway for keeping up optometric scope of practice up to date with current standards of care without the time and expense of fighting a battle in the Legislature every future update. The process for expanded authority for licensed doctors of optometry would require approval by both the Nebraska Board of Optometry and the Nebraska State Board of Health. Given the statutory charge of those boards and their track records in protecting public safety, the Legislature has no reason to assume that they would approve any additional authority unless they were sure that every licensed OD was already fully capable of assuming that authority or unless there were specific appropriate requirements for additional training and education that all licensees had to meet. Historically the Legislature has trusted these entities, rightfully so, and as regulatory bodies they have a proven track record of protecting the public. As I have already mentioned, this bill will not increase the scope of the practice for the profession. It allows for future increases in scope by passing this bill-- but passing this bill will not authorize licensed ODs to do anything more than they can do today. I believe that this change is necessary for a few reasons. First, it addresses weaknesses in the 407 process when it comes to being able to resolve and modify proposals. This will create a process that could be collaborative between optometrists and any opponents. We still have the 407 process and this bill does not eliminate that as a tool or a resource for the Legislature. It also does not limit the Legislature's authority to step in at any time and act to establish, clarify, or redefine boundaries or limitations for the profession. Secondly, it would allow for decisions about additional authority be made in a much more timely manner than going through the 407 process and the Legislature. Third, it would allow for decisions regarding the appropriate qualifications, education, training, etcetera, for the protection of consumers to be made by people who have specific familiarity and expertise in healthcare. If you're wondering why it would be appropriate for the Legislature to do this for optometry, I'll tell you that it isn't really that much different than current protocols and authority. The Board of Optometry has been interpreting and authorizing certain enhancements for years within the parameter of the statute. However, the issue in this case is that most future updates to their practice act involve "procedures" which are already allowed in statute or additional means of delivering medications which they're already allowed to prescribe. But many of those procedures in the future will bump up against the language in their law that categorically prohibits "surgery" or "laser surgery." The questions will be over what constitutes surgery and what constitutes a procedure and having the Legislature make those determinations is a highly political context, is not the most effective way of assuring that this profession can fully serve the needs of patients. The Board of Optometry will be testifying on the bill and explain this even more fully. I'll wrap up by saying that the authority being proposed for the Board of Optometry in this bill is not appreciably different than the authority given now at the licensing board for podiatry and dentistry, for example, except where even-- we're even proposing an additional level of safety in this bill by requiring approval by the Board of Health for authority involving expanded scope. I would be happy to answer any questions for you and assure you that there are testifiers here today that will be able to share much more information about the practice as it stands today, how far it has come, and what we could see in the future. And with that, I thank you.

**HOWARD** [01:46:14] Thank you. Are there questions? Senator Williams.

**WILLIAMS** [01:46:19] Thank you, Chairperson Howard, and thank you, Senator Hilkemann. And to a little bit set the stage for-- for this and the testimony to come, this committee and this Legislature has relied on the 407 process in these scope issues. If I'm not wrong, three years ago I think you brought legislation to substantially change, if not eliminate, the 407 process. But as a banker, not a healthcare provider, I have found that process to be rather important to me. The-- there have been several attempts to go through a 407 process with expanded scope for optometrists, and am I correct that so far the three levels have not all been achieved in those levels in the 407?

**HILKEMANN** [01:47:18] I believe that that's correct.

**WILLIAMS** [01:47:19] Yeah.

**HILKEMANN** [01:47:19] And-- and you-- and they will be able to address that better than I am.

**WILLIAMS** [01:47:24] Also can you help me so I just clearly know and we have it on the record that the Board of Optometry is made up of-- of how many people and how are they appointed or chosen?

**HILKEMANN** [01:47:36] I'm going to--

**WILLIAMS** [01:47:38] OK.

**HILKEMANN** [01:47:39] --have you ask that question to the-- to-- I'm not just sure--

**WILLIAMS** [01:47:40] And I would like the same-- I'd like the same question asked of the Department of Health so we clearly know who those bodies are and how those members of that body are selected, too, so that's my only questions at this point. Thank you.

**HILKEMANN** [01:47:57] OK.

**HOWARD** [01:47:59] Thank you. Any other questions? Senator Hilkemann, you'll be staying to close?

**HILKEMANN** [01:48:00] I'll be here.

**HOWARD** [01:48:01] Wonderful. Thank you. By a show of hands, who's interested in testifying on LB528? OK, so we're going to switch to a three-minute clock for the duration of the hearing. And now I'd like to invite our first proponent testifier to come up. Good afternoon.

**AMY DeVRIES** [01:48:28] Good afternoon. My name is Dr. Amy DeVries, spelled A-m-y D-e-V-r-i-e-s. I'm an optometrist practicing in Fremont and I serve as the vice president of the Nebraska Optometric Association. The NOA represents approximately 80 percent of the licensed optometrists in the state and I am appearing on their behalf in support of LB528. This bill is important in enabling our profession to keep pace with the rapidly evolving standards of care. Let me start by giving you a picture of what optometrists do today in Nebraska. We provide over two-thirds of the primary eye care in the state, and certainly that includes performing comprehensive examinations, prescribing corrective eyewear and contact lenses, but what my colleagues and I do in our practices every day includes far more. We-- there are systemic implications of almost every eye disease that we diagnose and treat, but to uncover those implications we take full medical histories on our patients, prescribe a broad range of topical and oral pharmaceuticals, and utilize minor surgical procedures to remove foreign bodies from the eye. Additionally, we provide pre- and postoperative surgical care for patients and must recognize and deal appropriately with complications of those eye surgeries. Just like other healthcare professions, our work involves the constant use of judgment, professionalism, and ethics. Regardless of my-- of what my license allows me to do, my oath and responsibility to the patients means that I need to know when to treat, when to get a second opinion, and when to refer, and it will be no different going forward. Because we're held to the same standards as medical doctors who provide care in the same situations and because those standards evolve constantly, it's essential that we are able to keep our authority up to date with the advancements, knowledge, and education available to optometrists. In order to do that, we need an alternative method of updating our scope of practice. Over the past four decades, every time we have sought to update the ability of optometrists to serve our patients, it has taken at least four years, and in some cases eight years or more, to eventually gain the authority through the legislative process. To illustrate this point, as far back as 1992, every optometrist in the state was being trained by accredited institutions and tested by a nationally certified body on all medications rational to the treatment of eye diseases, but because of unrelenting political opposition it took until 2014, 22 years for us to pass that legislation that finally removed some remaining restrictions on-- on our authority. With the pace at which healthcare is changing, that's simply not long enough. It's important to understand that we are already authorized to treat any medical eye or vision disorder with medications and other means, except for a categorical ban on surgery and the use of lasers. However, our current scope of practice already includes many procedures that are assigned surgical codes by the American Medical Association, such as the removal of corneal foreign bodies and the simple procedure of pulling eyelashes. What we are asking for is an alternative means of updating our scope of practice under limited circumstances and according to strict criteria when approved by two public boards that have an unblemished record of protecting the public. In this way, lengthy political battles can be avoided without affecting the Legislature's oversight and authority. Thank you, and I'd be happy to answer any questions that you might have.

**HOWARD** [01:51:53] Thank you. Are there questions? Senator Hansen.

**B. HANSEN** [01:51:58] Thank you. So what-- thank you for coming to testify, first of all. With the use of laser surgery, what are like the maybe like top two or top three procedures you would be accomplishing with this if you were able to do it?

**AMY DeVRIES** [01:52:09] Yes. First of all, let me just remind everyone that we would not be considering LASIK surgery. LASIK surgery is not the type of in-office laser procedure that we would be considering. That's completely off the table because optometrists are not trained on that. The same holds true for cataract surgery and retinal surgery. That's not being trained. It's not even being considered to being added to the curriculum. There is no-- no demand for optometrists to provide those procedures. But the types of laser procedures that we would consider asking for in the future are those that are already being performed by optometrists in other states, things such as the-- pardon me for using technical jargon, but I can explain if you would like the selective laser trabeculoplasty, the YAG peripheral iridotomy, the YAG capsulotomy. Would you like me to explain what those are?

**B. HANSEN** [01:53:02] [LAUGHTER] Hmm, I trust you.

**AMY DeVRIES** [01:53:05] Then again-- and I'd like to point out that these are procedures that are in-office laser procedures, nothing like LASIK surgery, being done by optometrists in other states and trained by every optometry school in the nation. Every optometry school graduate has to be tested by the nationally certified body on them. And if we were allowed to provide that [INAUDIBLE] yeah, we would do it at the same level of care as a medical doctor who provides that same procedure.

**B. HANSEN** [01:53:31] Do you know approximately how many other states make this or allow optometrists to perform these procedures?

**AMY DeVRIES** [01:53:37] There are seven, and I'd be happy to give you a list of that if you'd allow me to after the hearing.

**B. HANSEN** [01:53:42] Sure.

**AMY DeVRIES** [01:53:42] I would be happy to provide that for all of you, too [INAUDIBLE] that lists the specific states, but I know Oklahoma, Louisiana, Kentucky off the top of my head.

**HOWARD** [01:53:52] Any other questions? Seeing none, thank you for your testimony today.

**AMY DeVRIES** [01:53:56] Thank you.

**HOWARD** [01:53:56] Our next proponent testifier. Good afternoon.

**TERI GEIST** [01:54:16] Good afternoon. My name is Dr. Teri Geist, spelled T-e-r-i G-e-i-s-t, and I'm an optometrist and I practice in Omaha. I'm a past president of the Nebraska Optometric Association and I'm here to support LB528. One of the legitimate issues involving updates of-- to scope of practice for any health profession involves the level of education and training that should be expected or required in order to assure the competence of the provider and the safety of patients. You will hear today from opponents of this bill that our education and training related to any advanced procedure or any additional authority is inadequate. Why will they say it's inadequate? Because we haven't gone to medical school and I don't have the same degree as MDs. The assumption is that medicals-- medical school degree is the standard and if something doesn't equate to that, then it's inadequate. But this committee should know that it's the same argument opponents have made every time our profession has come to the Legislature. Beginning in the 1970s, it hasn't mattered what additional authority we have sought, whether it's using diagnostic eye drops, treating any kind of disease, prescribing any pharmaceuticals, treating glaucoma or performing-- performing procedures, the standard our opponents always hold up is that a medical degree is the only way to assure public safety. That argument has never proven true in Nebraska or any other state. In truth, there is no evidence that graduating from medical school is the only standard for measuring competence of the other health professions. In fact, there is evidence from all over the country and from our history in Nebraska that the optometric education and training is perfectly adequate foundation to support incremental advances in the care provided by doctors of optometry. The types of procedures that optometrists perform is part of our current scope of practice and the types of additional procedures we would be performing in the future are not the types of major surgical procedures performed by ophthalmologists in hospital operating rooms or ambulatory surgical centers. They are primary care, office-based procedures that are an extension of the kinds of things we already do. I work in a practice that includes optometrists and ophthalmologists. I see how the length and scope of ophthalmology education encompasses training on a range of surgeries that is far broader than the procedures doctors of optometry would be doing in office-based settings. I have a letter I will distribute to the committee from an educator who has a fairly unique qualifications for comparing and contrasting the education of ophthalmologists and optometrists. He is the assistant dean of the Oklahoma College of Optometry where he is an optometrist and an ophthalmologist. My colleagues and I have been educated and trained the same way as optometrists in other states who are currently allowed to do more than I can do in Nebraska for my patients. We're asking that two regulatory boards be given the ability to-- ability to evaluate whether our profession is able to provide training that will be adequate for our patient care to advance. In making that decision, you could choose to listen to the accounts that we first-- that don't have-- people that don't have firsthand knowledge of optometric-- optometric training and who just simply discount it because it doesn't meet their standard, or you can look at the facts, the reality that our training and education can adequately prepare us for advanced levels of primary care because it's been proven to be adequate in other states, and you could create a responsible option for the state's appropriate regulatory entities, both of which have a broad range of experience with healthcare education and training, to make many of the future decisions outside of the political arena.

**HOWARD** [01:57:48] Doctor, unfortunately--

**TERI GEIST** [01:57:49] I respectfully encourage the committee to support LB528. I'm sorry. I was trying to talk as fast as I could.

**HOWARD** [01:57:55] Right.

**TERI GEIST** [01:57:55] And I'm usually a really talk-- fast talker, so.

**HOWARD** [01:57:57] Yes, and I'm terrible at cutting people off so--

**TERI GEIST** [01:57:59] No, no, no, I understand.

**HOWARD** [01:58:00] --teamwork, teamwork--thank you. Are there any questions from the committee? Senator Hansen.

**B. HANSEN** [01:58:05] Thank you for coming and testifying. I was hoping you maybe could shed a little bit of light on because I'm trying to-- I don't know, maybe it's just my own ignorance a little bit about the need for certain procedures that we're trying to advance with this bill in rural areas versus urban areas?

**TERI GEIST** [01:58:23] Rural areas, I--

**B. HANSEN** [01:58:23] So like I know off the-- I'm assuming there's more optometrists than ophthalmologists--

**TERI GEIST** [01:58:27] Yes.

**B. HANSEN** [01:58:27] --in the state of Nebraska and so I didn't know for sure if the procedures we're talking about doing here are benefit-- are needed in rural areas and where optometrists might be able to help in those areas more.

**TERI GEIST** [01:58:39] Yes. Yeah. I grew up in western Nebraska, so I'm very familiar with the nearest doctor being 45 miles away, and not the nearest eye doctor ophthalmologist, but nearest primary care doctor. So, yes, it is definitely more crucial in the rural areas than Omaha and Lincoln areas, and so those types of procedures-- procedures some people just simply don't have the means to be able to travel to larger cities. So I think that would be something that would be extremely helpful in the outstate Nebraska

**B. HANSEN** [01:59:11] Thank you.

**TERI GEIST** [01:59:12] Uh-huh.

**HOWARD** [01:59:11] Any other questions? Senator Murman.

**MURMAN** [01:59:11] Yes, thanks for coming in. If I understand the 407 process correctly, there's three steps to that process and I think all three of you that spoke so far mentioned there would possibly be just two regulatory steps if this were changed.

**TERI GEIST** [01:59:30] Well, there would be-- go through the Board of Optometry and then the-- the Board of Health for that. So I do have someone testifying right behind me--

**MURMAN** [01:59:38] OK.

**TERI GEIST** [01:59:38] --that has much more information and experience with the 407 process, if that would be OK--

**MURMAN** [01:59:43] Yeah, that would be fine.

**TERI GEIST** [01:59:43] --if he can answer the more-- more difficult 407 questions.

**HOWARD** [01:59:48] Any other questions? Seeing none, thank you for your testimony today.

**TERI GEIST** [01:59:53] Thank you so much. I have handouts of that letter that I read.

**HOWARD** [01:59:57] Great. Thank you. Our next proponent testifier. Good afternoon.

**ROBERT VANDERVORT** [02:00:18] Good afternoon, Senator Howard, members of the committee. My name is Dr. Robert Vandervort, R-o-b-e-r-t V-a-n-d-e-r-v-o-r-t. I'm an optometrist in practice in Omaha. I currently serve as the vice chair of the Board of Optometry, and I'm testing [SIC] on behalf of the board in support of LB528. The Board of Optometry consists of three optometrists in active practice and one lay member. All positions are appointed by the Board of Health. The mission of the Board of Optometry and the Board of Health is to promote and protect the health, safety, and welfare of the public. With that mission in mind, the Board of Optometry supports LB528 for the following reasons. The bill defines a careful process for updating the scope of practice of optometry using strict criteria-- strict criteria to protect the public. The board fully supports those criteria and will work faithfully and diligently to ensure that these criteria are fully met when reviewing any proposed change in scope of practice. In reviewing a proposal, the board will have the opportunity to collaborate with other boards of optometry in other states that have already implemented any new proposed scope of practice. It has long been the desire of the Legislature that optometry and ophthalmology sit down and work out their differences over scope-of-practice issues instead of having heated legislative battles. However, LB528 creates a forum for that possibility. Ophthalmology's fundamental

argument against any expansion in scope of practice has always been that it will endanger the public. The board-- the Board of Optometry's mission is to protect the public; therefore, during Board of Optometry meetings where scope-of-practice changes are being reviewed in accordance with the criteria in LB528, safety to the public will be the foundation for all discussions. For the first time there will be professional, respectful conversation between optometry and ophthalmology regarding the scope of practice where both sides fully understand all aspects of the changes being proposed. In this context it's important to realize that the healthcare boards, including the Board of Optometry and the Board of Health comply, with the Open Meetings Act. Any interested party will be notified automatically prior to the meeting with a complete agenda. All proceedings are conducted in public. All decisions are made in public. All-- everything is done in a totally open fashion. All votes will be made in public. If any group or individual does not agree with the decision made by the Board of Optometry, they can take their case to the Board of Health because in the end it is the Board of Health that only has the authority in this bill to expand the scope of practice of optometry. Lastly, nothing in this bill limits the power of the Legislature. In closing, it is important to note that the Nebraska Board of Optometry has implemented five enhancements to the scope of practice over the last 40 years. Throughout that time, the opponents to those enhancements have made repeated pejorative statements against the profession of optometry. But not one time have they said the Board of Optometry did not do its job. Whether this bill should pass-- this should be passed by the Legislature really rests on two questions. Do you as senators want to create a responsible, open, and carefully regulated process that will free up the Legislature from having to be involved in tedious and contentious ongoing battles over even small changes in scope of practice? And do you trust the Board of Optometry and the Board of Health to protect the health, safety, and welfare of the public? We believe we've earned that trust and the public record testifies to it. We, therefore, respectfully recommend that you support this bill. Thank you, and thank you for your service to Nebraska.

**HOWARD** [02:04:04] Thank you, Doctor. Are there questions? Senator Hansen.

**B. HANSEN** [02:04:08] Thanks again for testifying. Of the other seven states were mentioned earlier that have included as their scope of practice with optometry, have there any-- have there been any instance of-- I think you said public endangerment. Are there-- have there been any instances of optometrists harming the public at all?

**ROBERT VANDERVORT** [02:04:29] There would be anecdotal cases of bad outcomes, but those would occur in ophthalmology, optometry, medicine. Every healthcare provider will occasionally have a bad outcome. Patients don't always respond to therapy. There have been no patterns of any problems in other states, no scope-of-practice bills over the last 40 years of any type of-- for optometry have ever been rescinded or removed to scale back the scope of practice because of a resultant danger to the public that was predicted ahead of time. That didn't happen. So the-- the-- there are plenty of avenues available for people to make complaints to the state board, even the malpractice courts, but tangent-- you know, to-- you

know, everything-- anytime you see a patient, you can have something not work the way you think. Healthcare is not computer science. You know-- well, even sometimes that's even pretty unpredictable. But the-- you can have bad outcomes and you will hear opponents to the bills of optom--these types of scope of practice bills quote some patient being harmed in some state, whatever. The-- the beauty of this bill, and this is one of the things that I as the-- as the Board of Optometry find very exciting, is to be able to sit down with ophthalmology and say, OK, you've got this case in Texas of this patient being harmed, let's look at it. The Board of Optometry, we-- that's what we do. We investigate claims. That's one of our primary roles. Our whole structure is set up to do that. So what we can do is then sit right across the table with ophthalmology and say let's look at this. We're concerned about any public safety issue. Let's fully vet it. Let's investigate it. If we need to, we'll even interview the patient. So that type of forum doesn't exist in the 407, it doesn't exist in the Legislature. With this bill we can actually have an intelligent conversation between optometry and ophthalmology where we really, fully investigate what's going on. I mean that has never happened and I've been around. I know I look a lot younger, but I've been around for 40 years and 35 years in-- in Nebraska, and I would be very excited to have a nice, intelligent conversation in a public way with ophthalmology. Optometrists and ophthalmologists have very intelligent conversations with-- with each other, day in and day out, over patient care. I'd like to translate that into the public forum.

**B. HANSEN** [02:07:13] Thank you.

**HOWARD** [02:07:14] Other questions? Seeing none, thank you-- oh.

**B. HANSEN** [02:07:16] Did--

**HOWARD** [02:07:16] Senator Murman.

**ROBERT VANDERVORT** [02:07:16] Excuse me, I didn't mean-- did you had a question on the 407 or--

**MURMAN** [02:07:18] Well, yeah, I could follow up on that. You mentioned the Board of Optometry and the Board of Health would-- would approve now. What parts of the 407 process would not be involved?

**ROBERT VANDERVORT** [02:07:31] This bill is a-- is an alternative to the 407 legislative process. It's not going to replace it. It doesn't have any impact on it. If a group or-- wants to go through this-- the 407/legislative process to change the scope, that's still entirely intact. If you actually look at the criteria in LB528, they in many ways mirror the criteria in the 407 process, so they-- but they ask the questions in a little bit more direct fashion and-- but safety to the public is what the Board of Optometry and the Board of Health are all about. So it's-- it's every question that's applied here regarding education, credentialing, safety, looking at claims in other states, that type of thing is going to be looked at from a position of public safety. So it's-- the 407

process is a-- is a separate type of evaluation. But it's in essence-- but it also includes the Board of Health.

**MURMAN** [02:08:35] Um-hum, yeah.

**ROBERT VANDERVORT** [02:08:35] So the three steps, you know, you've got the technical review committee, the Board of Health review, and then the director of the public-- of the Division of Public Health who make assessments on the five criterion of the-- of the 407 process. So this is just a variation of that.

**HOWARD** [02:08:55] Any other questions? Doctor, may I ask-- and this may be a-- a more appropriate question for your lobbyist when/if they're coming up.

**ROBERT VANDERVORT** [02:09:03] OK.

**HOWARD** [02:09:03] But last year Senator Ebke passed a bill, LB299, and in it, it requires a review of-- of occupational licensures and regulations around them every-- every five years, I believe, and part of that language specifically tried to exempt groups that were covered by the 407. And so if optometry is no longer covered by the 407, would you be subject to the LB299 reviews? That's a hard question.

**ROBERT VANDERVORT** [02:09:30] I-- I think the-- the global-- we would not be exempted from the 407 process--

**HOWARD** [02:09:35] Oh, OK.

**ROBERT VANDERVORT** [02:09:36] --under this bill. The 407-- if-- if-- if optometry wants to submit a bill to the Legislature, it's going to have to go through the 407 process.

**HOWARD** [02:09:46] OK.

**ROBERT VANDERVORT** [02:09:46] So we're not-- we-- we wouldn't be exempt from that process. Now the five-- LB528 creates an alternative process where we're not-- where optometry is not forced to go through the 407 process if-- and-- but if-- that's really-- that's probably the simplest way to describe it.

**HOWARD** [02:10:05] OK. And then if your lobbyist decides to come up and answer the LB299 question, that would be really helpful.

**ROBERT VANDERVORT** [02:10:10] Yep.

**HOWARD** [02:10:11] OK. Any other questions? Seeing none, thank you for your testimony today.

**ROBERT VANDERVORT** [02:10:15] Thank you very much.

**HOWARD** [02:10:16] Our next proponent testifier. Good afternoon.

**JUSTIN BRADY** [02:10:33] Good afternoon. Chairwoman Howard and members of the committee. My name is Justin Brady, J-u-s-t-i-n B-r-a-d-y. I appear before you today as the registered lobbyist for the Nebraska Optometric Association in support of LB528. I just want to go back-- it's-- go down-- I know a lot of you are new here to the committee, new to the body. A couple of years ago I went back-- the association asked me to go back and look through all the bills that have been introduced to deal with the Optometry Act. And that's what I have here, spent the last-- went back and read the last 40 years of bills, transcripts, floor debates, handouts, and basically the arguments haven't changed. You've kind of flushed some of those out today. It is-- one side says, you know, they-- if you do this it's not going to be done in a safe manner. As Bob testified, ironically, never once has anybody come back and said, see, we were right, now we need you to rescind that bill or we need you to change, go back to the way we were. There also could-- potentially here there's not an access problem. There's plenty of people that can do this out wherever you live. You'll-- you will also hear that-- that they didn't have the proper training, which was already previously addressed. And so it's kind of interesting over 40 years you come back to the same three arguments that will be opposed to this bill and not one of them seems to have ever proven, at least in Nebraska. The other thing I went and did was look-- went back and looked at the complaints to the Board of Optometry or the Board of Health on optometrists and never once did they go up after any change was made, any of these. There were 22, if you will, changes to the act over the years. Not once did any-- did those complaints to those boards go up after any of those changes. So with that, like I said, I was just kind of foreshadowing maybe for what you might hear for the next hour on the other side. But I think they are addressed here. I think to your question, Senator Howard, I don't think they would-- similar to what Bob said, they aren't exempt from the 407 process so that-- it wouldn't change by doing this, as far as I understand it. It does give two parallel tracks that basically they can go to the Board of Optometry for approval and then the Board of Health or they could go through the 407 process and bring a bill back to you depending on what that process went.

**HOWARD** [02:12:51] Thank you.

**JUSTIN BRADY** [02:12:51] And I do have-- I know Senator Williams left, not that you want me to read all 17 members of who's on the Board of Health, but he had asked that question, so.

**HOWARD** [02:12:59] Maybe you can provide it in follow-up.

**JUSTIN BRADY** [02:13:01] OK.

**HOWARD** [02:13:01] All right. Are there questions? Seeing none, thank you for your testimony today.

**JUSTIN BRADY** [02:13:06] Thank you.

**HOWARD** [02:13:07] Our next proponent testifier for LB528. Seeing none, we do have one letter for the record, Dr. Jeff Pape from the Nebraska Board of Optometry. Is there anyone wishing to testify in opposition to LB528?

**BRITT THEDINGER** [02:13:26] Good afternoon, Senators. I'm Britt Thedinger, Britt, B-r-i-t-t, Thedinger, T-h-e-d-i-n-g-e-r. I'm an ear physician and surgeon in Omaha and I have the distinct pleasure of being the current president of Nebraska Medical Association. I'm here on me-- I'm-- on my-- on behalf myself and the NMA in opposition to LB528. We in the house of medicine oppose this bill based on patient care and patient safety. Any surgery-based specialist is created over years and years of supervised training. In my own case, I did a year of general surgery and then four years of additional otolaryngology training in Boston at Harvard. I was on call at least every third or fourth night during those five years. During those five years I spent probably at least 20,000 hours early either in the office setting doing rounds, seeing consults, or in the operating room. I learned from members of the staff of how to determine when to do and when not to do surgery, and then learning various surgical procedures from the experts. I then went on and did another year of additional training in the field of otology/neurotology, or ear surgery, again, doing ear surgery after ear surgery after ear surgery, some-- from some well-respected individuals in the country. To support this opposition of LB528, I'd like to quote Louis Catania. He is an optometrist from Florida and a member of the editorial board of Primary Care Optometry News. "Invasive surgery for optometry is wrong for many reasons. First and foremost, procedurally oriented care such as invasive surgery and the management of its associated complications requires a unique educational process and philosophy that no optometric academic institution or training program provides. The only way to become competent in a procedurally oriented skill such as invasive surgery is to do lots of it. No optometric training program currently nor for the foreseeable future will be able to provide adequate numbers to produce a competent optometric surgeon." This bill would effectively allow optometrists to become surgeons if their optometry school had a single course or a webinar related to such a surgeon. This means they would lack years of experience and training in treating patients, following their patients and their related conditions over time, treating the multitude of variations in anatomy and tissue response, learning how to identify and treat complications appropriately. Another grave concern is the delegation of legislative authority which grants the Board of Optometry the ability to set its own scope of practice for optometrists. This is an unprecedented level of self-governance and determination of optometrists' own scope of practice. In no other health profession is the practitioner's own board allowed to set their own scope of practice. This bill also calls on the Board of Health to approve and authorize specific treatment and procedures which the Board of Health does not do and does not certify. Currently

surgeons of all medical specialties are certified by an independent organization, the Accreditation Council of Graduate Medical Education. In summary, while the NMA appreciates the vital role the optometrists play in the delivery of eye and vision care, the bill poses a significant risk to patient safety and the NMA would respectfully ask you not to advance this out of committee. Thank you.

**HOWARD** [02:16:43] Excellent timing. Thank you, Doctor. Are there questions? Senator Cavanaugh.

**CAVANAUGH** [02:16:46] Thank you, Chairwoman. Thank you, Dr. Thedinger, for being here today. Could you-- first, I missed the accrediting board that-- what was it called?

**BRITT THEDINGER** [02:16:55] It's called the-- I'm going to get this right-- the Accreditation Council of Graduate Medical Education. Most people refer to it as ACGME.

**CAVANAUGH** [02:17:04] And is that state--

**BRITT THEDINGER** [02:17:07] No, it's a-- a national organization.

**CAVANAUGH** [02:17:08] It's a national organization.

**BRITT THEDINGER** [02:17:12] Yes.

**CAVANAUGH** [02:17:13] OK. Is there-- you testified and I should say we've had other optical bills in here, and if anyone here was there they-- they will tell you how squeamish I was. So I don't want to get into the details of sur-- eye surgery. But it's my understanding that this bill is less about the specifics of surgery and more about the approval process. Is there-- and I'm just looking at my notes here: the Board of Optometry with the approval of the State Board of Health. Is there an option between-- somewhere between the State Board of Health and the Accreditation Council that we can work-- that you could work together to find?

**BRITT THEDINGER** [02:17:54] Well, remember, the Accreditation Council of Graduate Medical Education does not deal with anything with optometry because it's-- it's-- it's a medical specialty certification board.

**CAVANAUGH** [02:18:03] Sure. I guess I mean that they're-- they're asking for-- there's the 407 process and another process. Is there another process that you would be able to come agreement?

**BRITT THEDINGER** [02:18:14] As a simple country ear surgeon, I do not know that--

**CAVANAUGH** [02:18:16] OK.

**BRITT THEDINGER** [02:18:16] --answer.

**CAVANAUGH** [02:18:16] Thank you.

**HOWARD** [02:18:18] Other questions? Senator Hansen.

**B. HANSEN** [02:18:21] Thanks again for testifying.

**BRITT THEDINGER** [02:18:24] You bet.

**B. HANSEN** [02:18:25] And so if the Accreditation Council from-- doesn't fall under optometry because they're not medical professionals, wouldn't we naturally kind of rely on the Board of Health then to make the best decision?

**BRITT THEDINGER** [02:18:33] Well, our Board of Health does not do that. They don't determine scope of practice right-- currently.

**B. HANSEN** [02:18:37] OK. All right. Thanks.

**HOWARD** [02:18:41] Other questions? Seeing-- Senator Murman.

**MURMAN** [02:18:43] Thanks for coming in. I assume there's never been a state that's approved it and then kind of backed away from-- from--

**BRITT THEDINGER** [02:18:52] It's always hard to go backwards--

**MURMAN** [02:18:53] Yeah.

**BRITT THEDINGER** [02:18:54] --when you open the door.

**MURMAN** [02:18:55] And then a follow-up question to that, has there been, that you know of, any increase of like revoking licenses or anything like that?

**BRITT THEDINGER** [02:19:05] I will let my ophthalmology colleagues address that--

**MURMAN** [02:19:07] OK. Thank you.

**BRITT THEDINGER** [02:19:08] --because they'll have data for you with regards to that.

**HOWARD** [02:19:11] Any other questions? Senator Cavanaugh.

**CAVANAUGH** [02:19:15] OK. For scope of practice-- maybe this isn't something that you can answer. If you're not a surgeon and you're changing your scope of practice or seeking to change your scope of practice and the State Board of Health doesn't do that-- and I apologize because I'm new. Who does approve that?

**BRITT THEDINGER** [02:19:31] Well, normally it would be the-- some ACGME, a national organization, from a-- from a surgical specialist what we can or cannot do and then obviously you get your medical license here in the state.

**CAVANAUGH** [02:19:42] But for nonsurgical, if it's a nonsurgical?

**BRITT THEDINGER** [02:19:47] Oh, for nonsurgical, then there's a different accreditation can-- well, for education of the res-- you know, for, let's say, internist family practice doctors, it would still fall under accreditation of the Graduate Medical Education because they determine who has a com-- you know, the residency program, what does it entail, and how-- how do they get accredited.

**CAVANAUGH** [02:20:04] OK. Thank you.

**HOWARD** [02:20:07] Any other questions? See none, thank you for your testimony.

**BRITT THEDINGER** [02:20:10] Thank you.

**HOWARD** [02:20:10] Our next opponent testifier.

**MATTHEW APPENZELLER** [02:20:27] This is for everybody coming after me, just to make it easy for you now.

**HOWARD** [02:20:38] Good afternoon.

**MATTHEW APPENZELLER** [02:20:39] Good afternoon. Thank you, Senator Howard and the committee, for allowing me time to express my opposition to LB528. I am Matthew Appenzeller, that's M-a-t-t-h-e-w, last name A-p-p-e-n-z-e-l-l-e-r. I've been doing that all my life. I am a practicing ophthalmologist and retina surgeon in Omaha, Nebraska, live in District 6. I've been practicing for over ten years and I've been doing so in Nebraska for the past three after having moved here from the Carolinas. I am currently the president of the Nebraska Academy of Eye Physicians and Surgeons and we wish to express our significant concerns with LB528 and to try and dispel any potential concerns over access to care or comparative cost of care. Our first and foremost concern is always patient safety. This bill strikes statutory language currently prohibiting optometrists in Nebraska from performing surgery, laser surgery, and from prescribing certain medications and administering them by any route whatsoever. This allows any surgical procedure to be approved for optometric use and to allow any type of medication to

be prescribed or used. This includes but is not limited to surgical repair of ocular trauma, cataract surgery, retinal detachment, treatment of the eye and its contents with chemotherapy, glaucoma, lasers, eyelid repair or biopsies, prescribing of insulin of dia-- for diabetes, if you read it carefully, or narcotics for pain control. The list is extensive because there is simply in the statutory language no limitation on future approvals. Physicians undergo many years of rigorous education and training in order to understand these procedures and pharmaceuticals, their implications, when to use them, and many times, most importantly, when not to perform or use them. It is an arduous process that serves a very specific purpose. The standard of training for any physician or surgeon to practice their chosen specialty in Nebraska is established by the American Council on Graduate Medical Education. It is an organization that is independent from the State Board of Medicine. It is independent of any school of medicine or any residency training program. It requires a minimum amount of lecture-based instruction, minimum number of procedures performed under direct supervision on human patients, and minimum number of patient encounters during training. It takes anywhere from 7 to 12 years to complete after college, depending on your specialty. These standards are high and the state of Nebraska through its agencies has accepted them as the minimum. This bill will abandon this rigorous, uniformly accepted standard and potentially harm our citizens. Specifically, it simply states that if a procedure is taught in an optometry school anywhere in the U.S., then it can be approved for optometry-- optometric use by the Board of Optometry followed by the Board of Health. In a few states that have permitted extended scope of practice for optometry, such as Oklahoma and Kentucky, we see what those standards are and they are not acceptable compared to the American Council on-- or the Council on Graduate Medical Education. Therefore, given the data and the difference in training standards, we believe that the citizens of Nebraska will face an unacceptably lesser quality of medical or surgical care and we see no cost savings in that endeavor and there will be no change in access despite expansion of scope. We strongly encourage the committee to vote against moving LB52-- LB582-- LB528 forward. I knew I'd get there.

**HOWARD** [02:23:59] Thank you. Are there questions? Senator Hansen. Sorry. I saw his first.

**B. HANSEN** [02:24:06] My name was on here. All right. I might just propose the same question that I asked earlier is-- again, when we're looking to-- and it doesn't sound like we're--from my-- from what I've heard so far, expanding scope of practice so much as they're being trained on it already but more just kind of not-- or allowing them to do more with their license. Have we seen in other states that have passed this a trend of patient safety concerns or misdiagnosis or litigious-- litigious issues at all that you know of?

**MATTHEW APPENZELLER** [02:24:39] That's actually, Senator, an incredibly complex question, more complex than it seems on its surface. Just as was said before, there's always going to be patients that are harmed. The real question becomes, and there have been anecdotal stories that have been collected by professors at the University of Oklahoma, University of Kentucky, that track patients that have been harmed through optometrists

performing at an expanded scope of practice, many of these is felt by the professors who are charged with teaching in order to treat members of the state or citizens of the state feel that these complications or harm, that many of them would not have occurred if the standard of training was higher. The-- so is there a trend? The answer is difficult to say because the documentation requirements are not there such as they are for MDs or medical practitioners. When there's harm, we have to document; we have to report. That is not a requirement of our optometric colleagues in those states. So it is very difficult to ascertain whether there is a trend. All we have is anecdotal data that is collected by professors.

**B. HANSEN** [02:26:02] So if optometrists hurt somebody, they don't have to report it?

**MATTHEW APPENZELLER** [02:26:06] If optometrists-- it's-- they don't have to go through the same reporting standards that we do.

**B. HANSEN** [02:26:14] OK. All right. Thank you.

**MATTHEW APPENZELLER** [02:26:14] You're welcome.

**HOWARD** [02:26:15] Senator Cavanaugh.

**CAVANAUGH** [02:26:16] Thank you, Chairwoman. Dr. Appenzeller, I just wanted to ask, did you not hear about how squeamish I was at the previous--

**MATTHEW APPENZELLER** [02:26:24] You opened it, didn't you? I'm sorry.

**CAVANAUGH** [02:26:25] I started to, but I was warned by our page, Erika, not to, so that with it. Sorry.

**HOWARD** [02:26:35] Are there--

**MATTHEW APPENZELLER** [02:26:37] There's-- there's other stuff behind that that's like maps and so forth you could just--

**CAVANAUGH** [02:26:38] I'll have somebody hold them up for me.

**HOWARD** [02:26:40] Yeah, it's hard to get to them.

**CAVANAUGH** [02:26:41] Yeah, yeah.

**HOWARD** [02:26:42] All right. Any other questions? Seeing none, thank you for your testimony today. Our next opponent testifier. Good afternoon.

**OLIVIA SONDERMAN** [02:27:01] Good afternoon. Chairwoman Howard, members of the committee, my name is Olivia Sonderman, O-l-i-v-i-a S-o-n-d-e-r-m-a-n, and I'm a third-year medical student at the University of Nebraska Medical Center. I grew up in Columbus, Nebraska, and I attended the University of Nebraska-Lincoln for my undergraduate degree in global studies. As a third-year medical student I am considering ophthalmology as a specialty I would pursue in residency. I am here in opposition of LB528. While I was an undergraduate in Lincoln, I volunteered at the People's City Mission free health clinic. In this setting, nurses, staff, patients, and their families alike would turn to the physician for the final management decisions for a 44-year-old man with a scalp laceration or a 65-year-old woman with newly diagnosed diabetes. I decided to go to medical school because I wanted to become this larger-than-life person who possessed extensive scientific knowledge and skill which was elegantly applied to patients in a compassionate and digestible manner. My exposure to ophthalmology was set within a comprehensive medical curriculum. My first year at UNMC began with a nosedive into ten intense weeks of human anatomy. I loved the cadaver lab, and specifically I found myself fascinated by the dissection of the eye, picking tiny pieces of fat away from the slender nerves that make our eyes work. My apologies, Senator Cavanaugh. Anatomy was followed by six weeks of cellular processes, ten weeks on normal physiology, and six weeks of neurology. My second year about learning about organ systems and how they can go wrong with each of the blocks lasting five to six weeks. Within the framework of intense study of the human body I specifically pinpointed the eye as a system that I would like to work with, a system whose function exists in relation to every other system of the body. As a third-year medical student. I have two weeks left before I complete my general clinical clerkships which range from six weeks of family medicine in my hometown in Columbus to six weeks of surgery in Omaha. In considering ophthalmology as my future specialty, I look forward to my ophthalmology rotation in May and, if I so choose, four more years of medical and surgical residency training in eye surgery. It is for this reason that I'm here speaking in opposition to LB528. I have many years of training left before I would become a properly trained, practicing ophthalmologist. I am happy that this is the case and I assert that you should be as well. The safety of our patients depends on the rigor of our training. Changes to the scope of practice of optometrists requested in LB528 would allow those with insufficient training to perform surgery on the human eye and face. I support the collaborative model I witnessed at the People's City Mission led by highly trained physicians to ensure safety, quality, and efficient use of resources. Passage of this legislation ignores the well-known success of this model and places patients at unnecessary risk. Patient safety is at stake and for this reason I urge you to oppose LB528.

**HOWARD** [02:30:18] Thank you. Are there questions? Seeing none, thank you for your testimony today.

**OLIVIA SONDERMAN** [02:30:24] Thank you.

**HOWARD** [02:30:26] Our next opponent testifier. Good afternoon.

**DALLIN ANDERSEN** [02:30:45] Thank you, Chairwoman Howard and the HHS Committee, for allowing me this opportunity to express my opposition to LB528. My name is Dallin Andersen, D-a-l-l-i-n A-n-d-e-r-s-e-n. I'm a senior ophthalmology resident training at the University of Nebraska Medical Center. I would like to use this time to explain the intensity of my training and the reasons for it being so rigorous. First, one must understand that ophthalmology is one of the most competitive specialties in medicine. Those that match in ophthalmology average in the top 15 percent of their medical school classes, and specifically, at the University Nebraska Medical Center, only two are selected each year out of hundreds of applicants. However, being accepted in-- into the training program is only the beginning. Second, it is critical to this discussion to know that what follows is a grueling process of gaining the experience, knowledge, judgment, and skills necessary to treat the wide spectrum of ocular and systemic diseases. This is accomplished by receiving one-on-one supervision during all clinic encounters in surgical cases and spending hundreds of hours in clinic in didactic lectures and personal study. I see about 100 to 200 patients per week, each directly supervised by a staff ophthalmologist. Approximately 95 percent of these patients have active sight-threatening disease that cannot be corrected with glasses. By graduation I will complete several hundred cataract surgeries, over 200 laser surgeries, and hundreds of other ocular and facial surgeries totaling around a thousand surgeries. At every single step of surgery I have a staff ophthalmologist sitting at my side, looking through the microscope and able to guide me and ensure that I am performing at the highest level and performing the best care for each patient. The reason for this is simple. The stakes are high for the patient, for myself, and for the citizens of Nebraska that will depend on me in the future, given that I wish to stay and practice here. When this training is complete, I will be eligible to prove my abilities through the American Board of Ophthalmology certification process. This is a unified central authority that has the responsibility to ensure that newly trained ophthalmologists meet the very high standards of knowledge and skill that the public has come to expect from its ophthalmic surgeons. It requires passage of a written and oral examination. Therefore, it's-- it's obvious that ophthalmology residency training is deliberate, rigorous, and justified. This high level of standard training has been accepted-- has been the accepted norm for decades in the United States as the best way to ultimately protect the eyesight of its citizens. We can rest assured that upon completing this training process, I will be able to provide the highest level of care to the citizens of Nebraska. The sacrifices are tremendous but necessary. In the end, this is the best way to ensure safety and high quality in surgical care of the eye. The path is open for anyone to pursue but there are no shortcuts when it comes to safety. I encourage this committee to maintain the standards of education and training at the level that the citizens of Nebraska expect and deserve. This requires your opposition to LB528. I also want to make mention that I handed out a testimony that was submitted by Ronald Krueger-- he's the chairman of ophthalmology and visual sciences at the University of Nebraska Medical Center-- in opposition to LB528, and he-- he's at a conference currently and was unable to attend today.

**HOWARD** [02:34:22] Thank you. Are there questions? Senator Hansen.

**B. HANSEN** [02:34:26] Thanks for testifying, appreciate it. Almost done with school, some residencies?

**DALLIN ANDERSEN** [02:34:30] I have-- I have another year but then I'm going to do a fellowship in retina surgery, so that will be another two years after that.

**B. HANSEN** [02:34:37] Plan on staying in Nebraska, right?

**DALLIN ANDERSEN** [02:34:38] Absolutely.

**B. HANSEN** [02:34:38] Good.

**DALLIN ANDERSEN** [02:34:41] Yeah.

**B. HANSEN** [02:34:42] A common theme among the people in opposition, and I think maybe you might be able to attest to this or not, is that there is insufficient training in the type of procedures that optometrists are looking to perform. Now I know they're not looking to perform cataract surgery or LASIK--

**DALLIN ANDERSEN** [02:34:56] Sure.

**B. HANSEN** [02:34:56] --some of those other kinds of more types of procedures that might require more rigorous training like you're talking about.

**DALLIN ANDERSEN** [02:35:01] Sure.

**B. HANSEN** [02:35:02] But the ones that they are talking about, and she listed them off, which I don't really know what they were--

**DALLIN ANDERSEN** [02:35:06] Yes.

**B. HANSEN** [02:35:08] --what kind of in-- now when they talk about insufficient training, like what do-- what do they mean? Are they not being-- being taught that at all or just like one class in optometry school/ Would you know by chance at all or--

**DALLIN ANDERSEN** [02:35:16] I can't-- I can't speak to the exact numbers, but I personally will perform, you know, over 200 of these laser surgeries, versus 10 to 25, and some of these can be observed in, you know, versus-- you know, in optometry training. It can be done in a weekend course. It can be done in a-- in the school that could be observed, practiced on a simulator. They don't have to be performed on a person. They could be performed on-- on animals. So I perform, like I said, over 200. I mean it's-- it's at least ten times more. And all of these are-- are observed by a staff ophthalmologist, meaning I'm doing the laser and he's

watching me on every single one I do. And there are times when he has to take over or she has to take over. There are devastating complications that can come from these lasers. Some people feel like that these are easy to do. And while some of them you can gain technical, you know, acumen pretty-- pretty quickly, deciding who-- who should have this laser done or dealing with the complications is what the whole point is in terms of our training. And so there's been times, like I said, that they've had to take over. I've seen devastating complications of these specific lasers where the pressure goes too high in the eye and we're unable to bring it down with the simple drops and they have to have another surgery to bring the pressure down, putting them at more risk. So we see these complications and we have to deal with those and that's part of-- part of the training.

**B. HANSEN** [02:36:54] OK. Thanks. So you're saying typically on your-- on-- just making sure I get your words right.

**DALLIN ANDERSEN** [02:36:59] Yeah.

**B. HANSEN** [02:36:59] Optometrists might only do maybe ten of them--

**DALLIN ANDERSEN** [02:37:01] Ten to 25.

**B. HANSEN** [02:37:02] --and you do like 100? Is that what you see? Is that what you know or--

**DALLIN ANDERSEN** [02:37:04] This is what I have been told from other optometry students that rotate with us.

**B. HANSEN** [02:37:08] OK. Good. Thanks.

**DALLIN ANDERSEN** [02:37:11] Yeah. Thank you.

**HOWARD** [02:37:11] Any other questions? Senator Murman.

**MURMAN** [02:37:12] Thank you. But the type of surgery you were just talking about is not one of the surgeries that we're talking about--

**DALLIN ANDERSEN** [02:37:20] Yes--

**MURMAN** [02:37:21] --that would be [INAUDIBLE]

**DALLIN ANDERSEN** [02:37:22] I'm talking about-- So I'll do about 300 cataract surgeries and-- and-- but in terms of the three lasers that were mentioned, I will do over 200 of those during my ophthalmology residency program.

**MURMAN** [02:37:37] But that's not the kind of surgery we're talking about that optometrists--

**DALLIN ANDERSEN** [02:37:40] Yes, we are.

**MURMAN** [02:37:41] --want to do, is it?

**DALLIN ANDERSEN** [02:37:41] That's-- that is what we're talking about it.

**MURMAN** [02:37:43] It is?

**DALLIN ANDERSEN** [02:37:43] Yes.

**MURMAN** [02:37:44] OK. Thanks a lot.

**DALLIN ANDERSEN** [02:37:47] Yeah.

**HOWARD** [02:37:47] So-- so you're talking about laser surgeries?

**DALLIN ANDERSEN** [02:37:50] So surgery includes all-- everything, but I will do about 200 laser surgeries.

**HOWARD** [02:37:59] Well, my understanding was that the direct language of the bill said that they could never do laser surgeries.

**DALLIN ANDERSEN** [02:38:05] The three lasers that were mentioned-- YAG, YAG lasers, and SLT lasers-- those are the three that was mentioned initially by the optometry--

**HOWARD** [02:38:17] Thank you.

**DALLIN ANDERSEN** [02:38:18] --vice president.

**HOWARD** [02:38:18] Any other questions? Seeing none, thank you for your testimony today. Our next opponent testifier.

**DENISE HUG** [02:38:36] Afternoon.

**HOWARD** [02:38:36] Good afternoon.

**DENISE HUG** [02:38:36] First I'd like to thank the committee for allowing me to speak in opposition to LB528. My name is Denise Hug, D-e-n-i-s-e H-u-g. It's a real name. I have a unique perspective to speak on the subject of optometric scope of practice because I'm both an optometrist and an ophthalmologist. I'm just going to tell you my story. I grew up in a small rural

town where the only real doctor we had was an older family practice doctor. But we did have an optometrist that came to town once a month to-- from the big city, which was 20,000 people, by the way. I started wearing glasses when I was 12 and I thought the optometrist had a really cool job. At this time I didn't even know ophthalmologists existed. I went to college and then I went to optometry school and then after four years of optometry school-- optometry school, I graduated. I practiced for three years. I-- it quickly became clear to me that there was so much that I didn't know. I truly didn't understand both simple and sometimes complex diseases that my patients had. I actually thought I knew pharmacology because we'd studied it in optometry school. I did not. These were issues that bothered me, so I decided to do something about it and I went back to school, to medical school. There's simply no com-- comparison in the intensity or the scope of learning between medical school and optometry school. I worked very hard to finish at the top of my medical school class, to be able to earn a spot in the very competitive specialty of ophthalmology. After four years of medical school you're required to do a general medicine internship, which was an invaluable experience. It's really where you start to learn how to take care of patients, not just to treat a diagnosis but to truly care for people. Three years of residency follow where thousands and thousands of hours are spent learning and applying medical knowledge, and surgical skills are obtained through hundreds of surgical cases with one-on-one training. I then did an additional year of training in pediatric ophthalmology. That year alone, I performed over 300 supervised eye muscle surgeries. I think it's important to understand that each phase of the medical education is a building block and they're all critical to developing and training of physicians. There's simply no equivalent to the training in medical-- or in the optometric world. The main reason I oppose this bill is the potential public health risk. It requires thousands of hours of training to be able to provide the level of care that is being proposed by optometry. There is absolutely no role of op-- or-- I'm sorry. I'm so nervous. Sorry. There is absolutely a role for optometry in eye care, but it's not to manage medically complex diseases or to perform eye surgery. Finally, please understand I'm not antioptometry. My husband is an optometrist. My brother is an optometrist. My sister-in-law is an optometrist. I have six optometrists within the practice that I work. So I'm actually quite fond of optometry. I'd like to also add that not all optometrists want to increase their scope of practice. For example, my husband has no desire to perform or to practice medicine. For optometrists who do come to me and express that interest, I encourage them to increase their scope of practice but to do it the right way through education and not legislation. Thank you for your time.

**HOWARD** [02:42:20] Thank you. Are there questions? Seeing none, thank you for your testimony today.

**DENISE HUG** [02:42:26] Thank you.

**HOWARD** [02:42:26] Our next opponent testifier. Good afternoon.

**MARCUS SNOW** [02:42:41] Good afternoon. Good afternoon, Chairwoman Howard, members of the committee. My name is Marcus Snow, M-a-r-c-u-s S-n-o-w, and I am testifying on behalf

of the Nebraska Rheumatology Society in opposition to LB528. I am currently a practicing rheumatologist in Omaha. In short, I feel LB528 drastically undermines the safety of patients and puts the health of citizens of our state at risk. I'd like to briefly explain the basis for my remarks. I'm a rheumatologist and I've been in practice in Nebraska for ten years. I'm currently serve-- serving as the president of the Nebraska Rheumatology Society. Before starting my clinical practice, I spent 11 years following my undergraduate degree to become a board-certified rheumatologist and internist. As a rheumatologist, my practice includes treating various types of arthritis and many forms of autoimmune disease. Many of the diseases I treat are caused by a patient's immune system attacking itself and causing inflammation and damage. To treat this I use a multitude of medications that are very powerful and can help control inflammation. The systemic medications I use can be life altering by quickly halting inflammation and damage to the body and thereby preventing long-term debilitating consequences. These medications can save one's sight, prevent joint damage, reverse kidney failure, and in some circumstances, save one's life. Unfortunately, there are side effects to therapy. These medications can increase the risk of fracture. Increase the risk of cancer, make one infertile, and can increase the risk of infection, to name a few of the potential side effects. In short, there is a-- there is a delicate clinical balance in using these medications. You simply cannot use them appropriately if you do not understand the subtleties between the workings of the human body and the medications you have chosen. An optometrist is not trained to fully understand the complex organ systems and subtle interplay between the systems of these powerful medications. LB528 will allow optometrists to-- to prescribe systemic medications, as outlined in Section 4 of the proposed bill, with very few limitations. I feel this is inappropriate given the lack of training in systemic illness and pharmacology that is required to complete optometry training. I think it is worth noting that ophthalmologists and rheumatologists often work together to treat patients with inflammatory eye disease when-- when systemic therapy is needed. Despite medical training that-- that includes four years of basic science and disease study in all organ systems plus four more years of ophthalmology residency, very few ophthalmologists feel comfortable prescribing long-term systemic medications without comanagement by a rheumatologist. In this vein, I do not see how Section 4 of this bill is necessary nor why it is being proposed. In summary, LB528 is a bill that would allow an optometrist to prescribe systemic medications with minimal limitations. I believe that optometry training is too limited in scope to safely-- to safely be able to prescribe-- to provide adequate care in this regard. This proposed legislation is not appropriate and puts the health of Nebraskans at unnecessary risk. Thank you for your time and for the opportunity to speak today.

**HOWARD** [02:45:53] Thank you. Are there questions? Senator Hansen.

**B. HANSEN** [02:45:57] Thanks for testifying again. When you say their training is limited in scope when it comes to use of medications, what makes you think that, like what training do they receive?

**MARCUS SNOW** [02:46:09] I'm referencing the fact that they-- that their training is centered solely around the eye and the medications that-- that this bill would allow them to prescribe are systemic and would have effects throughout the body that-- that they do not cover during their training in depth.

**B. HANSEN** [02:46:23] But-- but I think any medication anybody gives is pretty much systemic to some degree. And one of the ones you're referring to a lot of times are steroids, probably, the use of steroids probably, the use of steroids--

**MARCUS SNOW** [02:46:30] Well-- well---

**B. HANSEN** [02:46:30] --when it comes to inflammatory issues and do-- do you know a lot of optometrists that use steroids safely?

**MARCUS SNOW** [02:46:37] So-- so first of all, yes, part of the-- part of what I'm referencing is actually corticosteroids. But other medications, cytotoxic medications, systemic medications, chemotherapy medications and those kind of medications are really what I'm referencing more in this-- in this regard. Topical therapy does have a systemic effect to a very small degree, certainly, but what I'm referencing more are the methotrexate, cyclophosphamide, the-- the-- the heavy-hitter medications that I use on a regular basis for severe, severe disease.

**B. HANSEN** [02:47:08] Is that something you would see optometrist using?

**MARCUS SNOW** [02:47:11] Well, no, I-- I-- I don't think we see them using it very often, but at this point, this bill would allow them to do that. There's no limitation listed on this bill on what they could prescribe.

**B. HANSEN** [02:47:22] OK. I-- I-- I'm just curious. Would you-- if we made a-- if we passed this bill, would you see them using that type of medication very often that would have such drastic systemic effects?

**MARCUS SNOW** [02:47:30] I can't-- I can't really comment on what they would do.

**B. HANSEN** [02:47:34] OK, just curious, wanted your opinion on that. Appreciate it. Thank you.

**HOWARD** [02:47:35] Any other questions. Seeing none, thank you--

**MARCUS SNOW** [02:47:39] All right. Thank you.

**HOWARD** [02:47:44] --for your testimony today. Our next opponent testifier.

**DAVID WATTS** [02:47:55] Chairwoman Howard, distinguished members, my name is Dr. David Watts, D-a-v-i-d W-a-t-t-s. I'm a dermatology/skin cancer surgeon opposing LB528 on behalf of the NMA, the Metro Omaha Medical Society, and the Nebraska Dermatology Society. Sometimes I remove skin cancers around the eyes, and I apologize for the photos that show what I do. I've got three points to share that go to the issue of patient safety. First, the broad language in this bill could allow optometrists to perform this same skin cancer surgery as long as it was taught in any accredited optometry school, as long as competence could be tested by any similar school of-- or the National Optometry Board and as long as the Nebraska Board of Optometry and the State Board of Health approve. That all sounds good but the question is, how much teaching is enough and of what type? I can't tell from looking at this bill. It looks like it would allow a Nebraska optometrist, from my reading, to do any eyelid surgery the national group decides to promote now or in the future. The training and competence testing criteria are unclear and as a surgeon that worries me. Our second concern is a missed cancer. Many lumps and bumps that appear to be simple cysts or inflamed glands turn out to be much more serious. Even for experienced surgeons it can be impossible to tell cancer from noncancer by appearance alone and a correct diagnosis can depend greatly on how a lump or bump is biopsied. A delayed or missed cancer diagnosis can lead to more surgery, impaired eye function, disfigurement, even death. Common skin cancers like basal cell and squamous cell skin cancer and even more serious cancers like sebaceous carcinoma and melanoma can all grow on the inside or on the eyelids. One in five of us will get a basal cell or squamous cell skin cancer and we see more of those every year on ever-younger patients. One of the photo sets-- don't look, Senator-- shows how hard it can be, how hard it can be to tell eyelid bumps apart. Not everything is a simple lump or bump. Third and most important concern is defining the standard of care as in this bill. How much training and experience and what kind of training is enough to safely and competently do surgery on people's eyelids or manage surgical complications even harder? Several review bodies, the technical review expressed concern about the low level of surgical training proposed by the previous optometry bill and each review emphasized the need for a standardized surgical training program with hands-on training on actual patients. However, to our knowledge, no such standardized surgical optometry program exists. To sum up, this bill allows any eyelid surgery, increases the possibility of missed cancers and only hints at the standard of care that our patients deserve. We respectfully ask that you recognize the extensive education, the thousands of hours of supervised surgical residency training, and the broad experience of specialty eye physicians and surgeons. We hope you will not advance LB528 which would allow eyelid surgery by optometrists with comparatively minimal training and experience even if they have the very best intentions. I'll be happy to answer questions.

**HOWARD** [02:51:19] Thank you, Doctor. Are there questions? Seeing none, thank you for your testimony today. Our next opponent testifier. Good afternoon.

**ANDREW BALDWIN** [02:51:36] Hi my name is Andrew Baldwin, A-n-d-r-e-w B-a-l-d-w-i-n. So I'm a board-eligible ophthalmologist practicing in the Columbus area. I'd like to talk about patient

access today. So ophthalmologists in the outside rural area do an unbelievable job of providing access or their rural patients. We provide access in three things, and I think this is important: clinical, surgical, and emergency access. In the-- the map in the packet will show that the primary offices and the satellite offices in Nebraska for ophthalmologists, 94 percent of Nebraskans live within 30 minutes of these clinics. So poor access to ophthalmology care just-- it isn't supported by statistical data. Now I want to talk about my personal experience of providing care in northeast Nebraska. So in our practice, we have two ophthalmologists, myself and Dr. Diedrichsen, and five optometrists. We provide-- provide clinics in Columbus, Norfolk, Neligh, Albion, Fullerton, and David City. My home base is Columbus, Dr. Diedrichsen's is in Columbus and Norfolk, and then the optometrists cover the other clinics. Now the way it works is the ophthalmologists hold satellite clinics at these outlying clinic locations and the patients we see are determined by the local optometrist that they need our surgical and medical expertise. If the surgery can't be done in the clinic, we'd perform surgery in the operating room in Columbus, Norfolk, Neligh, and Albion. Now if I sit in your shoes, my question then would be, well, access, OK, clinic and surgery, but how about emergency access? So I wanted to touch on that a little bit. So during clinic hours we accept triage clinic calls all day. We get them from local optometrists, optometrists in my own group, and healthcare providers, and we have 100 percent open-door policy. I'll-- I'll see any patient on add on at any point in the day. After-hours clinic rotation, this is where it gets really interesting. So we hold the rotation within our practice so we take weekly call. So when the optometrists in our group are on call, Dr. Diedrichsen and myself serve as surgical and medical backup, so if there is an issue we-- they can call us and we can help manage. Then Dr. Diedrichsen and myself alternate weeks in the Columbus emergency room 365 days a year, so all emergencies in the surrounding area can be seen by an ophthalmologist. Now, different than most fields of medicine, almost all eye emergencies can be managed medically. Currently optometry's scope of practice allows medical management of these eye emergencies. So scope of-- scope-of-practice expansion wouldn't help in these eye emergencies. For example, Neligh is the farthest clinic that we have, hour and 25 minutes away. I can't think of one eye condition that an emergency surgery or procedure performed by an optometrist would benefit that patient, and I stand by that statement. After my testimony, if it would be helpful for any of the senators, I'll field any questions about any eye emergencies that those in favor of the bill think would be beneficial for the patient to receive an emergent procedure, surgery. So in conclusion, Nebraska population has outstanding access to eye care. The patient access includes clinical access, surgical access, and emergency access. And time is up, so I appreciate that, and if there's any questions I'd love to hear those.

**HOWARD** [02:54:56] Thank you. Are there questions? Seeing none, thank you for your testimony today.

**ANDREW BALDWIN** [02:55:03] Thank you.

**HOWARD** [02:55:03] Our next opponent testifier. Good afternoon.

**JORDAN WARCHOL** [02:55:14] Good afternoon, Chairman Howard and members of the committee. My name is Jordan Warchol, J-o-r-d-a-n W-a-r-c-h-o-l, and I'm here on behalf of the Nebraska Medical Association and the Nebraska chapter of the American College of Emergency Physicians in opposition to LB528. I'm currently a practicing emergency physician and assistant professor at UNMC/Nebraska Medicine, and I also practice at our Bellevue location. I'm also the chairwoman and founder of the rural medicine caucus of the American Medical Association. Some people in the healthcare world like to think of emergency physicians as the jacks of all trades. I can simultaneously take care of a patient with a heart attack, set someone else's broken ankle, and even deliver a baby. This gives us a unique perspective on what scope various providers should be practicing within. Part of my role in the healthcare system is also to know what is an emergency situation that requires specialty assistance versus which thing can be temporized for today with follow-up as an outpatient. I think most emergency physicians would acknowledge that eyeballs are in a special category. Along with hands, they are some of the most essential piece of irreplaceable equipment that if damaged are unlikely to cause a fatality but can cause severe disability. As such, it is not uncommon, and actually is entirely appropriate, for a patient to be sent from an optometry office to the emergency department for further evaluation and the possible involvement of an ophthalmologist. Emergency physicians receive both education and training during medical school and residency on managing complaints that may involve the eye. I'm confident that most board-certified or board-eligible emergency physicians can appropriately discern if a patient's complaint rises to the level of needing emergent ophthalmologist involvement. For example, a simple scratch to the outer layer of the eye, known as a corneal abrasion, does not even emergent ophthalmology evaluation. However, disruption of the cell layer at the back of the eye, a retinal detachment, is an emergency and requires prompt ophthalmologist evaluation. Despite my years of training beyond my four years of medical school, I understand that there are ocular conditions which I may need to call my ophthalmologist colleagues to manage. I'm under no illusion that I could take care of a complex eye condition that takes four years of residency to diagnose and treat appropriately. Thankfully, my ophthalmologist colleagues at UNMC are excellent consultants and always willing to come see a patient when I ask. Having asked other emergency physicians in Nebraska about their abilities to have a patient seen by an ophthalmologist in an appropriate amount of time, including physicians who practice in more rural parts of our state, I did not hear one story of a patient being unable to receive that care. I know that most opt-- optometrists in our state practice responsibly within their scope of practice and to the level of education that they have. But I have seen patients negatively affected by diagnoses they were given by an optometrist. In fact, one of my partners had vision loss in one eye due to an incorrect diagnosis. Thankfully, his ophthalmologist was able to correctly identify and treat his illness and he did not have permanent loss of his vision. In closing, I would like to say that I greatly respect the work that optometrists do and feel that they are vital members of the greater healthcare team. However, without the currently accepted standards of training as specified by the American Council on Graduate Medical Education in ocular conditions and surgical management, I do not feel that allowing them to operate on the eyes of Nebraskans is in the best interest of our state. Thank you for giving me the opportunity to testify and I'm happy to take any questions.

**HOWARD** [02:58:29] Thank you. Are there questions? Senator Hansen.

**B. HANSEN** [02:58:33] Thank you for testifying.

**JORDAN WARCHOL** [02:58:34] No problem.

**B. HANSEN** [02:58:35] Sorry, I feel like I'm asking all the questions here. I apologize. I just-- I'm just trying to get my thought process right here--

**JORDAN WARCHOL** [02:58:41] Understandable.

**B. HANSEN** [02:58:42] --before making any kind of decision about anything. It seems like a lot of testimony here has been against the use of sur-- laser surgery or surgery on the eye--

**JORDAN WARCHOL** [02:58:49] Sure.

**B. HANSEN** [02:58:49] --but not-- there's been limited testimony on the use of pharmaceuticals. What's your thoughts on that?

**JORDAN WARCHOL** [02:58:54] So in my scope of practice, and especially in places where-- like more rural areas where you often have the ability for an ophthalmologist to come in, but, you know, I'm in a training location, so my residents need the training-- the ophthalmology residents need the training, so they will often come in sooner in the sense of we are more-- more ready to call them so that they can help us train our residents, if that makes sense. So often in other places we do dilate the eye but there are very few long-term medications that I would prescribe for an eye, whether I thought that was systemic or not. I personally don't feel comfortable prescribing steroids for eye conditions. You can-- if you are giving steroids inappropriately for a condition you can cause severe permanent damage to someone's eye. To me, it's more important that the patient has an appropriate diagnosis from a qualified ophthalmologist than that I have the ability or, you know, desire to prescribe the steroids. I'm legally licensed to prescribe everything that they can prescribe but I never would.

**B. HANSEN** [03:00:00] OK. And maybe just one more question, please. Maybe it's because I haven't-- it's probably my fault for not asking the-- the proponents about this, but what I'm trying to figure out, are the optometrists educated to do the procedures that we're talking about? Do you feel like they are-- they're not getting training with-- from what you-- from what you know of optometry school?

**JORDAN WARCHOL** [03:00:22] Right, for--

**B. HANSEN** [03:00:22] Because that seems like, again, the prevailing kind of theme here is they're not educated, they're going to hurt people, they're not-- they're not like educated we are, kind of, you know.

**JORDAN WARCHOL** [03:00:31] Right.

**B. HANSEN** [03:00:31] So what do you know of their training that would verify that statement?

**JORDAN WARCHOL** [03:00:38] So I personally do not know much about optometry training other than that it's four years of optometry school. It includes a clinical section training with other optometrists. What I can tell you in relation to their training is that I have extensive training from medical school, as well as on eye conditions specifically during my residency in emergency medicine, and I still do not feel comfortable in treating a lot of the things that I-- you know, that an ophthalmologist would be able to treat. So if I have that kind of training, which, granted, is not the same as an optometrist nor an ophthalmologist, and still don't feel comfortable, I don't-- I don't know that it's necessarily a-- you know, you don't have our training, our training is, you know, whatever. It's not a-- it's not a turf battle in that sense. It's more of a patient concern condition. I-- I have no problem saying that I'm not an ophthalmologist and should not be doing what an ophthalmologist does. And so I don't-- I don't see it as, you know, an issue of what's mine versus yours. I see it as an issue of what's truly in the best interest of our patients.

**B. HANSEN** [03:01:40] OK. Thank you. Appreciate it.

**HOWARD** [03:01:42] Any other questions? You're at the Med Center, right--

**JORDAN WARCHOL** [03:01:48] Yes.

**HOWARD** [03:01:48] --at the emergency room in the Med Center?

**JORDAN WARCHOL** [03:01:50] Yes.

**HOWARD** [03:01:50] Yes. You took care of my husband in November.

**JORDAN WARCHOL** [03:01:53] Oh!

**HOWARD** [03:01:53] Thank you.

**JORDAN WARCHOL** [03:01:53] So I did, apparently. You're welcome.

**HOWARD** [03:01:56] All right. Our next opponent testifier.

**PATTY TERP** [03:02:09] Good afternoon, Madam Chair and distinguished members. My name is Patty Terp-- excuse me-- P-a-t-t-y T-e-r-p. I'm a board-certified eye surgeon in Fremont. I'm happy to speak in front of this committee again, as you may remember me from the LB449 scleral tattooing bill which has passed unanimously. And patient safety is still a concern for me which is why I sit before you here today to oppose LB528. Since 2015 I've been in practice at the Fremont Eye Associates, a practice that my partner started more than 30 years ago. The patients we serve span numerous counties, including Dodge, Washington, Burt, Thurston, Wayne, Cuming, Platte, Colfax, Butler, Saunders, and western Douglas Counties. Aside from treating patients every day at our main location, my partner holds satellite clinics and does surgeries in West Point, Blair, and Wayne. We treat patients of all ages, all financial statuses, including Medicare, Medicaid, uninsured, and we all participate in a program called EyeCare America which-- through which we provide free medical care, exams, and even surgery if needed for medically underserved individuals. Patient-- patients' vision will always come first to us regardless of payment or scheduling concerns. In addition to making sure we're providing quality evidence-based care to our patients, we also have to consider the costs to the patient and the system with how we evaluate and treat patients. Ways to do this include prescribing generic medications when we're able to do so, avoiding unnecessary, expensive tests, and performing the correct procedures when appropriate. One study of-- and this is in a peer-reviewed journal and that is in your packet-- evaluated the utilization of selective laser trabeculoplasty, one of the lasers that they mentioned, and this is a laser that is done to-- to lower the pressure in an eye with glaucoma or at risk for glaucoma. So this procedure is one that they're allowed to do in their scope of practice in Oklahoma and the study found that patients who received this laser trabeculoplasty by an optometrist had a 189 percent increased risk of obtaining additional laser on the same eye relative to if that procedure was performed by an ophthalmologist. Many of these repeat lasers occurred within 30 days of the first laser even though the effect of the laser doesn't even reach its full potential until six to eight weeks since that laser's being done. That means that these people were twice as likely to have additional laser and what-- before you could even assess that they responded to that first laser, so you're putting patient safety at risk because there are risk of increased pressures, like my-- like the resident Dr. Andersen mentioned. And that adds cost as well because doing additional laser, that potentially unnecessarily adds cost to the system. We are fortunate really in Fremont. We have a great working relationship with our community optometrists. We comanage cataract surgery patients with them often and these patients appreciate the continuity and access to care that that allows them. Our nearby optometrists know that if they call us with a complex patient, someone requiring any surgical procedure, none of these lasers are-- that they've mentioned are emergency procedures. These are all procedures that could be deferred, could be elective, and we have good access to cover them. We-- they know that we'll see those patients in a timely manner when they're necessary. We respect our optometrists' expertise in nonsurgical eye care. And really in Fremont we could serve as a model for how optometry and ophthalmology can work together well within our current scope of practice. So thank you and I look forward to any questions.

**HOWARD** [03:05:44] Thank you. Are there questions? Seeing none, thank you for your testimony today.

**PATTY TERP** [03:05:49] OK. Thank you.

**HOWARD** [03:05:50] Our next opponent testifier. All right. We do have some letters for the record: Dr. Michael Bittles from the Nebraska Board of Medicine and Surgery; Dr. Stuart Seiff from the American Society of Ophthalmic Plastic and Reconstructive Surgery, Inc.; Laura Newton representing herself; Dr. Kayla Pope from the Nebraska Regional Organization of Child and Adolescent Psychiatry; Dr. Kelly Caverzagie from the Metro Omaha Medical Society; Dr. Anthony Krueger representing himself; Dr. Cynthia Paul, representing the Nebraska Psychiatric Society; Dr. Aaron Lanik from the Nebraska Academy of Family Physicians; Marvin Bittner from the American College of Physicians, Nebraska Chapter; Dr. Trisha Hultgren from the Nebraska Dermatology Society; Dr. Britt Thedinger from the Nebraska Medical Association, Dr. Greg Gordon from the Nebraska Radiological Society; Dr. Travis Teetor from the Nebraska Society of Anesthesiologists; Dr. Steve Martin from the Nebraska chapter of the American College of Cardiology; Dr. Matt Appenzeller from the Nebraska Academy of Eye Physicians and Surgeons; Dr. Ralph Hauke, Nebraska Oncology Society; Dr. Marcus Snow, Nebraska Rheumatology Society; Dr. Nick Bruggeman from the Nebraska Orthopaedic Society; Dr. Joan Anderson, the Lancaster County Medical Society. Is there anyone wishing to testify in a neutral capacity? We do have one letter for the record in neutral, Mr. Bo Botelho from the Department of Health and Human Services. Senator Hilkemann, you are welcome to close.

**HILKEMANN** [03:07:23] Thank you, Senator Howard and members of the committee. Let's just have a little talk. Why did I bring this bill? First of all, it is not a change in the scope of practice. It's a change in the way for optometrists to possibly expand their scope of practice through their board if they're trained and with-- with use of the-- of the Board of Health. I'm just going to be-- nothing like your own personal experience. I got a Ph.D. in my personal life and I'm sharing it. I'm a podiatrist. I'm proud to be a podiatrist. I came within a whisper of not coming back to Nebraska, even though I'm born and raised, loved here-- lived here all of my life except when I did my podiatry training in Chicago and my residency in Milwaukee. I wanted to come back to Nebraska to practice. But the laws for podiatry back in that time were so archaic, I could have gone to 49 other states and been able to do more than I could do when I came to Omaha, Nebraska. It was a friend of mine we just recently lost, Dr. Larry Lefler in Fremont. He said, Bob, come on back, we need guys like you that have had residency training and we'll get those laws changed. Well, you know what that means. We'll help you but you're going to go in front of the Legislature and get these things worked on. And that's what I did for about the first ten years. We were down here twice to try to get things changed and didn't get very far. And then finally I guess it was about 10 to 12 years into my practice we've got some work down with-- it was when Senator Wesely was Chair of Health and Human Services. I don't know. He took a liking to me, took a liking to some of the podiatrists. He said, let's get together. So he had the op-- and this-- this is a-- this is a war between the ophthalmologists and the optometrists. I have the

absolute most ups-- regard for ophthalmologists. I am not here to-- this is not antiophthalmologist. But I also have respect for optometrists. So at that point we've got the orthopedist in the room, got some people from medicine. We had the podiatrist and in your office, Senator, we worked out a compromise so that we could start doing some of the procedures that I had been trained. There were other people who'd been trained, but we couldn't get new people to come to Omaha, Nebraska, or to Nebraska to practice because they could go to Iowa, they could go to Missouri, they could go to any other state and practice. Well, it was out of this that senator Wesley got the idea of the 407 process. If we can get groups together and talk this out, maybe this is how we can-- because practices and scopes and educations improve and you learn new things and we-- and the college-- if-- if-- if our professional schools are teaching the same thing they did in 1950, shame on them. So that was where the 407 process came. Well, because part of my work with the podiatry association, I was nominated to the Board of Health. I was on that board. Several people apparently liked me and they put me on as vice chair and at one point I became the chair of the Board of Health, just at the time that the 407 process came through. So I was the chair of the Board of Health and we had to work through these first 407 processes. Now you talk about something cumbersome. We had our learning curve. But I thought, you know, this might be a good thing. I was chair of one of those 407 processes. I chaired two 407 processes. And so we have these different institutions come before 407 and from that they'd make a recommendation, along with the director of health, to the Legislature that this legislation should move on through. Maybe we have a little solution here. You see, it shouldn't take four or five or six years to get these things changed. That's what it takes now with this 407. You've heard that they've had, I don't know, what-- one of the testimonies was five or six times in the last 40 years. We're changing too quickly. This gives as professions change-- and-- and-- and, Senator Murman, you picked up on it really quickly. These procedures that we're-- that they're-- that they may be talking about, these are not the procedures that are going to be done in an OR. This-- they are not talking about retinal transplants and detachments and-- and-- and so forth. They're talking about procedures I think you should-- that was picked up early on that that could be done at an office. Well, these-- a lot of these procedures and a lot of these tech-- I mean the training that they have is outstanding. But there's also-- we can always be trained to do more. And if you look at this, there's not one of this-- I-- I-- it's very important that they have to have been trained, they'd have to have a board-- a way of testing on it. And so this is an avenue. I'm hopeful. Just as podiatry has had some success with the legislative process and moving forward, you know, I-- I-- I-- I'm sad to say that we had three or four very talented people from-- native Nebraskans from Bellevue, from Norfolk, one from McCook, that were-- I couldn't encourage them to come back because it's I don't want to, I know I could wait for it to-- because, I said, we'll get it changed. But they went on. One is in North Carolina; one is in South Carolina. I trained a lot of doctors that went on to other states who could do more things. This gives optometrists an option-- an opportunity. We're setting up another pathway that is not cumbersome to take four or five years and then you get there and then you bring it up then for the Legislature. You get-- if you don't get a-- the first hearing from the 407 process, then you have to go through it. I'm understanding, and I-- that Senator Williams mentioned early on. I brought three years ago that this 407 process needs to change. And I-- I

still think there are changes that should happen in the 407 processes. Most people will tell you that-- on the side that it should be, but no one wants to change it. Well, this gives an opportunity for them to go before their own board. And I mean to tell you, if you want to talk about somebody that's going to protect their own turf, the last thing you want to do is have people coming out there that are not trained to do things that you want to do. No one likes to hear report-- the one doctor here said that they-- they-- in Oklahoma, reporting 186 cases, whatever, from that. No one likes to hear that, I mean to tell you. I didn't want to have anybody doing something on me that they weren't trained to do. I didn't want to have-- do something up that I wasn't trained to do. This gives them an option. It's going to-- the question comes up, public safety. That's our most important aspect. And I mean to tell you, having served on that Board of Health, it's 17 different professions. I have the list for Senator Williams that I'll give to him. There's going to be a lot of hard questions asked there and there are going to be people-- people who are all part of that board. If the optometry boards are not tough enough on whether this-- the Board of Health is going to be there to help. It gives another avenue. And maybe it isn't going to take four or five years to go through this cumbersome process with the Legislature. That's why I brought it, folks. Thank you for listening.

**HOWARD** [03:17:13] Thank you. Thank you. Are there questions? No? Seeing none, thank you, Senator Hilkemann. This will close the hearing for LB528 and conclude our hearings for the day. We will not be having an Executive Session. Thank you.