HOWARD: [RECORDER MALFUNCTION] Services 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: I'm Senator Dave Murman from District 38, Glenvil, Nebraska, and that's-- I represent seven counties south of Kearney, Hastings, Grand Island area.

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

ARCH: John Arch, District 14: Papillion, La Vista, and Sarpy.

WILLIAMS: Matt Williams from Gothenburg, Legislative District 36, that's Dawson, Custer, and the north portion of Buffalo Counties.

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

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

HOWARD: Also assisting the committee is our legal counsel, T.J. O'Neill; and our committee clerk Sherry Shaffer. And our committee pages today are Hallett and Angenita. A few notes about our policies and procedures: please turn off or silence your cell phones. This afternoon, we'll be hearing three bills and we'll be taking them in the order listed, 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're 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 hearings. 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 handout submitted by testifiers will also be included as part of the record as exhibits. We would ask if you do have any handouts that you please bring ten copies and give

them to the page. We do use a light system for testifying. 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. And when the light turns red, we'll ask you to wrap-- end your testimony and wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone and then 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, and 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 do have a strict, no prop policy in this committee. And with that, we'll begin today's hearing with LB811. Senator, Senator McCollister's bill to change pharmacist reporting requirements under the Parkinson's Disease Registry Act. Welcome, Senator McCollister.

McCOLLISTER: Thank you, Chairwoman Howard and members of the committee. My name is John McCollister, J-o-h-n M-c-C-o-l-l-i-s-t-e-r, and I represent the 20th Legislative District in Omaha. Today, I'm introducing LB811 to make needed changes to the Parkinson's Disease Registry Act. Under current statute, pharmacists are required to report, among other data, the Social Security number of people to whom the pharmacist has dispensed drugs used in the treatment of Parkinson's disease. However, Social Security numbers are not collected by pharmacists, so LB811 simply eliminates that data point and replaces it with the date of birth. It is important that the Department of Health and Human Services has the necessary data to-- data identifiers to track diagnosis of Parkinson's disease. Nebraska is one of the first states to create the Parkinson's registry, but updates are needed to make the registry as effective as it can be. The goal of the registry is to collect data for research so we can find trends and correlations to help us learn more about Parkinson's disease in Nebraska. This can include dates of diagnosis, longevity after diagnosis, clusters of diagnosis, and so on. Thank you for your kind intentions and I would hope that you could Exec on this bill as soon as possible. Thank you very much.

HOWARD: Thank you. Are there questions for Senator McCollister? Seeing none, will you be staying to close?

McCOLLISTER: I think not.

HOWARD: OK. All right.

McCOLLISTER: Thank you.

HOWARD: Thank you. We'll invite our first proponent testifier for LB811.

RANDI SCOTT: Good after-- good afternoon, Chairman Howard and members of the Health and Human Services Committee. My name is Randi Scott, R-a-n-d-i S-c-o-t-t, and I'm testifying on behalf of Parkinson's Nebraska today in support of LB811. Parkinson's Nebraska provide support for those stricken with Parkinson's disease across the state. We are supportive of efforts by the Department of Health and Human Services to make efficient updates to the Nebraska Parkinson's Disease Registry. The data that is gathered from physicians and pharmacists is vital for research efforts not only in Nebraska, but nationwide. We need to be able to collect the right information to further research efforts and to identify possible public health issues. The Parkinson's Disease Registry Committee meets-- met last in November, and that is where the idea for this bill came up was at that meeting where we discussed data points that are, that are captured, what can be captured, and needed changes. We support the extremely hard work that DHHS is putting into moving the registry to an electronic exchange and by making sure that the data required can be reported. So LB811 is helping really to create a more efficient registry. Thank you for your time and I'll take any questions.

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

RANDI SCOTT: Thank you very much.

JONI COVER: Good afternoon.

HOWARD: Good afternoon.

JONI COVER: Put my little cheaters on here. Senator Howard, members of the Health and Human Services Committee. For the record, my name is Joni Cover, J-o-n-i C-o-v-e-r. I'm the CEO of the Nebraska Pharmacists Association. And on behalf of the members of the Nebraska Pharmacist Association, I'm here today in, in support of LB811. And I'd like to thank Senator McCollister for introducing this legislation. The NPA has been an active participant in the Parkinson's, Parkinson's Disease Registry Advisory Committee for many years and supports the great work

being done to address the high prevalence of Parkinson's disease in Nebraska. Physicians and pharmacists are required to report to the Department of Health Human Services specific data relevant to the diagnosis and treatment of Parkinson's disease. One element that was included in the required reporting by pharmacists when the bill passed years ago is a patient's Social Security number. And because pharmacists do not collect that information, we've just never reported it. Our physician colleagues do, however. LB811 would update the required reporting elements and replace the Social Security number with the patient's date of birth, which is something that we do collect on our patients. We support the work of the Parkinson's Disease program and we support LB811. And I'd be happy to answer any questions. And for a handy reference on the back of my testimony sheet is the drugs that we do report. So some of those are specific to Parkinson's disease and some of them are used for other diseases, too.

HOWARD: Thank you. Senator Arch.

ARCH: Thank you. So is the date of birth simply another patient identifier?

JONI COVER: Um-hum.

ARCH: Is that what it's used for?

JONI COVER: Yes.

ARCH: Like Social Security would be, but--

JONI COVER: Right.

ARCH: --date of birth would help--

JONI COVER: Right, right.

ARCH: --make sure you have the right patient.

JONI COVER: Right.

ARCH: You've not been collecting date of birth up to this point.

JONI COVER: No, we've-- we always collect date of birth.

ARCH: Or not report it,--

JONI COVER: Right. We just--

ARCH: --not report it.

JONI COVER: Well, I, I would guess that maybe they do to help identify--

ARCH: Oh, OK.

JONI COVER: --and we report the drug and then the physicians will re-- will confirm whether or not the patient has Parkinson's disease. I think that's-- that's my understanding of how it works, so.

ARCH: OK. All right. Thank you.

JONI COVER: You're welcome.

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

JONI COVER: Thank you.

HOWARD: Our next proponent for LB811. Good afternoon.

MICHELLE WALSH: Yeah, good afternoon, Chairwoman Howard and members of the committee. My name is Dr. Michelle Walsh, M-i-c-h-e-l-l-e, last name is W-a-l-s-h. I am the incoming president for the Nebraska Medical Association, and I'm testifying on behalf of the NMA in support of LB811. Currently, I'm a pediatrician here in Lincoln. I've been here for 22 years. Part of that, I did receive an electrical engineering degree with a biomedical engineering specialization from Southern Methodist University. I went and received my doctorate of medicine at the University of Iowa and then I did my pediatric residency training at Children's Mercy Hospital in Kansas City, Missouri. The NMA is proud to sit on the Parkinson Disease Registry Advisory Committee and fully supports the legislative change to better reflect the data pharmacists collect from patients. As we move forward in healthcare and the delivery of that care forward, it is vital that all the patient data is in a format that fits with the work properly at every level of care. The law also has to reflect this and that should encourage to facilitate the streamlining of care that may be achieved and that there's uniformity across all healthcare. The existing law by requiring pharmacies to report a piece of data that they have never collected does not accomplish this. So through changes like these found in LB811, the delivery of healthcare can be one step

closer to moving forward in the right direction. We believe that in the years to come, this will also help play an integral role in how we can lower the costs of care, while at the same time making it easier for patients to navigate the system. The NMA respectfully ask you to support and advance the bill from committee. And I thank you for your time and I would be happy to answer any questions that you may have.

HOWARD: Thank you. Are there questions?

MURMAN: I've got one.

HOWARD: Senator Murman.

MURMAN: Thank you for testifying. I am curious, is there a reason to collect Social Security number to identify the patient for research maybe on to like whether a certain drug would be effective in treatment?

MICHELLE WALSH: No, you can use other identifying numbers. So years ago, I think before identity theft and that type of thing, we all collected Social Security numbers and that's how we did identify our patients in the office. But now that times have changed and identities get stolen and everything else, now we like to change identifier. So date of birth is one way to do that. But also they can do other identifying numbers to accomplish that.

MURMAN: OK. Thank you very much.

MICHELLE WALSH: Um-hum.

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

MICHELLE WALSH: Thank you.

HOWARD: Is there anyone else wishing to speak as a proponent for LB811? Seeing none, is there anyone wishing to speak in opposition? Anyone in a neutral capacity? Seeing none, Senator McCollister waives and this closes the hearing for LB811. All right, and this will open the hearing for LB755, Senator Blood's bill to provide for and change home services, permits for barbers, cosmetology, and nail technology. Welcome, Senator Blood.

BLOOD: Thank you, Chairperson Howard. It's nice to see all of you again. Seems like it was just yesterday that I saw you. So good

afternoon, Chairperson Howard and the Health and Human Services Committee. My name is Senator Carol Blood. That is spelled C-a-r-o-l B as in boy l-o-o-d as in dog, and I represent District 3, which is comprised of western Bellevue in southeastern Papillion, Nebraska. Thank you for the opportunity to bring forward LB755, which creates the Nebraska Barber Act. Approximately 1 in 4 Nebraskans is over the age of 60. Baby boomers have been turning 60 and will continue to do so for the next 10 years. Additionally, just over 22 percent of adults in Nebraska have some type of disability. As part of both demographics, you have individuals who primarily stay inside the home. Certain physical or mental disabilities may prevent them from leaving the home for basic services such as grocery shopping, visiting friends or relatives, social events, attending church, or self-care errands such as getting a haircut. When we speak of those who are immobilized at home, we must remember that many have family members or other caretakers who also cannot easily leave the home due to the needs of their loved ones with disabilities. This is where the Nebraska Barber Act comes in. A barbershop may allow their licensed barbers perform home barber services if they obtain a home barber services permit. To obtain a home barber services license from the Nebraska Barbers Board, the barber shop must have a current barber shop license and apply at least ten days before home barber services are expected to begin. If the barber shop meets these criteria, the Board will issue a permit if the two requested criteria are met. The owner of said barber shop holding a home barber services permit shall have a full responsibility for ensuring that the home barber services are provided in compliance with all applicable, all applicable laws and are liable for any violation that may occur under this license. A home barber permit applies to consumers who are immobilized and cannot leave their home. This can include infirmities associated with aging, conditions that leave them temporarily incapacitated, people with mental health challenges such as agoraphobia or anxiety, and sole caregivers who do not have the option to leave for basic self-care tasks like a haircut. The barbershop will determine the client meets the criteria based on the description given in the statute and submit an information form to the Barbers Board. The barbershop must also post a list of barbers who are taking part in home services and the clients they serve so can easily be reviewed by the Board. Barbers cannot offer home services unless they are connected to a barber shop. And lastly, the home services permit will be renewed when the barber shop's license is also renewed. As we look to remove hurdles for licensure, we need to also look for ways that we can expand services to address Nebraskan's needs as our demographics change. Also, you will note that nail technology

home services are described in this part of state statute. We felt it was important that we brought consistency and language throughout this part of the statute and expanded the definition to include persistent circumstances to better explain those immobilized within the home as well as including mental disability as part of that description. Now this is a really simple bill that's going to help a lot of Nebraskans who, for one reason or another, cannot leave their homes to reserve these type of services. You will note that both our disabled community and our senior citizen advocates support this bill because they know as the world and our needs change, our statutes need to change as well. And with that, I close my opening. I'm happy to answer any questions, but encourage you to listen first to our supporters and perhaps save any remaining questions at my closing as I feel many of your questions will be answered by our testifiers. Thank you for letting me share this bill today with your committee.

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

ARCH: Thank you. I do have a question you don't have to answer it, this is for those that are gonna testify. I want to make sure it gets answered. Why don't we just expand the existing license for barbers and include that as, as one of them, rather than create a separate one? But like I say, you don't have to answer that. We'll, we'll allow--

BLOOD: OK, we will let the Barber Board answer that. But I do have an answer for that if it doesn't get answered.

ARCH: OK. Thank you.

BLOOD: All right.

HOWARD: Other questions? Seeing none, thank you, Senator Blood. Our first proponent for LB755.

KEN ALLEN: Good afternoon,--

HOWARD: Good afternoon.

KEN ALLEN: --Senator Howard and the committee staff. My name is Ken Allen, K-e-n A-l-l-e-n. I'm the director of the Board of Barber Examiners. This bill is a fairly simple bill. It was brought to my attention by a constituent in District 3, and I figured it'd be best addressed if we took it to Senator Blood, who has graciously taken this on, along with attaching some other amendments to similar type

things. I say this, this party contacted our office late last spring and wanted to know how they could create some kind of revenue through doing home services such as this bill introduces. After lengthy conversations, they wanted to write their own legislation, which we advised them better to leave it to the professionals or the people elected. So this bill was drafted along with some other ideas from the Senator's office to incorporate a lot of things that need to be incorporated to make this bill simpler. In other words, things like including other people than what was initially listed like, oh, and off the top of my head, people that are incapacitated that can't make it, or for some medical reason will not make it into a licensed barber shop, this bill includes those type of things. So we brought this to Senator Blood, she brought it on, she, she grasped it with open arms and included her little things. She was in full contact with our office the whole time, which was a beautiful thing. That doesn't always happen with these kind of bills. So anyway, biggest part of this bill is legalizing, in other words, giving a permit to a licensed barber to go into a home which is not licensed to do these kind of services. That is the biggest-- and I hope that answers your question, Senator Arch. Currently, if you were to go into, whether your license or unlicensed, to go into a home unless their immediate family members you could not perform these acts legally under the state statutes. OK. That's the basic setup. Now we in the past have allowed people in emergency situations who need a haircut if they're confined to a hospital bed, we look beyond that. Those are within the statutes as well. We allow that to happen. But to go into somebody's home, that has never been part of our criteria. So anyway, I'd like to thank Senator Blood and her staff for working graciously with us on this bill. If anyone has any questions pertaining to this bill, please ask them and I'll try to answer them.

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

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

KEN ALLEN: Sure.

WILLIAMS: We've had a lot of discussions over these years, haven't we?

KEN ALLEN: We have.

WILLIAMS: These kind of things. The reason that we are oftentimes involved with legislation like this is to be sure that public safety

is being protected. That's why we have a lot of these registration and things. And right now there's a level of safety, sanitary conditions, and chemicals. Can you explain to us how those same standards would be maintained by a licensed barber going into a home?

KEN ALLEN: Correct. The biggest thing that we look at is: number one, licensure; second thing is sanitation to make sure that the equipment which leaves the shop, and we're gonna restrain this to shop only permits because we don't want this coming out of a garage or somebody's home. It's hard for us to get in and do the inspection. So the tools and equipment leaving and, and chemicals, for that matter, leaving the shop in their transport cases will be examined to make sure that they meet all the criteria being sanitized, that they are legitimate products to be taken out to the field. And once they get in the field, they will also be instructed to if there is, what we call, a dirty item or something that's been used will be put into another container to be transported back to be sanitized back at the shop. So as far as sanitation in the field, they will carry their spray, disinfectants, and hand sanitizers, and that kind of stuff, but most of it cannot be done in the field just because of logistics.

WILLIAMS: You mentioned, Mr. Allen, in your explanation, they will be examined. How does that--

KEN ALLEN: Sure.

WILLIAMS: --part work?

KEN ALLEN: Sure. Part of our, our job-- part of my job is to go around and inspect all shops. Every two years, we must inspect all shops. So the first thing we look at is licensure and sanitation, the procedure's done, the cleanliness of everything, including floors, walls, ceilings, just to make sure safety things, light switches-- you know, if there's not an that outlet plate on there, it can be documented and required to be fixed. But yeah, we go through and we inspect all of the tools that are used. We go through dispensary areas to make sure that they are in an orderly fashion so that we're not walking into some big surprise and just public safety stuff. I mean, it's general, make sure that you're using the right chemicals, make sure they're using chemicals at all. I mean, just little simple things.

WILLIAMS: Thank you.

KEN ALLEN: Sure.

HOWARD: Other questions? Senator Arch.

ARCH: Thank you. Have you identified a fee that you would anticipate charging for this?

KEN ALLEN: I knew you were gonna come up with that. I have not. We have--

ARCH: OK.

KEN ALLEN: --this is so new, we have a board meeting on Sunday. And that was on my agenda. I don't have a number for you.

ARCH: OK.

KEN ALLEN: I don't make that decision. I can recommend-- I recommend it's gonna be roughly about 50 bucks a year type fee.

ARCH: I know that Senator Blood referenced removing hurdles for licensure and that, so that, that would've been a concern.

KEN ALLEN: Correct. Yes, yes.

ARCH: Thank you.

HOWARD: Any other questions? Seeing none, thank you, Mr. Allen.

KEN ALLEN: OK. Thank you.

HOWARD: Our next proponent for LB755. Is there anyone wishing to testify in opposition to LB755? Seeing none, is there anyone wishing to testify in a neutral capacity? Seeing none, Senator Blood, you are welcome to close.

BLOOD: Thank you, Chairperson Howard. And I do believe you also have some letters in support of today's bill. I wanted to address Senator Williams' concern, and I encourage you when you have a moment to look at page 8, because it does specifically talk about inspections and sanitation. And also in reference to the tool kit that would be utilized when these services are provided. And then Senator Arch, in reference to the expansion of services question, just to build on was already said, one of the things we wanted to do was to, quite frankly, avoid a 407 hearing because we didn't want to change scope of practice. And many, many months ago, I spoke with Chairperson Howard,

who said that if indeed we did change scope of practice, we would want to make sure that we would jump through that hoop. And to make sure that we were not doing that, we did contact Matt in DHHS and several other entities within that body to make sure that we were on the right track. So to be really frank, we're not trying to change the scope of practice. We're just trying to provide some services to people that are in dire need of these services and bring some humanity back into their homes. I wanted to address what we-- what I personally added to the bill. Originally, it was just for people that were homebound with a physical ailment. But as we know, there are many people with mental health illnesses that prevent them from leaving their homes. And then as we have our population aging, we know that more and more caretakers are also homebound because they can't leave their loved one. And so there's no reason that we can't help fill their vessel periodically and let them do some self-care as well. It just makes sense, and it's the compassionate thing to do. And so with that, I appreciate the opportunity today. It's a very simple bill. We didn't bring a big entourage. I believe you do have letters, though. I'd be happy to answer any questions that weren't answered yet.

HOWARD: Thank you. Any questions? Senator Arch.

ARCH: For some reason, this-- I don't know, I, I pay a lot of attention to my own hair so I thank you.

BLOOD: And you do a lovely job, Senator.

ARCH: Thank you. Thank you. Can a person just ask to have their hair cut in their home as it is right now? I mean, do they have to qualify as under these particular disabilities and so forth, I just,--

BLOOD: No, they cannot.

ARCH: --I just want a barber to come over and cut my hair in my house?

BLOOD: It depends on how you look at it. First of all, that would be taking away from our brick and mortar stores. Right? If you have the ability to drive, you just don't want to go out because it's snowy today, I think that, that makes a gray area that, that takes away from how important bills like this happen to be. Second of all, this is a very limited group of people that are going to be able to receive help. I think that you're really putting a big burden on the Board if you just say, hey, anybody that wants to go and cut hair can go cut hair. Because think of the implications when it-- when they have to go

and check for cleanliness and to make sure they're utilizing the right tools and treating people effectively and so--

ARCH: All right.

BLOOD: That's, that's my personal answer.

ARCH: OK. Thank you.

HOWARD: Other questions? Senator Murman.

MURMAN: Thanks a lot, Senator Howard. And thanks for coming in. The barber and cosmetology, I can totally understand. I'm a little bit concerned, I guess, about nail technology, we, we saw some gory pictures last year in this committee from things that can happen I guess from--

BLOOD: Yeah.

MURMAN: --nail-- things being done to your nails.

BLOOD: Valid, valid question. I actually have a client that lost several portions of her body from a, from a bad pedicure. But you'll note that we don't really touch that part of the statute, that was already in the statute. All we did was expand definitions. We're expanding the definitions for our part of the bill. So as far as what they're allowed to do in the homes, we didn't change that at all.

MURMAN: So--

BLOOD: Because they were already allowed-- nail techs were already allowed to go into homes and help people that were homebound.

MURMAN: OK, that was my question.

BLOOD: Um-hum.

MURMAN: They are allowed now--

BLOOD: Yeah, we didn't change that.

MURMAN: --so this isn't changing that at all.

BLOOD: No, we just expanded the definition. So if you were, for instance, had a mobility issue and you were in your home and you wanted to get your nails done, they could currently come and do that.

But if you are a person that was maybe agoraphobic, they couldn't get their nails done. So what we did it again was expand it. To me when I hear homebound, it's not one single picture in my head, it's people who are sincerely homebound, be it mental health, be it physical health, and their caretakers. So-- but we did not change anything as far as what services they can or cannot provide, it's who they provide it to. We just expanded some definitions because they are in the same part of statute. So if it had been-- I don't know, I can't even think of an example, say it had been somebody that was a painter, which would not be that part of statute. But we allow them to paint within a certain area. And if there's something else in that statute that we're expanding the definitions we'd want to touch on the painters, too.

MURMAN: OK,--

BLOOD: So that's all we've done.

MURMAN: --so with nail technology, the person who would be providing the service would have to bring their equipment into the home.

BLOOD: Which they do already.

MURMAN: OK, so that's--

BLOOD: Right.

MURMAN: --already in--

BLOOD: That's-- again, all we did was expand what it meant to be homebound. And since they're in the same part of statute, we included them and we got-- when once the bill got launched the first day of our session, I got all kinds of emails from nail techs that were like thrilled. Who knew?

MURMAN: Thank you.

HOWARD: Any other questions? Seeing none, thank you, Senator Blood.

BLOOD: Thank you for your time.

HOWARD: We do you have letters for the record. I'm remembering them at the right time today. Proponents: Edison McDonald from the Arc of Nebraska; Laura Ebke, from the Platte Institute, Daniel Ullman, from the Nebraska Psychological Association; Jamie Summerfelt, from the Nebraska Home Care Association; and Todd Stubbendieck, from AARP

Nebraska. There were no letters in opposition or neutral. Thank you, Senator Blood.

BLOOD: Thank you, Senator.

HOWARD: All right, this will close the hearing for LB755 and open the hearing for LB828, Senator Hilkemann's bill to change provisions relating to the scope of practice of a licensed optometrist. Welcome, Senator Hilkemann.

HILKEMANN: Thank you, Senator Howard. Good afternoon, my name is Senator Robert Hilkemann, that's R-o-b-e-r-t H-i-l-k-e-m-a-n-n. I represent District 4 and I'm here to introduce LB828. The intent of LB828 is to expand Nebraska's access to eye care. This bill would allow doctors of optometry to perform procedures that treat cysts and inflamed glands in the eyelid. Optometrists are here and will be testifying to describe these procedures more fully, but they would simply be a logical extension of the education, training, clinical skills, and decision-making authority that Nebraska optometrists already have. This is about increased access to healthcare, which is a public policy priority across this country. And right now in more than a third of the states in the United States, patients have greater access to eye care services than they do in Nebraska. By advancing this legislation, the Legislature would allow Nebraska citizens to benefit from care that patients are receiving from local optometrists in 19 other states. By allowing optometrists to use their training and provide this care in their practices, we would save many of these patients days or weeks of discomfort waiting to get an appointment for follow-up care, and we would be saving patients and their family the time and expense of second office visits. Although opponents will try to characterize it otherwise, these procedures would not require an entire new skill set or an entirely new body of knowledge for Nebraska optometrists, the training they have already received, the additional training that would be required by this bill, and the day-to-day clinical evidence they have in evaluating, diagnosing, treating, managing all forms of eye health issues, [INAUDIBLE] they would be appropriately qualified for this new authority. LB828 is nearly identical to a bill that was introduced in 2017. And the authority that is being sought in this bill was included as part of a much broader bill that first came before the Legislature in 2013. The subject matter of this bill was included in a 407 review process in 2013, and one of the proponents following me will be discussing the outcome of that 407 review. In some detail, I can answer questions you

may have regarding to that 407 process. I would hope you as a, as committee members will continue to ask yourself if optometrists in Nebraska aren't capable of providing the care that's proposed in this bill, how is it that optometrists in these other states who are similarly trained and educated can effectively provide the same care? If patients in these other states are benefiting from this kind of accessible, effective quality care from optometrists, why should we be preventing Nebraskans from having a similar option? Does our Legislature believe that there is something about our licensed optometrists that make them less capable than their colleagues in these other states? Following me, you will hear from optometrists who will describe the bill in some additional detail, describe the education and training related to this proposed new authority, discuss the impact of improved patient access to care and describe the outcome of the 407 review of this proposal. Thank you for your time and consideration and I'll try to answer any questions you may have at this time.

HOWARD: Thank you, Senator Hilkemann. Are there questions? Before you go, do you want to clarify the difference between this bill and the bill that we heard last year about the 407 process from you as well?

HILKEMANN: I will certainly try to take a stab at that. Last year, our bill was basically to, to expand the, the practice through who would be doing the authorization. We were going to do it through the Board of Health and through the Optometry Board and, and so this, this-- that would have been a process that could have been an ongoing type of process. Since there was no real interest in that bill last year, they're coming back to just go for a specific change. And this is for to doing the procedures on the cysts in the eyelids. So the difference is really in last year we would had been setting up more of a, of a precedents where we would be using the Board of Health plus the Board of Optometry, and that could have opened up more areas where we wouldn't have to be coming before the Legislature each time. Since that did not gain any traction, we're just coming with the specific procedures that they want to add at this time. Does that answer your question, Senator?

HOWARD: It does. Thank you, Senator Hilkemann. All right, any last questions? Senator Williams.

WILLIAMS: Thank you, Senator Howard. And thank you, Senator Hilkemann. You just used the term surgery on cysts of the eyelid. Can you tell me if that is what was specifically a focus of the 407 in 2013?

HILKEMANN: Senator, there will be someone behind that will know more about that--

WILLIAMS: OK.

HILKEMANN: --407, but it is my understanding that was the, the focus of 407 in 2017.

WILLIAMS: And the terminology and the surgery on cysts of the eyelid.

HILKEMANN: That's correct.

WILLIAMS: I want to be sure on that one when somebody comes up.

HILKEMANN: Yes, ask, ask that--

WILLIAMS: Thank you.

HILKEMANN: --whoever talks about that, ask them that question and make sure that that--

WILLIAMS: Thank you.

HOWARD: All right. Any other questions. Will you be staying to close?

HILKEMANN: I will.

HOWARD: Thank you, Senator Hilkemann.

HILKEMANN: You bet.

HOWARD: We'll now invite our first proponent for LB828. Good afternoon.

ANDREW BATEMAN: Good afternoon. Thank you, Chairwoman Howard and committee members. My name is Dr. Andrew Bateman, A-n-d-r-e-w B-a-t-e-m-a-n. I am the current president of the Nebraska Optometric Association. On behalf of the 307 members of the Association, I would like to thank Senator Hilkemann for introducing this bill to enhance the eye care services that Nebraskans can receive from their local doctor of optometry. The new authority that would be granted to optometrists by LB828 involves procedures that are sometimes needed to

treat cysts and inflamed or clogged glands in the eyelid when other frontline treatments like warm compresses and oral medications aren't sufficient. We described these kinds of treatments to the committee a few weeks ago and the briefing we were able to provide. But as a reminder, a common example would involve styes that people get on or just under their eyelids. What this bill would authorize us to do would primarily be to lance those glands just like people sometimes do to themselves if we have a blister or pimple in order to express out the trapped material in the gland. In some cases, it would involve an injection into the eyelid to numb the area that we would be treating. Occasionally, there may need to be a small incision large enough to scoop out the caseous material. These are all minimally invasive procedures done with the patient in the exam chair in our practices. I want to make it clear that this bill would allow no additional procedures or authority involving the eyeball. LB828 deals only with cysts or inflamed glands of the eyelids. I am sure opponents will do everything possible to draw attention to the broadest possible interpretation of what the bill would allow. They will likely cite examples of extreme cases and complications that can arise related to eyelid procedures which this bill could authorize optometrists to treat. First, I can assure you that no optometrist is going to do any of these new procedures if there is a simpler remedy or option that would address the condition. And second, I can assure you that my colleagues and I are well aware of complications and risks, including how to distinguish between benign and malignant lesions, since that is currently part of our scope of practice. We have been removing foreign bodies from the eyeball for several decades, and if something is too deep or beyond our expertise to remove, we refer. Similarly, my license allows me to treat even the most severe or unusual cases of glaucoma and other diseases. Do I treat every case just because I'm allowed to do it? No. There are times I seek a consultation and times I send a patient to another doctor. It will be no different with the authority that would be granted in this bill. We already manage post-surgical complications for these and many other procedures that are far more complicated than what's covered in LB828. We understand complications. We understand risks. We understand ethics. Patient safety and quality of care come first with the professional judgments we make every day with every patient. I know there is a high degree of uncertainty and confusion when the Legislature is asked to evaluate bills like this. You hear proponents say it's safe. You hear opponents say it's not. In summary, as you listen to the testimony today, I encourage you to keep in mind that you do not need to rely solely on an informed guess as to who is right. We encourage you to rely on the

knowledge that what you are considering here is not opening new frontiers to optometry. This is not unchartered territory. There are at least 10 states that allow all of the authority described in this bill and at least 19 other states where optometrists have varying degrees of this authority. Because of the experience of those other states, we don't have to guess at what will happen. We know it's safe. We know the training and education of optometrists is appropriate for providing this care. We know patients in those states are benefiting. We respectfully urge you to support LB828 and I would be happy to take questions.

HOWARD: Thank you. Are there questions?

WALZ: Oh, I'm gonna ask a question.

HOWARD: Oh, Senator Walz.

WALZ: Since nobody else is, I will. Can you, can you describe the, the training a little bit, the hands-on training--

ANDREW BATEMAN: Sure.

WALZ: --for this procedure? How does that work?

ANDREW BATEMAN: One of my colleagues will be able to get into that--

WALZ: OK.

ANDREW BATEMAN: --a little bit more in detail. But in terms of the hands-- hands-on training, it is a wet lab where you actually get to practice-- you're practicing the injections and, and procedures that are necessary to perform these.

WALZ: Are you practicing those procedures on the eye?

ANDREW BATEMAN: Um-hum.

WALZ: OK. All right. Thanks.

HOWARD: Senator Williams.

WILLIAMS: Thank you, Chairperson Howard. And thank you, Dr. Bateman, for being here. In his opening statement, Dr. Hilkemann talked about expanding access to healthcare. In, in, in your-- where's your practice located?

ANDREW BATEMAN: Mine happens to be here in Lincoln.

WILLIAMS: Here in Lincoln. OK. So you're close to ophthalmologists and to optometrists both in this territory. In your practice, how often do you see a cyst or inflamed gland?

ANDREW BATEMAN: Oh, I would say at least a couple times a week.

WILLIAMS: OK. And, and with that, how often does the hot compress or, or medication fail to resolve the situation?

ANDREW BATEMAN: Very few times. That is certainly the first line of treatment that we use the majority of the time.

WILLIAMS: So do you have any estimate of, of how many people? What, what percentage of people are we talking about here that we are trying to expand access to care for?

ANDREW BATEMAN: That is a good question. One of my colleagues probably would be able to answer that a little bit better, more specifically

WILLIAMS: OK. I would, I would appreciate knowing that. And I know it's different here in Lincoln and Omaha and I'm from a rural area, which is-- which I'm concerned about, too.

ANDREW BATEMAN: Yes.

WILLIAMS: Thank you.

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

ANDREW BATEMAN: Thank you.

HOWARD: Our next proponent for LB828.

CHRISTOPHER WOLFE: Good afternoon, Senator Howard, committee. My name is Dr. Christopher Wolfe. I practice in Omaha, and I'm here today to discuss the 407 review of the proposals since that is an important advisory resource for members of the Legislature. The subject matter of LB828 was included as part of a proposal that was reviewed in 2013. In addition to the authority being sought in this bill, that 407 review addressed removing remaining restrictions on oral medications, and that prescriptive authority was subsequently authorized by the Legislature in 2014. As you know, credentialing reviews have three

components: the Technical Review Committee votes separately on six different criteria, then takes an overall vote. Our proposal satisfied three of the criteria and narrowly failed the other three. The committee's final vote was 4 to 3 to recommend against the proposal. And it's worth noting that many of the reasons listed by the committee members for voting against the proposal involve concerns over oral medications. And to reiterate, prescriptive authority for those medications was subsequently granted by the Legislature and that is not an issue dealt with in LB828. In Step 2, the State Board, comprised predominantly of healthcare professionals, voted 9 to 4 in favor of the proposal. Of note, the four negative votes came from two medical doctors on the Board, a doctor of osteopathy, and the public member who chaired the technical review committee who understandably was obligated to vote against it. Representatives of the non-MD/DO health professions all supported it. The Board of Health support included a recommendation that hands-on, clinical workshop training should be part of the education requirements, and that recommendation has been incorporated into LB828. In Step 3, the medical director recommended against it, and I believe this has been the case in every 407 review that has been conducted on optometric scope of practice proposals. In his report in 2014, the director summarized his opinion with the statement that it was not established that optometrists can perform the procedures and prescribing practices safely and effectively. I would respectfully, I would respectfully point out the director's opinion has already been proven wrong in terms of the prescribing authority over the five years since the Legislature granted the authority despite his objection. And the fact that optometrists in multiple other states are currently providing the care outlined in LB828 safely and effectively is evidence that his opinion is wrong on that point, too. Three years ago, this committee heard testimony from opponents that this proposed authority had already been rejected by the 407 review and by the Legislature. And I already commented on the 407 review, but it's worth noting that in 2014, that-- the bill that contained provisions similar to those in LB828 was, in fact, advanced from this committee on a 4-0 vote and given first round approval by the Legislature. On the 58th day of a short session, we accepted a compromise from the opponents on Select File that would-- that allowed provisions pertaining to oral medications to pass that year in return for us abandoning the provisions related to procedures we're requesting in LB828. The full Legislature has not had the opportunity to consider the provisions in LB828 since the favorable General, General File vote in 2014. And we ask for your

support of this, support of this bill, and please send it to the floor this year. Thank you very much.

HOWARD: Thank you. Are there questions?

CHRISTOPHER WOLFE: If I can, Senator Williams, I believe you asked about whether or not cysts were specifically named in the 407 review, and, and they were. It specifically talked about allowing the injection of medication for the treatment of anaphylaxis, which has already been passed in 2014, pharmaceutical agents injected into the eyelid for the treatment of cysts or infected or inflamed glands of the eyelid.

WILLIAMS: Thank you.

CHRISTOPHER WOLFE: You're welcome.

HOWARD: Seeing no questions, thank you for your testimony today.

CHRISTOPHER WOLFE: Thank you very much.

HOWARD: Our next proponent testifier. Good afternoon.

HOLLY TERNUS: Good afternoon. Thank you, Chairwoman Howard and the Health and Human Services Committee for allowing me this opportunity to express my support of LB828. My name is Dr. Holly Ternus, H-o-l-l-y T-e-r-n-u-s. And I'm an optometrist practicing in Omaha, Nebraska. The purpose of my testimony is to describe optometric education and training as it relates to LB828 as a supplement to the information we presented in the briefing we did for the committee last month. First, it's important to understand that optometry is not a subset of ophthalmology. We are an independently licensed profession with extensive knowledge, education, and training in the eyes and visual system and the systemic diseases that can impact them. Second, it is critical to this discussion to know that in addition to unique postgraduate education about the eyes and visual system, we receive extensive and intense clinical training and experience in the management of ocular disease. This is accomplished by receiving one-on-one supervision during all clinical encounter-- encounters and minor surgical cases and spending thousands of hours in clinic and didactic lectures and personal study. During my training, I saw up to 100 patients per week, each directly supervised by a staff ophthalmologist or optometrist. Approximately 50 to 75 percent of these patients had active sight-threatening disease that could not be

corrected by glasses. By graduation, I completed hundreds of procedures to train me about the delicate tissues around the eyes. We begin learning these skills during our first semester, during cadaver dissection in our anatomy courses in our first year. We start training on minor surgical procedures such as chalazion drainage and injections early in year three, as you can see in that handout comparing the training of ODs versus MDs that I distributed to you. And as I noted in the briefing last month, nurse practitioners and physician's assistants can perform these procedures we're asking to be authorized with far less training and clinical experience than optometrists. Our opponents will argue that malignant tumors of the lids will be missed if we we are allowed to drain these lesions. However, the clinical appearance of a clogged gland or benign cyst is far different than a malignant lesion. Our training and clinical experience, including getting a detailed patient history and monitoring of the lesions for irregularity census, are they growing onto other tissues or are they irregular in color or ulcerating, this gives us the ability to diagnose and manage these malignancies in a timely and appropriate fashion. And detecting malignant lesions has been part of our scope of practice for more than 40 years. Every single step of my training, I had a staff optometrist sitting at my side looking through a microscope and guiding me to ensure I'm performing the highest level for my patients. In addition to passing a large number of written and clinical exams to graduate from optometry school, an optometrist must pass the standardized National Board of Optometry Examination, and it requires the passage of two written board examinations and a clinical skills practical before we are allowed to practice. The clinical skills portion is proctored by the National Board of Examiners and includes performing injections safely with a proper sterile technique. For doctors of optometry who have been practicing for a while and have not recently taken the National Board Examination, there are established training curriculum that have been implemented in other states to further educate and certify optometrists to perform these minor surgical procedures. And that's what would be required by this bill. We know that these additional certifications work because they have implemented for over 20 years and in 10 other states, and there's no evidence that ODs performing these procedures and treatments have a higher complication rate than the MDs performing them and no authority given to optometrists and other states has ever been revoked. Last year you heard from an ophthalmologist who went to optometry school and her optometric education took place a long time ago. Education and training has changed significantly in the past 40 years much like all healthcare professionals have changed in the past 40 years. We have

submitted a letter that I distributed to you from another ophthalmologist who went to optometry school and trains optometrists currently at Northeastern State University, and he describes our training in more detail. He argues that the training and education of an optometrist is far more extensive and detailed than ophthalmology has ever conveyed to you in the past. In addition, all optometry schools must be accredited by the Accreditation Council of Optometric Education and have similar curriculum in order to be accredited. This is to ensure that optometrists are all competent to standards of care and can pass all portions of the National Board Exam. In summary, optometric training is thorough and rigorous with high standards for testing competency. Upon completing this education, training and certification, doctors of optometry are capable of providing the highest level of care to the citizens of Nebraska. Therefore, I respectfully ask for your support of LB828. Thank you and I'll be happy to take any questions.

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

WALZ: I have a, a couple questions, I guess. And I asked it before, but I'm gonna ask you again, can you kind of describe the on-- the hands-on training that you received prior to doing this procedure--

HOLLY TERNUS: Of course.

WALZ: --or your ability to do this procedure?

HOLLY TERNUS: The reason we're so comfortable with this procedure is because we manipulate the lids. We flip the lids. We already manually drain these lesions without incisions, but the required training course would require us to practice on an eye. And so everybody would have experience on patients prior to having to perform these procedures.

WALZ: OK. And again, just to clarify, there are-- there is extra education that will be required prior to you being able to have the ability to--

HOLLY TERNUS: Correct. And that's, that's laid out in this bill.

WALZ: OK. Thank you.

HOWARD: Other questions? Senator Williams.

WILLIAMS: Thank you, Chairperson Howard. And thank you for being here. And I would like to follow up on that. How often do you have to do a procedure to be proficient at it?

HOLLY TERNUS: Well, this type of procedure is, is not complicated, like, say, cataract surgery, where you have to go inside the eye. It's just a superficial gland that-- so me personally, I would be comfortable after one because I am so familiar with the eyelid, manipulating the eye, removing foreign bodies from the eye. So for me, it wouldn't take much. But for someone that doesn't have any training in that area, it would probably take more. But for optometrists who all receive the same training, it's kind of what we do every day already.

WILLIAMS: Take me back then and walk me through, if, if you have a patient that comes in and-- well, first of all, let me go back, Dr. Bateman testified that he may see in his practice, I think it was three of these a month, something like that. Is that kind of what you're seeing, too? And again, the vast majority of them are taken care of with the compress and medication.

HOLLY TERNUS: Yeah, in my particular practice, it's a little more specialized. So we get a lot of referrals from other doctors. So I do see this a little more often. And I do have to refer out probably three or four on a monthly basis to get drained.

WILLIAMS: So right now, other optometrists are sending patients to you, is that what I just understood?

HOLLY TERNUS: If, if they see a, a gland that they don't feel comfortable with, yes, in another practice setting.

WILLIAMS: OK. And then when you see one that you're not comfortable with, tell me what you do today.

HOLLY TERNUS: Well, it's not that I'm not comfortable. It's just they don't, they don't--

WILLIAMS: That's beyond your scope of practice, what do you do?

HOLLY TERNUS: Right. So I'll do form of compresses-- well, if something is beyond my scope of practice, I'll refer it out.

WILLIAMS: So if you've tried the things that are in your scope, compress, medication and it doesn't work, then you refer it out and do

you have a relationship with a ophthalmologist or something that you refer it to?

HOLLY TERNUS: Yeah, I'm, I'm in Omaha so I refer to ophthalmologist, but it requires another copay, another visit for the patient, establishing care with another doctor.

WILLIAMS: So is that more or less cumbersome than another optometrist referring something to you the first time and then you referring to an ophthalmologist?

HOLLY TERNUS: Well, the-- it's, it's not necessarily an optometrist, sometimes it's, it's medical doctors, too, in primary care that have these glands because they're not comfortable with them either.

WILLIAMS: Sure.

HOLLY TERNUS: If, if they could be treated without having to make an incision and drain them, that's always ideal. So that's why they send to us. We do the orals, warm compresses, maybe a topical ointment. But it's just because I see them so frequently that's--

WILLIAMS: That's helpful. Thank you.

HOLLY TERNUS: Yeah.

HOWARD: Any other questions? Senator Walz.

WALZ: I just, I just have one more question just because I like to learn about this. So I understand that there's not an optometry school in Nebraska. Correct?

HOLLY TERNUS: Correct.

WALZ: When you say that you've received-- or that there will be training-- hands-on training on the eye, is that nationwide? Is that the same training nationwide or does that differ from state to state?

HOLLY TERNUS: In, in the states that allow these procedures that have these courses, they're, they're all the same--

WALZ: OK.

HOLLY TERNUS: --to-- that, that allow-- that get us trained to perform these procedures.

WALZ: OK. So if you go to a school that doesn't allow that, they don't train you, how does that then [INAUDIBLE]--

HOLLY TERNUS: Well, you can't-- yeah, you can't, you can't practice outside your scope. Yeah.

WALZ: OK. OK, got it. Thank you.

HOLLY TERNUS: Yeah. Yeah.

HOWARD: Let me help with that one, so are there schools in states that don't allow you to, to do this, optometric schools?

HOLLY TERNUS: We-- well, we can't-- if you can't do them, if you can't perform them in that specific state, then it's out of your scope. So there are, there are these training courses you can go to that's, that's laid out in this bill that you can go to and get the training to do these procedures. And that's what's required by what is in our bill is we'd all have to take this training course.

WALZ: Prior to--

HOLLY TERNUS: Yes.

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

HOLLY TERNUS: Thank you.

HOWARD: Our next proponent testifier. Good afternoon.

AMY DeVRIES: Good afternoon. My name is Dr. Amy DeVries, spelled A-m-y D-e-V-r-i-e-s. I am an optometrist practicing in Fremont and I am the president-elect of the Nebraska Optometric Association. Thank you for taking the time to hear my testimony. I am here today testifying in support of LB828. And I am here specifically to discuss how this bill will improve access to care and help control costs. We distributed information in our hearing last month that it just-- that addressed the distribution of eye care providers across the state. As it showed, optometrists practice in 59 of our counties providing access to eye care for 94 percent of our population. Optometrists are the only eye care providers in 49 counties. There are roughly three times as many optometrists as ophthalmologists in Nebraska. At a hearing in 2017, our opponents presented information that 99 percent of Nebraskans are within a 30-minute drive of an ophthalmology satellite clinic. While

that may be technically accurate, it is critical to clarify that many of those satellite clinics have an ophthalmologist available to see patients only one or two days per month. The main purpose of those clinics is to perform cataract surgery and retinal surgery, not to perform the procedures outlined in LB828. It is common for patients to have to wait weeks to months before they can receive the care they need, especially for nonemergent care such as what we are discussing in this bill. I am distributing a collection of comments from some of our members describing the challenges their patients have in getting timely care when they need to be referred out for these minor procedures. I encourage you to read them and to consider how inefficient and frustrating it is for a patient to have to wait for another appointment when their local, trusted, highly trained optometrist could have helped them the same day. Allowing optometrists to perform the minimally invasive procedures proposed in this bill also means the ophthalmologists will be allotted more time to focus on their surgical specialties. We want to work with ophthalmologists as an effective team that does not result in waste of available resources or unnecessarily delay care to patients. In 2017, our opponents to the prior bill claimed that there would be no cost savings from this proposal, that it would only redistribute dollars among professions. That is simply not true. A report from Avalon Health Economics in 2019 concluded that increased access to primary eye healthcare services from optometrists further reduces redundant visits for follow-up care. The report noted that patients spend an average of 2.06 hours each time they obtain medical care. Based on the average U.S. hourly wage of $27.77, that is a cost of $57.21 on average just for their time, each time they have an appointment. In addition, the cost of the second office visit adds another $155 in direct expenses based on Medicare rates on top of any travel-related costs. Expanded, expanded access to care will, in fact, save time and money for our citizens and for the healthcare system in Nebraska. Our opponents may argue that access and convenience are not as important as quality of care and patient safety. We agree, and the reality is that there is no demonstrated evidence from around the country that quality of care by optometrists is any different or less than it is for ophthalmologist related to this new authority. There are only unfounded predictions and random examples of poor outcomes. We believe LB828 will provide better access to care and save time and money for our patients without sacrificing our number one priority of patient safety. All Nebraskans need local, timely access to care. I therefore respectfully ask for

your support of this bill and thank you for your time and your service to our citizens.

HOWARD: Thank you. Are there questions? Senator Walz, I'm sorry.

WALZ: Since you brought up costs, I'm just curious of what-- how much is like a typical procedure for somebody to have this done? What, what does it cost?

AMY DeVRIES: So I didn't actually look up the Medicare rate on that, I would like to defer that to one of my colleagues. But before the procedure would be done, another office visit would be done to establish that patient relationship. And that would be an average of $155 based on Medicare rates for our area. Whatever the cost of the procedure would be, would be the same whether the optometrist or the ophthalmologist perform the procedure. So that part is a wash. It's the additional office visit that establishes that patient relationship.

WALZ: And then I just have another question. So-- just so I understand the process, so if you refer to an ophthalmologist, it's $155, whatever, for an office-- what did you say?

AMY DeVRIES: Office visit or like a, a 99 CPT code.

WALZ: And is that-- can the procedure be-- is the procedure typically performed that day?

AMY DeVRIES: It depends on the individual doctor and the individual patient, of course. But one does not bill the 99 code the same day as the procedure code. One would select which of the two was more fitting for the visit. That specific answer really does depend on the person, the way the lesion appears, the way the doctor feels, if they think another treatment should be done before an incision would be made, so it's hard to answer that directly.

WALZ: OK.

AMY DeVRIES: The answer is, it depends.

WALZ: Sure.

AMY DeVRIES: Sometimes they might do it right away. Sometimes they would establish within an office visit first.

WALZ: OK. All right.

AMY DeVRIES: And if I might be allowed to answer another part of the question you asked and correct me if I'm wrong, but I believe you asked if different schools in different states provide different training. Every optometry school has the same curriculum because each school has to prepare their students to pass the National Board Exam. Every single student graduating from optometry school takes the same test, identical test. You can't graduate that year and pass if you haven't had that test. So while there might be slight nuances of differences in curriculums between the schools, each school's goal is to prepare their students to pass the test. So each curriculum is very, very similar. Now what I think my colleague was trying to explain is once you've graduated from school and you have your license, you can only perform the procedures that you're licensed to by your individual state, whether you know how to do it or not. So for example, a graduate coming out of school would be presented with the option of going to a state that did allow full authority for what they were trained to do, such as Oklahoma, or choose a state like Nebraska where they know they're limited. Even though they're trained, they passed the test, they know in that state they can't do those procedures. Does that clarify your answer a little more?

WALZ: Um-hum. Yes, thank you.

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

AMY DeVRIES: Thank you.

HOWARD: Our next proponent testifier. Good afternoon.

ROBERT VANDERVORT: Good afternoon, Senator Howard and members of the committee. My name is Dr. Robert Vandervort, it's V-a-n-d-e-r-v-o-r-t. I'm an optometrist in practice in Omaha and testifying in support of LB828. To the best of my recollection, I have attended every optometric scope of practice legislative hearing since 1985. Yes, I am a glutton for punishment.

WALZ: That's a lot.

ROBERT VANDERVORT: Each time I carefully listened to the repetitive arguments against our bills made by ophthalmology and organized medicine. Because their arguments today will likely be very similar,

I'd like to address some of them advance-- in advance. When you boil it down, their goal will be to try to scare you or at least make you uneasy about the safety aspects of LB828. You will hear a lot of opinion to try to make that case, but you will not hear any objective data to back it up. They will talk at length about how ophthalmologists first go to medical school, then internship, followed by three years of residency. What they will not tell you is that medical schools and internships teach students next to nothing about the eye. That only occurs during their three years of ophthalmology residency. The main goal of most ophthalmology residents is to learn how to perform advanced ocular surgeries like cataract surgery, which are highly intricate and performed inside the eyeball in a sterile operating room. Ophthalmology residents certainly learn how to treat the eyelid cyst described in our bill, but they are not going through all this training to learn how to drain what amounts to a variation of an eyelid pimple. To assert that you have to become an ophthalmologist to safely perform these straightforward, office setting procedures is without foundation. The object of data from at least ten other states that allows optometrists this scope of practice clearly demonstrates the fallacy of their opinion. You may hear assertions that we are trying to learn to do surgery in a weekend course. That is simply not accurate. As I testified before this committee during our briefing last month, we already perform a host of procedures within our current scope of practice. The procedures described in this bill are an extension of what we already do and several of the procedures we have been performing for years like corneal foreign body removal require more skill and a steadier hand than anything required in this bill. The educational track described in LB828 has been successfully used to provide additional education and training needed for optometrists to be certified to safely perform these procedures in many other states. This process has a proven track record. You may hear testimony that distorts what is allowed in this bill. Nothing in this bill allows an optometrist to remove a benign or cancerous lesion from the eyelid. Diagnosing and referring eyelid cancers are an integral part of optometric education and a frequent topic of our continuing education programs. There is no data or evidence that optometrists misdiagnose eyelid cancers with any greater frequency than ophthalmologists. Ophthalmologists have opposed every single advancement of our profession, not only in Nebraska, but across the country. Today, you may hear them make a patronizing statement such as we have the highest regard for our optometric colleagues, but then immediately followed with their opinion that we are unsafe and the public will be harmed if this bill passes. In reality, what they are saying is that they do not

trust or respect the knowledge, experience, and professional judgment of doctors of optometry. However, as optometry has incrementally enhanced its scope of practice over the last 45 years, history clearly demonstrates that their warnings and predictions have been unfounded and unreliable. Time does not allow me to review all of the predictions they have made that have not come true. But a good example is a recurrent assertion by ophthalmology first heard in the 1970s and repeated in every decade since that if we were allowed to use particular eye drops or a particular oral medication, patients would die. Decades later, there is not one reported incident of a patient dying, not one from an eye drop or oral medication used or prescribed by an optometrist anywhere in the country, and realize that this is after literally hundreds of millions of installations of those medications. And that's a conservative number. The unfounded and reliable predictions and fears of our opponents have never come true and they will not come true if LB828 is enacted. We believe we have earned your trust and we can assure you that we will safely implement this legislation if enacted. We respectfully ask your support of LB828. Thank you for your service to Nebraska. I will be happy to answer any questions, especially as it relates to what you may be hearing from your-- from our opponents on this legislation. And if possible, I'd also like to-- I guess, I've got a little time left. Your question about the numbers, you've been asking how many patients who are affected? One of the greatest frustrations for a patient and for the doctor-- and I get this a lot in my practice, and it's not just these cysts, but this would be a good example. As I say, you need to go-- you need to have this done. You need to have this procedure done. The patient looks me in the eye and says, do you do that? Hoping the answer is, yes. They trust me. I work hard for my patients, every optometrist I know works hard for the patients. And when I say, no, I've got to-- if I-- if we lived in Oklahoma, Arkansas, Iowa, Louisiana, I could do this for you. But we live in Nebraska and we're restricted. And so I got to refer you. So that means they know they have to go to another, another office, fill out more paperwork, sit in the reception area, wait around for a doctor, take time off work. It's a royal pain. Nobody-- we're all busy, nobody wants to have this level of inconvenience. I can safely perform the procedure and my colleagues can safely perform the procedure, get the patient on your way, that's what we're-- that's what this bill is about. It's, it's getting people functional quickly and safely.

HOWARD: Thank you. Are there questions? I, I would ask, has there been any harm to any patient since the 2014 bill has passed?

ROBERT VANDERVORT: No. The-- and again, that was-- in particular, the last expansion or scope of practice was to remove restrictions on some oral medications that are very powerful medications: oral steroids, oral immunosuppressants. And ophthalmology, again, testified heavily that and rheumatologists and everybody came before this committee saying, you know, we're gonna do great harm. No-- there have been no complaints to the State Board. I'm a member of the State Board. I'm not here on behalf of the State Board, but there've been no complaints to the State Board about any inappropriate prescriptions, no malpractice claims, no reported incidents of any problem with the bill that passed in 2014.

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

ROBERT VANDERVORT: Thank you very much.

HOWARD: Our next proponent testifier. Seeing none, is there anyone wishing to testify in opposition? Good afternoon.

MICHELLE WALSH: Good afternoon again, Senator Howard and members of the committee. My name is Dr. Michelle Walsh, M-i-c-h-e-l-l-e, last name is W-a-l-s-h. I am the incoming president for the Nebraska Medical Association. I'm testing on behalf of the Nebraska Medical Association opposition of LB828. Currently, I'm a pediatrician here in Lincoln. I received four years of undergrad-- an undergraduate degree at Southern Methodist University. I received an electrical engineering degree with a specialization in biomedical engineering. After that, I did four years of medical school at the University of Iowa and I did three years of pediatric residency training at Children's Mercy Hospital in Kansas City. And I've been here now for almost 22 years in Lincoln practicing as a pediatrician. The NMA would like to join our colleagues, the ophthalmologists united as an entire house [INAUDIBLE] medicine to oppose this bill. This bill would effectively allow optometrists to become surgeons of the eye area and administer pharmaceutical agents. The training and education requirements in LB828 pale in comparison to the years of experience in training medical doctors possess. This training is vital to understanding the multitude of variations anatomy and tissue response. Learning how to identify, how to treat and, in times, refer appropriately for those decision-making skills necessary to perform surgery on one the most

essential parts of the body, the eye. So as a pediatrician, over the past 22-plus years, I've done numerous circumcisions, spinal taps. I've put stitches in all parts of the body that you don't want to know about. The eyelids are not one. The eyelids are one that to me that is so important, your vision, not just vision, but for a lot of people cosmetic that you want the most trained person, the most experienced person working on that eyelid. Therefore, I refer to an ophthalmologist. And even with some of my special pediatric patients, it will be a pediatric ophthalmologist, not just an ophthalmologist, but one that is specially trained beyond ophthalmology into pediatrics to take care of these patients. The surgery requires just a lot of broad educational foundation that can only be received in medical school, and there is no substitute or even remotely equivalent of all the supervised clinical hours and trained, med trained surgical credentialing of the medical school and the residency programs. The procedures identified in LB828 are elective and they're not emergent. These allow adequate time then to find an ophthalmologist as nothing that they have to have an emergency, they have to be seen that day or anything like that, these are elective if it can be scheduled. If you look at Nebraska, 99 percent of Nebraskans are living within 30 miles of a primary satellite ophthalmology clinic. Therefore, access to the specialized care is not an issue, not an issue at all. The NMA appreciates and recognizes that this is a vital role that optometrists play. I think it's also very important to know that over the years, anyone who has done surgery, they're gonna realize that and not even one's anatomy is the same. So out of all the procedures I've done over and over again, the tissue can be different. When you get into that tissue, you can find things that are not what you thought you would find there. Every person's different. And even though you've maybe done maybe a couple of these, it's-- you might find another patient that has a different anatomy and then you go in to do an incision or something like that, it may not be what you want to find. But those people that are specialized have had hours and hours of training, all the specialized training, those are the ones that are more likely to recognize that there's an issue, a change in the anatomy or anything like that. So this bill would pose a significant risk to patient safety. The NMA respectfully will ask you to not advance the bill through committee. I appreciate your time and I would be happy to answer any questions that you might have.

HOWARD: Thank you. Are there questions? Just for the record, are these conditions painful?

MICHELLE WALSH: Yes, I mean, it's like anything else, so if you think like you have a pimple or like an abscess on any other part of the body and then you have to remove that, that would be painful. Now you have it on an eyelid, which is a very sensitive area, and then that would be painful, too. And that's why they would often do injections to numb up that area so you want to make sure that you're numbing up the correct area, making sure that the anatomy is there and that you're not getting anywhere where it should not be, because this is your eye, this is your vision. This is to me is so important. I have patients that have lost sight in an eye. And it's, it's life changing not just for them, but for their families, for the ability for them to do their regular activities. As they grow, especially for kids, they can't play certain sports. Now they're driving, it inhibits that. There's just a lot of things, it's life changing to have anything go wrong in that area.

HOWARD: Thank you. Senator Walz.

WALZ: Thank you, Chairwoman Howard. That is a really good point. So they're-- they are, painful?

MICHELLE WALSH: Yes.

WALZ: Does it-- would you think that that would prevent somebody from being able to do their job or--

MICHELLE WALSH: It depends on the circumstances. So my population is pediatrics, they're not gonna sit still for this. So we actually do sedation for that. They usually go to the operating room for that. Another reason why to go to a pediatric ophthalmologist if they need surgery on the eyelid or if they need surgery on the eye. Adults, yes, they might be able to tolerate an injection there, the numbing medicine and the removal there, but also depends on the person because some people, they, they get very nervous. No different than going to the dentist. It doesn't matter if everything is going well, they don't like needles. They don't like blood. They don't like an office. And for some people, they may not tolerate that very well.

WALZ: Yeah, I meant prior to the procedures.

MICHELLE WALSH: Oh, sorry. Yes, yes, so styes, styes are painful.

WALZ: It could prevent somebody from being able to do their-- perform their job and drive and things like that.

MICHELLE WALSH: If the stye's bad enough, yes.

WALZ: OK. Thank you.

MICHELLE WALSH: Um-hum. Yes.

HOWARD: Are there any other-- oh, Senator Hansen.

B. HANSEN: Just a quick question. Are you OK with optometrists-- say somebody comes into their office with a stye [INAUDIBLE]-- are, are you OK with optometrists providing oral medications like a steroid to help with-- you know, the inflammatory process of that and provide compress?

MICHELLE WALSH: I'm OK with them providing the compresses and external treatment of that in the sense that stuff that the patients would do at home. They could put hot packs on it, that type of thing. Sometimes they have some antibiotic ointments they can do. Steroids in the eye with children have to be careful of, just the side effects of steroids in children.

B. HANSEN: OK.

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

MICHELLE WALSH: Thank you.

HOWARD: Good afternoon.

DALLIN ANDERSEN: Hi. Thank you, Chairwoman Howard and HHS Committee for allowing me this opportunity to express my opposition to LB828. My name is Dallin Andersen, D-a-l-l-i-n A-n-d-e-r-s-e-n. I am a chief ophthalmology resident in my final year of training at the University of Nebraska Medical Center. I also testified in opposition to LB528 last year with concern for the safety of Nebraskans. So I'd like to use this time to explain the intensity of my training and the reasons for 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 at UNMC there are only two ophthalmology residents selected per year out of hundreds of applicants. However, being accepted into the training program is only the beginning. Second, it's critical to this discussion to know that what follows is a grueling process of gaining the 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 clinical encounters, surgical cases, and spending hundreds of hours in didactic lectures and personal study. So I see approximately 150 patients per week, each directly supervised by a staff ophthalmologist. Our first two years of training are mostly at the University of Nebraska Medical Center, and then our third year is mostly spent at the VA Medical Center in Omaha treating the veterans. Also deeply integral to my residency training, of course, is the development of surgical skills. I first had to prove my abilities on simulators, cadavers, and animal tissue. And then slowly advancing to perform parts of and eventually complete surgeries start to finish on real patients. These are all strictly supervised by a senior ophthalmologist. In every step of surgery, my staff supervisor sits directly next to me and ensures that I perform at the highest level for each patient. Thus far in my training, I have completed over 300 cataract surgeries, over 200 laser surgeries and hundreds of other ocular and facial surgeries including injections, totaling a little over a 1,000 procedures both in elective and emergency scenarios. This excludes the thousands of other surgeries I've partially performed or simply observed. This level of training is the standard at the residency program in Nebraska and across the nation, set by the American College of Graduate Medical Education and the American Board of Ophthalmology. The reason for me to perform a high level of clinic visits, participation in didactic education, and supervised procedures on real patients is simple, the stakes are high for me and for every Nebraskan that will depend on me upon completion of my residency. When complete, I will be eligible to prove my abilities through, through the American Board of Ophthalmology Certification process. This is a unified, central authority that has the responsibility to ensure that newly-minted 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 written and oral examinations, which notably only about 70 percent of eligible applicants pass on their first attempt. Therefore, it's obvious that ophthalmic residency training is a deliberate, rigorous, and justified. This high standard has been the accepted norm for many decades in the United States as the best way to ultimately protect the eyesight of its citizens and limit complications. We can rest assured that upon completing this 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 face and eye. The path that, you know, I have chosen to

take is open to anyone, but there are no shortcuts. I encourage this committee to maintain the standards of education and training at the level that the citizens of Nebraska expect and deserve. And this requires your, your opposition to LB828.

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

B. HANSEN: Thank you for coming and testifying and sharing your impressive resume on your sheet here. So just curious about, I-- one thing I talk about is you talk about your whole scope of education, which obviously makes sense when it comes to more surgical procedure to the eye compared to optometrists, but one thing I'm kind of curious about is what does your education compare to like, say, injecting pharmaceutical agents into the eye versus an optometrist? Are they comparable? Do you get much more--

DALLIN ANDERSEN: So--

B. HANSEN: --just that procedure--

DALLIN ANDERSEN: Yeah.

B. HANSEN: --right there, for instance?

DALLIN ANDERSEN: So first of all, the major difference-- and it's actually been stated a couple times incorrectly that optometry training performance procedures on real patients, which is incorrect. So in optometry school-- so the University of-- Indiana University Optometry School, we have two students at the University of Nebraska that rotate with us from Indiana. It's very commonplace for optometrists in, in school to rotate in other states. So here in Nebraska, we have an affiliation with the Indiana University School of Optometry and they perform it-- they have a two-credit hour class. So out of about 150 credits for their entire training, they have two credit hours, which is called ocular disease, lasers, injections, and minor surgical procedures. So during this, they learn-- you know, aseptic techniques and performing procedures. But in discussion with the students, they don't perform any of these procedures on real people. So this is in a wet lab. And it's been noted already by Dr. Bateman that, you know, wet-- these are performed in a wet lab. A wet lab is a simulation environment. You have model eyes. You, you practice on a model eye. You'll shoot a laser into a model eye. It's not a real person. You might do an injection into a plastic arm or a, you know, artificial tissue or maybe an animal. And that is the--

first of all, that's the major difference. And so it's in my opinion that to allow a provider to then to, to attempt to perform a surgery on a patient without ever having been supervised performing said procedure on a real person is frankly reckless, in my opinion. It's not the same to perform a procedure on a model or tissue and then go to a person who is moving around, bleeds, you get into a bleeding situation where you have to cauterize these. And so we do lots of chalazion incisions. These aren't simple pimples that you push and pop. I mean, these-- the definitive treatment for this, if it's not going away with conservative therapy, is, is, is an incision. You use a 11 blade-- I mean, that's the definitive, definitive treatment. You use an 11 blade, you curette it out, you remove the capsule, and so it doesn't come back. If you try to just pop it, it will come back. And so you get into a situation, I've been in a situation where there's bleeding that won't stop and you have to cauterize it. And I mean, it's, it's complicated. It's not, it's not something that's-- you know, I don't like the attitude of going about this in a cavalier way. Like it's taken very seriously. And, and there's nothing more terrifying than being, you know, in the OR and having, you know, uncontrollable bleeding. And so, so we do, we do hundreds of these procedures, injections in and around the eyelids. We treat [INAUDIBLE] spasm and hemifacial spasm with Botox around the eyes, which in and of itself can, can be complex. And then, you know, incisions and removal of, of, of tumors, of suspicious lesions, and drainage of chalazions.

B. HANSEN: So you're saying somewhere around two hours is what you think they [INAUDIBLE]?

DALLIN ANDERSEN: Well, according to their website, it's a two-credit hour class.

B. HANSEN: OK.

DALLIN ANDERSEN: So out of their entire curriculum, they take one class and, and it's two credit hours out of approximately 150, 200 hour-- credit hours.

B. HANSEN: I was trying to compare that to like when I'm reading the bill, they're required to take a, like I think, an eight-hour, accredited class or at least have accredited hours like [INAUDIBLE].

DALLIN ANDERSEN: Correct. Right. Now I will defer most of this discussion to my colleague, Rao Chundury, who's done extensive research and has actually researched every single optometry school in

the country to see what the curriculum-- and has read a lot about these eight-hour classes. And so-- and it's similar in the eight-hour classes, it's a simulation environment. So there's not real people that go to these, you know, weekend courses and volunteer to have, you know, procedures done on them. And so, so it's all in a simulated environment. And it is-- frankly, you know, it just, it just feels, you know, dangerous to allow someone to then perform a procedure on a person. So these students graduating from, from Indiana, could then go to Oklahoma and perform this procedure on a real person having never actually done it on a person before and in a, in a supervised manner. And you know, an analogy, it would be, you know, would you allow someone to fly your plane only having practice on simulators? You know, it's, it's-- I think it's in our best interests for Nebraskans of the state to, to protect them and keep that standard where it's at currently.

B. HANSEN: Thank you.

HOWARD: Other questions? Senator Walz.

WALZ: Thanks for coming today.

DALLIN ANDERSEN: Yeah.

WALZ: This piece of legislation requires additional education and clinical training pertaining to this new authority. Do you know, does this additional education require students to perform procedures on real people?

DALLIN ANDERSEN: So I'm, I'm gonna defer to Dr. Chundury.

WALZ: OK. All right.

DALLIN ANDERSEN: But the curriculum of all 23 accredited optometry schools that provide this curriculum and these eight-hour courses that we are discussing in the bill are not performed on people. These are simulations. These are are model eyes. They're wet labs.

WALZ: OK. Thank you.

DALLIN ANDERSEN: Yeah, they're not actual people. Yeah.

WALZ: OK.

HOWARD: Other questions? Do doctors learn anything by simulation?

DALLIN ANDERSEN: Yeah, so I mentioned in my testimony that I started-- before I was allowed to perform surgery on real people, I had to first prove my abilities on simulators and cadavers and animal tissue. So that's a natural process in training before you're allowed to be supervised. So you go from-- so for example, cataract surgery, we have a machine called an Eyesi, it's a simulator and we will perform, you know, cataract surgery, start to finish. You practice, you know, first, you know, moving a ball around in the eye and, and then you perform more and more of like parts of cataract surgery. And then you perform the entire cataract surgery on a simulator. And, and at University of Nebraska Medical Center you are not allowed in the eye at all until you have passed these, these tests on the simulator where you've performed a complete cataract surgery in 15 minutes without complications. So--

HOWARD: Actually, I think that answers my question.

DALLIN ANDERSEN: Yeah, but then,--

HOWARD: Thank you.

DALLIN ANDERSEN: --but then, like, of course, we have to be supervised by someone that knows how to do it. So then the rest of my training in the next few years is, you know, thousands of procedures then supervised by someone that's done it on real people, and that's the major difference. Yeah.

HOWARD: All right. Thank you for your testimony today.

DALLIN ANDERSEN: You bet.

HOWARD: Our next opponent testifier.

PATTY TERP: Well, hello, my name is-- Madam Chair and committee, thank you for allowing me to come speak today. My name is Patty Terp, P-a-t-t-y T-e-r-p. I am a board certified eye surgeon ophthalmologist in Fremont with the Fremont Eye Associates and I'm the current president of the Nebraska Academy of Eye Physicians and Surgeons. Just to point out the three things being passed out. First, we have a letter of a colleague from Iowa who, unfortunately, with the short notice, was not able to come. But he did his optometry training, graduated in 2009, and then went on to medical school and ophthalmology residency. And so he wrote a great letter about the

difference between the two in particular for these procedures. And then I'll reference this Vermont study that's being handed out bullet points. I'll be referencing that momentarily. Just to discuss-- again, a colleague of mine will discuss a lot more about that there is really no such thing as a minor eyelid procedure just because it can be performed in the office setting. There is a significant degree of training, experience, and skill required not only to properly diagnose an eyelid lesion, but really to also determine a treatment plan which is many, many times observation, medical management that does not require any surgical management. The eyelid procedures requested here in LB828 are all elective, nonemergent surgeries that can be scheduled with the appropriately trained ophthalmologist, even if it's a Nebraskan that has to visit their ophthalmologist at a satellite clinic that's only being staffed once or twice a month, none of these cannot wait two weeks. There is no emergency for this. And in regards to Senator Walz's question about pain, in the meantime, even if it is the rare chalazion or inflamed gland that does need to be cut into, the significant majority of these between when they're initially happening and if we were to lance into them, were being treated medically with warm compresses and with ointments that significantly lessen the swelling and pain. So the rare, and it's way fewer than 5 percent of these that even need any cutting into them, it's those that are more just the chronic kind of hard stuff that's not coming out after the acute inflammation and in pain. And I will say for those that do need to be cut into, you know, that's not an unpainful process either so most people afterwards look kind of bruised and, and don't necessarily want to go to work right after that either. But we can handle their pain and discomfort in the meantime to really get them, you know, back on their feet. In terms of the study that's handed out, last year, Vermont optometrists proposed a bill to their state legislature to allow them to perform, quote unquote, advanced procedures, including all those requested here in LB828. By request of Vermont legislators, The Vermont Secretary of State Office of Professional Regulation performed an exceedingly thorough study to evaluate the safety and public health needs of enlarging the scope of practice of optometrists to include so-called advanced procedures. This study was actually published and just released just this last week. We have provided a copy and we will be providing the full 40-page copy, but mostly right for today just gave bullet points. Overall, their final assessment was that they, in quotes, cannot conclude that optometrists are properly trained in and can safely perform the proposed advanced procedures. Furthermore, they found that there is little need for and minimal or no cost savings associated

with expanding the optometric scope of practice to include advanced procedures. And in terms of some of the questions answered before, they explicitly looked at states where these procedures are performed, the significant majority of them were performed in urban areas. So they actually noted that in these states there was not any improved access in rural areas because most of the optometrists doing these were in urban areas that had ophthalmologists in the same town. Furthermore, they looked at in terms of in maintaining competency-- so to answer Senator Williams' question, their assessment looking at numbers was that there were so few of these that it was-- that they could not conclude that there was enough to maintain competence in states where optometrists are able to do them given the significantly low volume. And they even in some areas estimated that there might be improved-- or increased costs because of the increased utilization of the number of people that may be able to do these procedures. In reference to the Nebraska 407 process that happened in 2013, I'd like to quote a little bit from some of the conclusions. This bill is almost identical to what was rejected by the 407 committee. The committee discussion revealed that there was agreement among the majority that the utilization of minor surgical procedures are not adequately supported by optometric education and training and should not be approved. I'd like to quote more from the chief medical officer. He additionally recommended against approval, saying that there was compelling evidence indicating-- or that there was not compelling evidence indicating the existence of an accreditation standard for the proposed changes to the scope of practice. And he really could not find any evidence that they were adequately trained and educated to uniform standards to the proposed surgical procedures. And I'd like to point out that what that determination was in 2013 is the exact same as the determination earlier this year in Vermont that is analogous to what's being proposed today. So I'd like to thank you for your time. And then can I answer one more question from Senator Hansen? We actually never prescribe oral steroids for a chalazion. We manage them with topical steroids. So that's usually an ointment that can go inside of the eye. So it's heat and topical steroids, never oral prednisone, so that wouldn't be into play to answer your question.

B. HANSEN: Makes sense. Thanks.

PATTY TERP: Any other questions?

HOWARD: Any other questions? Senator Walz.

WALZ: I have a question. I-- whoa, whoa. Sorry.

_____: Good catch.

WALZ: Thank you. So you said that these procedures are pretty rare, 5 percent.

PATTY TERP: I would say of chalazion, 5 percent at the most actually need to be. And that would be like the inflamed oil gland in the eyelid so basically like a stye--

WALZ: So you have to--

PATTY TERP: --where we would have to lance it. The rest or managed medically--

WALZ: OK.

PATTY TERP: --with heat and ointments.

WALZ: So you're not having to do this consistently which--

PATTY TERP: No, I, I honestly, I would say almost daily I see a chalazion in my practice. I would-- I mean, it's-- I would say at best once every month or two that I'm having to cut into one at best, whether that's kids or adults.

WALZ: OK.

PATTY TERP: Most of them respond medically and, and don't need--

WALZ: And I would suppose that in a rural area it would be a lot less.

PATTY TERP: Yes.

WALZ: Right. So do you in your education or furthering education, what's it called, recertified? Do you have to be recertified or have additional education? What that's called?

PATTY TERP: Continuing education.

WALZ: Called continuing education on this procedure since you don't have to perform it very often? I'm just curious.

PATTY TERP: This, this specific procedure, no. That's not how our-- we do have 25 continuing education hours. We do maintenance of

certification. So plenty of other like tests and things, but not necessarily on this procedure as we as referral doctors and doing so many other eyelid surgeries, aside from just lancing these cysts, we're able to-- I mean, I'm doing eyelid surgeries often. So even though this might be rare, we're able to maintain competence within our practice. And honestly, for ophthalmologists that do go through residency and then specialize in other things where they feel like they haven't maintained their competence, they're referring these to either comprehensive ophthalmologists or eyelid plastic surgeons to do these because they know that they've not maintained competence. And similarly for me, certain procedures that, not this, but other, you know, glaucoma and retinal surgeries that I did, dozens of in residency and after residency was well-prepared that I really haven't done, I refer those as well, because you really don't know what you don't know until you realize that you don't know it. And so it's,--

WALZ: Right.

PATTY TERP: --you know, we, we don't have to prove competency but are able to maintain it just in, in clinical practice.

WALZ: Yeah, that was-- it was just a good point that you brought up. I mean, if somebody in a rural community is not performing that procedure very often, is it something that they should have, continuing education.

PATTY TERP: And it was nice that that study looked at that and they actually looked at specific numbers and they said, all right, we'll say for Oklahoma-- I don't-- off the top of my head, I can't remember the exact numbers, but they said, well, if you divide the number that optometry performed among all of the optometrists, it was like one a year or something exceedingly low. So you know, that's why they could make that assessment that there wasn't adequate enough volume.

WALZ: OK. Thank you.

HOWARD: Other questions? Senator Williams.

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

PATTY TERP: Yeah.

WILLIAMS: I guess, Fremont is as rural as it's gonna get. Is that right?

PATTY TERP: Well, I will say, my partner that's not here he does do satellite clinics in Blair and West Point and Wayne and he does do these there.

WILLIAMS: My question's really simple, when, when in, in your practice, when when a patient is referred to you from an optometrist,--

PATTY TERP: Yes.

WILLIAMS: --how long does it take them to get in?

PATTY TERP: It, it-- depending on the complexity, if-- so Dr. DeVries and I practice if if she or her clinic calls me, if it's something that needs urgency, we will see them immediately, they'll come right over. In terms of something like this, they can get in my clinic within a week.

WILLIAMS: Thank you.

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

PATTY TERP: Thank you.

HOWARD: Our next opponent testifier. Just by show of hands, how many more are wishing to speak? Is anyone else wishing to speak by show of hands?

_____: Two more.

HOWARD: Just two more?

_____: Two more.

HOWARD: OK, perfect. Good afternoon.

DAVID WATTS: Good afternoon, Madam Chairwoman, distinguished committee members. I'm Dr. David Watts, D-a-v-i-d W-a-t-t-s. Thank you all for your work to keep public safety-- public healthy and safe. I'm a skin cancer surgeon, not an eye doctor. I'm opposing LB828 on behalf of the Metro Omaha Medical Society and the Nebraska Dermatology Society. After my medical school and training years, I've spent 20-plus years in practice learning about and treating malignant growths on the skin. It's what I do. I'm a mole surgeon. That includes malignant growths on

the skin of the eyelids. So here's a question, how do you know if a growth on an eyelid is a cyst or an inflamed or infected gland or something more serious? A nuisance or a potential threat to eyesight or to life? The answer is it's a judgment call and there is no shortcut to developing sound judgment, whether it's in doing adjustments on a neck, foot surgery, an ailing cow, or evaluating or treating growths on an eyelid. Take a sebaceous carcinoma, for example, it's a cancer of oil glands most commonly found on the eyelid. You've heard of chalazia, that-- that's plugged oil glands. A sebaceous carcinoma can grow fast, can spread through the body, and it kills people. It can look identical to a cyst or an infected or inflamed gland. If you just injected and treat the inflammation, you can mask the symptoms and delay the diagnosis. If you biopsied it in the wrong place and don't know when not to trust a negative biopsy, you can miss a cancer that might have been curable with a timely diagnosis. Those are matters of judgment and that comes with experience. Melanoma on the eyelid can be the same thing. Or take basal cell carcinoma, the most common cancer in human beings. They usually don't kill people, but they can be invasive and they can be very sneaky on the eyelid. Show up just like a cyst. In fact, there's even a type called cystic basal cell carcinoma that has fluid in it and lance it and get the fluid out. I treated a lady from out by Kearney who had a neglected basal cell carcinoma, sneaky one that got into the tissue around the eyeball over the rim of the bone. She wound up losing a perfectly good eyeball in order to get all the cancer out. That's the, that's the sequela of a missed diagnosis. After over 30 years of training and experience, I still bring every bit of my experience to every person and to every growth in front of me. Not everything that looks like a cyst or an infected or inflamed gland is one. I can't imagine making that judgment call with only 16 hours of class in a clinical workshop. A professor once told me the eye can't see what the mind does not know. And it's what you don't know, what you don't know you don't know that can hurt someone. How about judgement in managing postoperative complications? I treated a cardiac surgeon once and I made a self-deprecating remark about minor surgical procedures in comparing my work to his. He said there's no such thing as a minor surgical procedure, only a minor surgeon. I was a little taken back, but what I think he meant is that anytime you enter the body, whether it's with a needle or a scalpel, you must be as prepared as possible for what you're doing and what might go wrong. And this goes double for the eyes. One of the most delicate and intricate organs of the body. To be fair, the 16-hour class in workshop does introduce the topic operative and postoperative complications, but

it's only an introduction. Do they provide the judgment necessary to keep patients safe from, say, a rapidly advancing staff or strep infection in the so-called facial triangle of death, cavernous thrombosis behind there. Surgical complications don't happen often, but neither does a bird strike or engine trouble on a jet airplane right after takeoff. But I would much rather have Captain Sullenberger at the control with thousands of hours of experience than a pilot with a 16-hour introductory class and workshop. I must respectfully disagree with the distinguished cosponsors of this bill that it will result in safer or better care in either urban or rural communities in our state. In our opinion, this national initiative to expand scope of practice with training that is just OK doesn't serve the patients whom all of us want to be safe and well cared for. Does it open the door to better access or does it open the lid to Pandora's box? Thank you for your attention. Are there any questions?

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

RAO CHUNDURY: Just wait for them to pass it out to you guys. Good afternoon, Madam Chair and distinguished members of this committee. My name is Rao Chundury, R-a-o C-h-u-n-d-u-r-y, and I wish to express my personal views regarding LB828. I'm an assistant professor and practicing ophthalmic plastic and reconstructive surgeon. I completed medical school, followed by a surgical ophthalmology residency and an additional two-year fellowship in just eyelid surgery. I'm also boarded by the American Society of Ophthalmic Plastic and Reconstructive Surgery. Senators, I operate within data, facts, and evidence. I run clinical trials, which I've brought to the state, and I've authored numerous publications, book chapters, and presentations. More importantly, and specific to LB828 is that I've been involved in the development of both clinical and surgical eyelid curriculum at a local and national level. And I've trained dozens of medical students, ENT residents, plastic surgery residents, dermatology residents, international faculty, and ophthalmology residents. Therefore, I hope my perspective can add to your understanding of this bill. So let's start with the data. The Association of Schools and Colleges of Optometry, or ASCO, accredits numerous optometric schools in this country. Surgical curriculum is not required to be ASCO accredited. So I independently reviewed the curriculum of all 23 ASCO accredited schools, including Northeastern State University, and I was unable to find explicit documentation of a single school which had surgical curriculum in which clinical supervision of actual patients was

performed. In contrast, ophthalmology residents received three and a half years of surgical ophthalmology training, and they'll spend no less than six months of direct preceptorship, not mentorship, proctorship, or observership in my 100 percent eyelid disease clinic. Residents need this time because cancers, genetic syndromes in kids, side effects of medications can masquerade as cysts, lesions, and inflamed glands. There is no replacement for the direct individual training needed to master every step of the in-office eyelid evaluation and surgery. And when there is a mistake, when Dr. Andersen makes a mistake, and there will be a mistake, I'm there to immediately correct, educate to prevent serious complications. I've personally taken care of patients needing blood transfusions, emergency surgeries, and serious eyelid infections after, quote, minor eyelid procedures. Next are the facts. There are two components to this bill, injections and surgery. This bill would allow numerous pathways to achieve Nebraska approval and both components. One method is if you complete a certification in another state. In those states in which surgery is certified, I found there to be significant variability in the requirements, with many not having any. An elective National Board of Examiners of Optometry, or NBEO, skills test is a second possible way for Nebraska certification, which Dr. Ternus had mentioned. The skills tests are offered to any optometrists regardless of their training. Senators, on the first page that I provided for you, I would like to direct your attention to the, to the skills exam for this year. This is page 6. And as you can see, the injection certification is not performed on an eyelid, but in fact, a rubber artificial arm. I don't think you need to be a medical professional to recognize that there is no equivalency in injecting an eyelid where you're just millimeters away from the eye to that of injecting into an artificial arm. Finally, the third pathway is through a lecture course and that's the second flyer I've given you, similar to the 2019 American Optometric Association's official COPE approved course on advanced surgical procedures. After this one-day course, participants will receive a certification in, quote, surgical procedures for the optometric physician. No surgeries are performed. Finally, evidence. In my exhaustive analysis, I was unable to find a standard of care or application of evidence-based didactics anywhere. And it is very clear that within the varied pathways of LB828, individuals would be able to perform surgical procedures without ever having done them on actual patients. To better demonstrate the dangers of mismanagement, I'd like to end my testimony with two patients from my clinic who I have seen in the past three months, Patient Smith and Patient Jones, they've been de-identified. Patient Smith was told for years that the spot on

his cheek was age related. It was not age related, but in fact a large pre-melanoma which required disfiguring removal of all of his cheek, lower eyelid, tear duct system and a four- hour, reconstructive surgery because of this delayed diagnosis. Patient Jones came to our clinic with a two-year history of inflamed eyelid glands. Our first year resident acutely recognized it as cancer, but unfortunately she lost 95 percent of her lower eyelid. Senators, these are not cases from an esoteric journal or another state, these patients are Nebraskans. This is not about optometry versus ophthalmology, optometrists are my respected colleagues whom I work with on a daily basis. But as I evaluate the data, facts, and evidence, I think back to patients like Mr. Smith and Mrs. Jones. Because I fear if this bill passes, that my clinic will be busier, it may be busier at the expense of the health and safety of your own constituents. Thank you.

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

RAO CHUNDURY: Thank you.

HOWARD: Our next opponent testifier. Seeing none, is there anyone wishing to testify in a neutral capacity? Seeing none, while Senator Hilkemann is coming up, I'm gonna read the letters into the record because I'm remembering that today. All right, proponent letters are: Laura Ebke, from the Platte Institute. Opponent letters are: Sheila Wissel, from General Surgery Associates; Dr. Jenna Derr, from Nebraska Academy of Eye Physicians and Surgeons; Dr. Kyle Myers, the Nebraska Academy of Eye Physicians and Surgeons; Dr. Aleh Bobr, Nebraska Academy of Eye Physicians and Surgeons;. Dr. Supriya Bhatia, self; Dr. Merlin Wehling, self; Dr. Daniel Gih, Nebraska Regional Council of the American Academy of Child and Adolescent Psychiatry; Dr. Cynthia Paul, Nebraska Psychiatric Society; Dr. Mark Lucarelli and Dr. Stuart Seiff, American Society of Ophthalmic Plastic and Reconstructive Surgery, Inc.; Dr. James Madara, American Medical Association; Dr. Steven Williams, Dr. Josue Gutierrez, and Dr. Brett Wergin, Nebraska Academy of Family Physicians; Dr. Anthony Akainda, self; Dr.-- Emily Besser, American Society for Dermatologic Surgery Association; Dr. Cindy Ellis, Nebraska Chapter of the American Academy of Pediatrics; Dr. Steve Gogela, Neurological and Spinal Surgery; Russell Hopp, Nebraska Osteopathic Medical Association; Dr. Steven Martin, Nebraska Chapter of the American College of Cardiology; Dr. Corey Auch, Oral Surgery Associates, Dr. Chad Ott, Nebraska Society of Anesthesiologists, Dr. Marcus Snow, Nebraska Rheumatology Society; Dr. Nicholas Bruggeman,

Nebraska Orthopedic Society; Dr. Tricia Hultgren, Nebraska Dermatology Society, Inc.; and in neutral letter from Darrell Klein, from the Department of Health and Human Services. Thank you. Senator Hilkemann.

HILKEMANN: OK, Senator Howard. Well, let me close with this, just gonna share some personal observations. As one who, prior to serving here in the Legislature, spent almost 40 years practicing podiatry as a limited, licensed practitioner. And when I came to this state, we were very, very limited in what we could do. In fact, I almost did not come to Nebraska because at the time that I was done with my training, we had about the most antiquated laws in the state in the country. I could have gone to Iowa or Kansas or any-- and, and had a broader scope, but I was a Nebraskan and I came back. I know what it's like to try to recruit someone to come back to the state to practice with you. And you say, well, but you can't do this and you can't do this even though you've been trained in your residency or in your school to do this. In Nebraska, you can't do that. So you're practicing with your arms behind your back. And you have-- we-- I cannot-- I know of three Nebraskans, two who graduated from the University of Nebraska, I tried to get back here and ended up going into podiatry and did not come back to the state of Nebraska because of the limitations that we had placed upon their scope of practice. And these are very, these are very competent people. And I wish we could have gotten them back. One of the things that-- so I-- it just does a lot to your psyche as well and people are-- need to be-- with the limitations that you know that you can do, but yet we have a barrier because of our practice laws. One of the things that's been pointed out and boy I am big on public safety. We need-- our jobs as senators is to protect the public. I have yet to meet a doctor who went into the medical profession with the intent to hurt people. The integrity of a doctor is that they're here to help to serve, not to hurt people. Believe me, we are not gonna have doctors of optometry who do not feel comfortable or trained in these procedures that are going to be doing it without proper training or supervision that they've had that training. Because part of this whole thing, and I'm just gonna get down and dirty, the real scope of practice protector is a thing called medical malpractice. And if you're not trained and you do not have the supervision and you are not able to do it, believe me, you're gonna get-- malpractice is gonna come to come back and haunt you. I can assure you that the Optometry Board is gonna make certain that people who are doing this are going to be capable of doing these type procedures because nobody wants to have around their neck that they have a lot of malpractice cases because of this. And so we have to trust our Optometry Board is gonna

be working within to self-policing this. It took about 20 years for Nebraska to get its practice law for Nebraska for podiatry to be equal with what other states were doing. I can tell you what has happened in my profession since we got our law equal to what our training was, we have communities where we could never get a podiatrist now have three podiatrists. When I came to the state, there were 36 podiatrists. And now we're getting close to 100 podiatrists across the state. We have the best and brightest. I am, I am so impressed with the people who are coming to this state to practice because they don't have this barrier that you can't do the things you were trained to do. And we have to trust the training process. Just as many optometrists today are employed by ophthalmology practice, the same thing is happening with podiatrists. Those who at one time were here opposing this are having podiatrists in their offices and are practicing together. So I'm gonna ask you to advance this bill. It will increase access to care, particularly in rural Nebraska. It's good for economic development because we are going to be bringing-- we're, we're removing a barrier for people who want to come and practice in the state, the practice of optometry. And we're also going to be bringing the best trained optometrists to this state because they can do the full scope of what they've been trained to do, and it removes that barrier. And I have to end up this, we need to pass it this year. What other time would we ever have an opportunity to practice an optometry bill in 2020?

HOWARD: Been saving that for a while.

HILKEMANN: It there's any other questions, I'll try to answer them for you.

HOWARD: Thank you, Senator Hilkemann. Senator Walz.

WALZ: I have a quick question. Thank you, Senator Hilkemann. One of the things that you said was that we have to trust the training process. And I know that you don't have a-- you may not have a whole lot of information on the additional education requirements, so it-- in sometime in the future, the near future, is there a possibility that we could get more information regarding the additional education that won't be required prior to allowing this procedure?

HILKEMANN: I think there are probably four optometrists that'll take care of that for you for-- soon, yes. We will give that information to you.

HOWARD: OK. Any other questions? Seeing none, thank you, Senator Hilkemann.

HILKEMANN: Thank you, Senator Howard.

HOWARD: This will close the hearing for LB828 and conclude our hearings for the day. Thank you.