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 Walz.

WALZ: Hi, I'm Lynn Walz and I represent District 15, which is all of Dodge County.

ARCH: My name's John Arch. I represent District 14, which is Papillion La Vista in Sarpy.

WILLIAMS: Matt Williams from Gothenburg, Legislative District 36: 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 Kaitlin 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 on the agenda outside the room. On each of the tables near the doors to the hearing room, you will find green testifier sheets. If you are planning to testify today, please fill one out and hand it to Sherry when you come up to testify. This will help us keep an accurate record of the hearing. If you are not testifying at the microphone, but want to go on record as having a position on a bill today-- being heard today, there are white sign-in sheets at each entrance where you may leave your name and other pertinent information. Also, I would note if you are not testifying, but have written testimony to submit, the Legislature's policy is that all letters for the record must be received by the committee by 5:00 p.m., the day prior to the hearing. Any handouts submitted by testifiers will also be included as part of the record, as exhibits. We would ask, if you do have any handouts, that you please bring ten copies and give them to the page. We do use a light system in this committee. Each testifier will have five minutes to testify. When you begin, the light will be green. When the light turns yellow, that means you have

one minute left. And when the light turns red, it's time to end your testimony, and we'll ask you to wrap up your final thoughts. I'm going to be a little bit stricter about the red light today because it looks like we've got a lot of testifiers. When you come up to testify, please begin by stating your name clearly into the microphone, and then please spell both your first and last name. The hearing on each bill will begin with the introducer's opening statement. After the opening statement we'll hear from supporters of the bill, then from those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given an opportunity to make closing statements, if they wish to do so. We do have a very strict no-prop policy in this committee. And with that we'll begin today's hearing with LB834, Senator Arch's bill to change provisions of the Engineers and Architects Regulation Act. Welcome, Senator Arch.

ARCH: Good afternoon, Senator Howard--

HOWARD: Good afternoon.

ARCH: --and members of the Health and Human Services Committee. For the record, my name is John Arch, J-o-h-n A-r-c-h, and I represent the 14th Legislative District in Sarpy County. I'm here today to introduce LB834, which would make changes to the Nebraska Engineers and Architects Regulation Act. The legislation was brought to me by the Board of Engineers and Architects, and I think it is important to read to you the board's mission. The mission reads, in part: overseeing the laws and rules which govern the practice of engineering and architecture in the state in order to safeguard life, health, property and promote the public welfare. The board has put much work and consideration into LB834, takes very seriously its mission to oversee the laws and rules governing the practice of these professions to promote the public welfare. It's the board's intention to present the best legislation for engineers and architects in the state. The changes proposed in LB834 are designed to reduce barriers to licensure for architects and professional engineers, to encourage recent architectural and engineering graduates to stay and work in Nebraska, and to attract and encourage these same highly skilled professionals to have the ability to become licensed in Nebraska. The board is confident these changes will maintain the standards needed for practice of these important professions, while also making it easier to attract new design professionals, already licensed in other states, to have the ability to work in Nebraska. Many of the remaining changes are technical, editorial in nature, but they serve to make the act

more cohesive and much clearer. I'm not going to go into further detail, as the testimony following me is much more versed in these professions and will be able to explain the benefits of the proposed changes in more detail. And I'd be open to any questions if you have some.

HOWARD: Do you want to address the fiscal note?

ARCH: The fiscal note that is attached actually shows a net-- expenditures in the, in, in this first year of $1,600 and $2,500 in revenue, expenditures $1,600 and $8,100 in the out years. And so you can see that it's not going to cost the state to make these changes, and, and there will be revenue attached.

HOWARD: Other questions? Seeing none, will you be staying to close?

ARCH: I will be staying to close.

HOWARD: Thank you. Our first proponent testifier for the LB834?

JON WILBECK: Good afternoon.

HOWARD: Good afternoon,

JON WILBECK: Senator Howard and members of the committee, my name is Jon Wilbeck. It's spelled J-o-n W-i-l-b-e-c-k. I'm the executive director of the Nebraska Board of Engineers and Architects. Before I go into detail on LB834, let me give you a brief overview of the minimum requirements for licensure in Nebraska, as described in the E and A regulation. To qualify, individuals must meet three basic requirements: education, experience, and examination. First, both professions typically require an accredited degree to meet the education component. Next, the law also requires that licensure candidates gain acceptable experience in the profession. Architects usually do this by completion of a specific experience program, and engineers typically need to demonstrate four years of experience that shows they have taken on more responsibility and more complexity in their work. Finally, there are examinations. For architects, there is one exam, and engineers take two exams, the first being the fundamentals of engineering, and the second exam tests their knowledge of the principles and practice of engineering in a specific area such as mechanical, structural, or electrical engineering. The second one is referred to as the PE Exam. These requirements are summarized on one of my handouts, along with a chart showing that, based on the pass

rate of the PE Exam, it successfully tests an individual's knowledge of both engineering principles and knowledge gained through work experience. The first major proposed change in LB834 would allow professional engineer candidates to take the Principles and Practice Exam, the PE Exam, before gaining four years of experience. This concept, which I will simply refer to as decoupling, allows candidates to take this exam after meeting the educational requirement and passing the Fundamentals Exam. Experience requirements, in addition to all others, would still have to be met before they qualify for licensure. Decoupling is supported by NSPE, the National Society of Professional Engineers, and it's my understanding that the Nebraska chapter of the society also supports decoupling. National engineering Model Law also supports decoupling for professional engineers, as shown on two additional handouts. The board's position is that decoupling makes it more convenient for potential licensees to take this exam and sees no reason why engineers who may have the ability to pass the exam should be prevented from taking it. Also, the board believes the act current-- the current act unfairly impacts the ability of some young engineers, particularly women, to become licensed. There will be another testifier after me who will do a better job of describing this specific concern. I also point out that architects have been decoupled since 2007. My final point on decoupling is this: LB834 would not prevent a candidate who decides to wait to take the PE Exam until they have four years of experience, if they want to reduce-- or the risk of potential mobility issues in other states, if they seek engineering licensure there. It's my understanding that this committee received a letter from a structural engineer who is opposed to decoupling, with licensure mobility being one of his main concerns. In my handouts, you will find an analysis, by me, of that concern and why I do not agree with the points raised in that letter. Next, I'll talk about the changes for architects. This bill would allow architect candidates to begin taking their professional exam without prior board approval. As with engineers, all requirements would still have to be met before they would qualify for licensure. Another important change allows architects to become licensed even if they took their architectural exams prior to graduation. The current act prevents this, as it states the exams must be passed after graduation. And here's why the language in the current act is problematic. Beginning in 2015, some architectural schools in the U.S. began offering an optional pathway within their program that would allow students to complete experience and examination requirements for licensure, while earning their degree. In 2018, the first students of these optional programs graduated. But again, this

existing language of the act prevents these individuals from being able to be licensed as an architect ,since they took their exams prior to graduation. In closing, these three issues, along with specifying the degrees from accredited Canadian programs, satisfy education components of licensure are the major changes this bill intends to accomplish. Besides what is on the bill statement of intent, I have summarized the remaining changes in a final handout, along with some diagrams showing how other states' laws compared to the proposed changes in this bill. I will end with saying that these major changes made by LB834 are intended to reduce unnecessary barriers to licensure so that our state can attract and keep more of these highly technical professionals working and able to become licensed in Nebraska. That concludes my testimony. I'd be happy to answer any questions.

HOWARD: Thank you.

JON WILBECK: Yes.

HOWARD: Are there questions? Senator Williams.

WILLIAMS: Thank you. Thank you for your testimony--

JON WILBECK: Yeah.

WILLIAMS: --and being here today.

JON WILBECK: Um-hum.

WILLIAMS: So at the-- what you just talked about there, this would bring us more in line with what our competitive states are around us, on licensure and--?

JON WILBECK: It would. There, there are several states, Missouri,just decoupled for engineers. Wyoming is another one. I can't recall what the percentage wise of the jurisdictions in the U.S., but it-- this is not an isolated idea of decoupling for engineers, not at all.

WILLIAMS: OK.

JON WILBECK: No.

WILLIAMS: Thank you.

HOWARD: What was the thought behind coupling in the first place?

JON WILBECK: You know, I, I don't know. I think when national-- again, engineering Model Law was first developed and at work, we're talking 1930s, 1920s. I think that was the thinking then, that they needed to have that four years before they could take the exam. And again, we're still-- this bill would still allow someone to wait to take the four years because the, the, the Practice Exam, there is a practice component of that exam. And so to be able to pass that exam, you do need to have gained some experience, you know, working at engineering firms, doing engineering work. But LB834 realizes that some individuals may get that experience sooner than others. And to just put an arbitrary four-year, four-year roadblock in front of someone, the board sees no reason why it, it needs to maintain at that, so--

HOWARD: Thank you.

JON WILBECK: Um-hum.

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

JON WILBECK: Thank you.

HOWARD: Our next proponent testified for LB834?

BRIAN KELLY: Good afternoon, Senator Howard and members of the committee. Thanks for the opportunity to speak to the-- today concerning the LB834. My name is Brian Kelly, spelled B-r-i-a-n K-e-l-l-y, and I'm a licensed architect in the state of Nebraska. I'm also a tenured faculty member at the College of Architecture at the University of Nebraska-Lincoln, the architectural licensing advisor for the Program of Architecture, and a board member on the Nebraska Board of Engineers and Architects. Although I hold these positions, I want to be clear that I'm not here today representing faculty or the students of the college, nor am I representing the board. My testimony reflects my own personal opinions on LB834. When considering testifying about this legislation, I reflected about how one might engage the process of designing a stance to take. I surmise that before any information is reviewed or evaluated, most likely a person will find themselves neutral, without opinion to its content or impacts. As one learns more through scrutinizing the substance, they would tend to agree or disagree and move into a position of supporting or not supporting the changes. After participating in this process and evaluating the potential impacts of the proposed bill, I submit that the changes have very little effect on the quality of licensees or the

built work they produce. That being said, these changes do reduce the hurdles to licensure, which might be difficult for-- to negotiate for some candidates who choose to seek licensure as an architect in Nebraska. As was already clarified by Mr. Wilbeck, the requirements for licensure remain the same. The three legs of the licensure stool, as we refer to it on the board-- education, experience, and examination-- are still the conditions which must be met to qualify for licensure in LB834. The changes in this bill simply allow for a candidate to take the exam prior to receiving an accredited degree. Ultimately, I believe that this bill reflects an attempt to reduce barriers to licensure for architects while maintaining the quality of the process. One of the ways these proposed changes help in doing this is, it allows for students enrolled in academic programs with an integrated path to licensure, to take the test concurrent with their degree path, making Nebraska their home state for licensure. Currently, this is not possible, as existing law requires the exam to be taken after graduation. The experience component administered through the National Council of Architectural Registration Boards' Architect Experience Program, or AXP, can already be satisfied concurrent with the degree path and, assuming that they're successful in passing the exam, these changes allow for licensure in Nebraska upon receiving their accredited degree. Although this is currently not an option for-- or only an option for students from institutions outside of Nebraska, as the UNL College of Architecture does not offer this type of degree path, the legislation offers flex-- flexibility to expand existing curricula and offer this opportunity in the future, should that be the desire of the faculty. In summary, long range projections from these changes, from these changes could see an increase in professionals becoming licensed in Nebraska, but the reality is, at this point, it has very little impact. Thank you for your time-- and would be happy to answer any questions you might have.

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

BRIAN KELLY: Thanks.

HOWARD: --testimony today. Our next proponent testifier for LB834? Good afternoon.

KYLIE STEEL: Good afternoon. My name is Kylie Steel, K-y-l-i-e S-t-e-e-l. I graduated with my master's degree in civil engineering in May of 2014, and immediately started working at Olsson in Omaha on their Rail/Bridge team. I was first eligible to take the PE Exam in

the fall of 2017, a date that was in the back of my mind during most, if not all, life decisions. My first son was born in September of 2015, and I remember having the discussion with my husband, soon after, about when we would have our second child. We are both engineers, so we like to attempt to plan out every detail of our lives. I didn't want to be pregnant when I sat for the PE Exam, so the options were to either try to have our second child before, or get pregnant after, my PE Exam. Because of our desire to have our kids close in age, my second son was born in May of 2017. So I did it. I was not going to be pregnant while I sat for the PE Exam in 2017, and I had five whole months to prepare for the exam. I was a master multitasker. How hard could it be? While I was on maternity leave, I made a detailed study schedule and began looking into some study materials that I had received from colleagues. I went back to work in August, and reality hit me right in the face. As I had progressed in my career, my responsibilities at work increased tremendously. As I had progressed in my life, my responsibilities at home had also increased. I was now faced with more demands at work, while continuing to gain that valuable engineering experience. At the same time, I was mothering my one-and-a-half-year-old son, mothering and maintaining a nursing schedule for my newest infant son, sticking by my study schedule, and, of course, trying to get adequate sleep because sleep is vital in preparing for anything as rigorous as the PE Exam. I made accommodations, recruited family members to help my husband with the kids, and went to the library to study. However, since I was nursing my infant son, a full day of study consisted of two hours of studying with pumping and nursing sessions in between. But I stuck with it. I followed my study schedule, and continued to make accommodations for my family. In addition to studying and preparing my reference material to take to the exam, I had to plan out how and when I was going to pump on exam day. Typically, I needed an outlet, refrigerator, privacy, and time to pump every three to four hours. So I bought a battery for my pump, packed a cooler full of ice, and crawled in the back of my car in the exam location parking lot, to pump right before the exam, in between the morning and afternoon sessions, and after the exam. It certainly wasn't the most physically comfortable day of my life. When I left that day, I knew I had failed, and a few months later my official results confirmed it. Extreme disappointment and feelings of incapability immediately followed. I was a good student, labeled a high performer at work, and a hard worker. But life had gotten in the way. Some may be thinking, why didn't I wait to take the exam until after I was done nursing my son, or was in a place in my personal life where I was able to complete more focused study? My

answer to that is that I had been waiting for this moment since I started my career. It had been my goal to become a professional engineer for as long as I can remember and, in a way, pushing it off would have counted as a failure to me. I chose to wait to take the exam again in October of 2018, to ensure I had adequate time for focused study. My study schedule consisted of coming home from work, Monday through Thursday, and studying from 6 p.m. to 10 p.m., and then performing practice exam problems for at least ten hours on the weekends. I also was fortunate to have colleagues who met with me once a week to discuss specific topics or questions I had. Preparing for the PE Exam takes an immense amount of time and focus, and because I had the circumstances to do that in the fall of 2018, I am now a licensed professional engineer. I am proud to say I am a high performing engineer, and I am proud to say I am a wife and mother of two. Unfortunately, one of my passions got in the way of the other, in a way that I don't feel is necessary. My experience is related to the physical demands that are put on me, as a woman starting her family. But I have colleagues and friends who are also having to make life decisions around the PE Exam. The example I will, will share of this is a male colleague of mine who is engaged to be married. He is eligible to take the PE Exam in the fall of 2020, and he and his fiancee planned their wedding and honeymoon around that period of time so he would have adequate time and focus to prepare. I am in support of decoupling because I feel it will provide both men and women with the flexibility they need to fulfill all aspects of their life, without diminishing the requirements to become a licensed professional engineer. Thank you for your time. I will answer any questions that you have.

HOWARD: Thank you. Are there questions? Thank you for sharing your story with us.

KYLIE STEEL: Yeah.

HOWARD: We appreciate it.

KYLIE STEEL: Absolutely.

HOWARD: Our next proponent for LB834? Good afternoon.

JAN BOSTELMAN: Good afternoon, everybody. Good afternoon, Chair Senator Howard and honorable members of the HHS Committee. My name is Jan Bostelman, J-a-n B-o-s-t-e-l-m-a-n, and I'm here before the committee to testify in support of LB834. I am a licensed professional

engineer in Nebraska, current vice chair of the NBEA, currently serve on the National Council of Examiners for Engineers and Surveyors' main oversight committee of Examinations for Professional Engineers. First, I support LB834, based upon a personal, professional experience background. This bill will, in my professional opinion, continue to uphold the safety, health, and well-being of the public. The necessary qualifications will not be diminished as a result of the proposed statute changes. Second, I understand that a letter has been submitted to you regarding some statements about NCEES PE Exam procedures and policies, especially related to structural engineering exams. I am putting on record, based upon my current involvement with the NCEES main committee facts to refute those statements, most of which are based on outdated information. The NCEES EPE Committee oversees the development and scoring of 16 different professional engineering exams, which includes the structural engineer's exam and other disciplines, whether that's chemical or civil. It reviews, questions performance, monitors the training of exam development volunteers, and recommends changes to exam policies and procedures. All 16 of the disciplines of the PE Exam test for a minimum level competency in a particular engineering discipline. They are all designed for engineers who have gained a minimum of four years postcollege work experience in their chosen engineering discipline, whatever that may be of the sixteen types. The 16-hour SE Examination is not the only examination written to test postcollege work experience; and I can explain further on that, if anyone has questions. The, the NCEES computer-based exams-- of which there are seven of those right now-- include not only multiple-choice items, but also alternative-type questions. These types of questions are of various formats of which I can further explain if so-- if anybody has a question. Thus, they are much more than just multiple-choice questions. The NCEES procedures related to scoring are very distinct for each PE discipline and established well before the exam itself. The NCEES scores each discipline exam with no predetermined percentage of examining that should pass or fail. The decoupling process, as stated in this bill, has no bearing whatsoever upon the national procedures for scoring, and therefore, categorically, there will not be an automatic allowing of more applicants to pass the examination with less knowledge. The statement about a written-calculation type of structural engineering being referred to as being better than another type for testing experience levels is not valid. Calculations are also necessary, when taking other types of PE Exams, to obtain the correct answers, even though they may not be reviewed by the national group. By approval of NCEES, all PE Exams must be transitioned to computer-based testing. And at

that time, once that happens, then potentially the structural engineering exams also will be transitioned to computer-based. And once that occurs, there may no longer be written calculations within those types of exams. I respectfully request each of you to support the LB834 and would be very happy to address any questions that you may have. And I appreciate your time to listen to my testimony in support of LB834.

HOWARD: Thank you.

JAN BOSTELMAN: Thank you.

HOWARD: Are there questions from the committee? Seeing none, thank you for visiting with us today.

JAN BOSTELMAN: Thank you.

HOWARD: Our next proponent testifier for LB834? Good afternoon.

KEN KILZER: Good afternoon. Chairperson Howard, members of the committee, my name is Ken Kilzer; that's K-e-n K-i-l-z-e-r. And I am here in support of LB834, based upon my 26 years of experience as a licensed professional structural engineer in the state of Nebraska. Full disclosure: I am currently the president of the Structural Engineers Association of Nebraska, known as SEAON. But I am here to testify on my own personal experience and opinions. The primary purpose of the Engineers and Architects Regulation Act is to safeguard life, health, and property, and to promote the public welfare of the citizens of our state. Over the years, these statutes have served us well, and any proposed changes to those laws must be first scrutinized as to the effect upon their primary purpose. These laws should also serve the state of Nebraska by focusing on, and being limited to, those elements critical to ensuring their primary purpose is realized. Requirements that do not serve to ensure the primary purpose, and that may prove restrictive to those aspiring to becoming registered as professional engineers, should be eliminated. In my opinion, the requirement to wait four years to take the PE test is one of those requirements that should be eliminated. Through my involvement in the engineering community. I have not sensed a strong sentiment against this change, except in the case of some structural engineers. Although SEAON is neutral on decoupling, there is a contingent that feel strongly that those candidates who wish to become SEs in Nebraska should be wait-- should be required to wait the four years to sit for these exams. I respect their views and opinions, but I disagree.

Structural engineering is different from other engineering disciplines in that currently a candidate must pass a 16-hour test in order to gain the title Structural Engineer, or SE. The SE includes in-depth seismic design requirements that one needs to design structures in seismically active areas. It is important to note that most engineers practicing structural engineering in Nebraska are actually licensed as professional civil engineers. This is the norm for a large majority of the states. There is concern by some of my colleagues that, by allowing candidates to take the SE test early in Nebraska, they may, they may denied, be denied reciprocity in western states that remain uncoupled and require those practicing structural engineering to be licensed as SEs. In fact, most western states, such as California, Oregon, Washington, and Alaska, require those pursuing licensures as SEs to become registered as professional civil engineers first, then obtain a certain number of years of structural design experience before being eligible to sit for the SE test. If Nebraska candidates are interested in becoming registered as SEs in western states, they need to be aware of the structural engineering requirements in those states, prior to starting the licensure process, and plan accordingly. It should be noted that there are only eight states that restrict the practice of structural engineering to SEs, and most of those only restrict the design of essential facilities to SEs. In the great majorities of, majority of states, qualified individuals, licensed as either civil or structural engineers, may design any and all structures. In fact, 27 states don't publicly recognize engineers by their specialties, including structural engineers. Some have expressed concern that, by allowing candidates to take the SE prior to getting their four years of experience, will somehow diminish the exclusivity or esteem of the title "SE." While I am proud of my SE title, I don't feel the intent of the Engineers and Architects Regulation Act is to separate SEs into a different category than everyone else. In my career, I've had the opportunity to work-- of working with many outstanding professional civil engineers, practicing structural engineering without the title "SE." While I respect my colleagues' concern, it is my opinion and experience-- it is, in my opinion, that experience, personal integrity, and a passion for the profession counts more than the title. We do damage to the profession of engineering if we start ranking disciplines according to importance. Over the years, I've seen a welcome increase in the number of women in the engineering profession. As a father of two daughters, one who will be enrolling in an engineering program next year, I want her to have the flexibility to plan her career path in the way that works best for her, while still meeting the demanding and necessary requirements to

earn the title of "professional engineer." As you heard from Miss Steel, women choosing engineering as a profession are sometimes negatively affected by what I consider to be an arbitrary rule. This change will allow candidates to plan the test around their lives instead of planning their lives around the test, while maintaining the primary purpose of the Engineers and Architects Act to protect the public. I agree with you-- with the position of the Nebraska Board of Engineers and Architects, as well as the National Society of Professional Engineers, in supporting this bill, and I urge its passage. I'd be happy to answer any questions you may have.

HOWARD: Thank you. Are there questions?

WALZ: I have a question.

HOWARD: Senator Walz,

WALZ: Thank you. Thanks for coming today.

KEN KILZER: Um-hum.

WALZ: I have been trying to find this information. Can you-- can you just give me a little bit of explanation about the principles and practice? What does it consist of? Is it one class? Is it several classes?

KEN KILZER: It's not a class. The engineering test is called a PE test, and it is divided into many different disciplines. So myself and Ms. Steel took-- well, originally she took the civil engineering test, right? Even though she does structural, she designs railroad bridges. So that's what she does, and so she took the civil test, right? Now other engineers, mechanical guys that do building designs for mechanical and electrical systems, would take either the mechanical PE test or the electrical PE test. So everybody sits down in a big room and they hand out the tests to everybody. But depending on your discipline, you take a different exam.

WALZ: OK.

KEN KILZER: So if you pass that exam, you are then a PE; you can call yourself a professional engineer and stamp or seal documents such as building plans and drawings that affect the public. Structural engineers as, like myself, I could have taken the civil engineering test and done exactly what I've done my whole career. And I went on and took the second one because I wanted to be able to do seismic

design. And I was just getting out of grad school, so I had a better chance of passing it since I was just in an academic mode. But if you're out in the west, out in seismic country, you-- to design more-- if you're going to design big buildings out there-- and even in Illinois, in Chicago or in that area-- you have to be a licensed structural engineer, which means you have to pass two tests, showing breadth and depth of structural engineering, as well as seismic design.

WALZ: OK.

KEN KILZER: So it's been a-- over the years, it's been a change, ongoing, in how things are licensed and, and if you have to have your own title as a mechanical, structural. This bill before us is the first step of kind of making it easier for everybody. So is that-- hopefully that answers your question.

WALZ: Well, that helps a lot. Thank you.

KEN KILZER: OK, sure.

WALZ: Appreciate that.

HOWARD: Other questions? Oh, all right. Seeing none--

KEN KILZER: Thank you very much

HOWARD: --thank you for your testimony today. Our next proponent testifier for LB834? Good afternoon.

JEANNE McCLURE: Good afternoon. I am Jeanne McClure, J-e-a-n-n-e M-c-C-l-u-r-e, and I am the executive director for the American Council of Engineering Companies, also known as ACEC. We represent about 47 engineering firms doing business across the state of Nebraska. As the only organization representing the business interests of the engineering industry, we work to promote the initiatives that create an enhanced business clients-- climate for our members. Our members are engaged in engineering and construction projects that propel Nebraska's and the nation's economy and enhance and safeguard America's quality of life. ACEC Nebraska supports decoupling, which allows candidates for professional engineering license to take the Principles and Practices [SIC] of Engineering Exam before they gain four years of experience, or anywhere along the line during those four years of experience, as has been explained to you by other testifiers. One of the most pressing issues for our industry, and for many

industries nationwide, is work force, and especially in Nebraska. We talk about this a lot. How do we keep, retain, attract work force? And we think LB834 brings a practical method of encouraging graduates to pursue their professional licensure and continue into positions that are well compensated, right here in our state. I would anecdote, anecdotally say that, all in all, if an engineering firm is looking for someone to hire-- a new graduate-- and they know they're going to be ready and able to take that exam in the first couple years of their experience, that person is more likely to get hired because-- especially once they've passed the exam. And then they can continue with that firm to get their experience and stay on. And I used to work for a healthcare company and we know a lot about that. And one of the things we know about that is, when doctors and residents, when they get placed in the residency program at a hospital-- say at the University of Nebraska Medical Center or CHI Health-- they're more likely to stay in that area. Same goes for engineers. Once they get established working for a firm in a particular area, they're more likely to stay here. So that seems like something that, overall, we've talked about as-- economic development measure is, you know, just one more layer to how we keep people in our state. So I just would add that to that. So we would like to thank-- thank Senator Arch for introducing LB834 and ask the committee to advance the bill. And I'd take any questions, if you have them.

HOWARD: Thank you. Are there questions? Seeing none, thank you for your testimony today. Our next proponent testifier for LB834? Good afternoon.

NICOLE FOX: Good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. My name is Nicole Fox, N-i-c-o-l-e F-o-x, and I'm director of government relations for the Platte Institute. Thank you, Senator Arch, for introducing LB834 and to have opportunity to discuss occupational licensing burdens in our state. I'm here testifying in support of this bill. LB834 adjusts the state's Engineers and Architects Regulation Act, in a positive direction, for less burdensome work requirements. This bill is a great example of the governing board of an occupation taking the initiative to update their laws, to reduce entrance barriers for a profession under their jurisdiction for regulation. LB834 proposes improvements to the licensure process, as several have referred to as decoupling, things such as timing issues, such as when they can take the professional exam and whether, you know, where their professional experience lie. It also allows them to take the exam without first

getting board approval, and it also allows for programs accredited by the Canadian Architectural Accreditation [SIC] Board and the Canadian Engineering Accreditation Board, to satisfy education requirements for licensure in Nebraska. As you may recall, LB299 was passed in 2018, with the goal of conducting periodic reviews of occupations requiring occupational regulation every five years. We need to make sure that requirements for all occupations regulated in this state are allowing individuals to work without undue burden. This bill helps Nebraska to attract and retain talented professionals. I'd like to thank the Nebraska Board of Engineers and Architects for their proactive work in recognizing that their license, licensure requirements needed to be updated and to make entry into Nebraska's workforce easier. I ask that you advance LB834 out of committee. And with that, I'm happy to take any questions

HOWARD: Thank you. Are there questions? Seeing none, thank you for your testimony today. Our next proponent testifier for LB834? Is there anyone wishing to testify in opposition to LB834? Good afternoon.

JEFF STEVENS: Good afternoon, Senator Howard, members of the committee. My name is Jeff Stevens, Je-f-f S-t-e-v-e-n-s. I live in Omaha, and I've been practicing engineering for more than 35 years. I'm a licensed professional civil engineer. My opposition to LB834 is specific to decoupling the work experience requirement for taking the structural engineering exam. Nebraska, like many other states, does not limit the practice of structural engineering to engineers holding the SE-- or structural engineering-- title. However, the recognition of the SE title in Nebraska has promoted the reciprocity of the SE title in other states, where the practice of structural engineering is limited, either partially or completely, to engineers who hold the SE title. Given the greater complexity of the SE title process among the states, it is important that young engineers have sufficient experience and mentoring before-- in order to make a more informed decision as to which exam to take and when to take it. Decoupling will open the door to reduce both the experience and the mentoring that can occur prior to taking the exam. Nebraska exports a lot of engineering services to other states and, in my opinion, an unintended consequence of LB834 would be a reduction in the export of structural engineering services, an unwise decision for a state concerned about our brain drain of young professionals and our desire to achieve greater economic activity. As an active volunteer for our local Structural Engineers Association and our representative to the professional engineers' coalition, I lobbied the Nebraska Board of Architects and

Engineers to amend LB834 to address my concerns. The board has chosen to proceed with the bill without our proposed revision, leaving our association divided to the point of having no working majority opinion of support or opposition, and leaving individual members, such as myself, to speak as each of us sees fit. If adopted, our proposal would have protected the current standing of Nebraska engineers with the SE title, while having no impact on the NBEA-stated advantages to decoupling the other engineering disciplines or the supply of structural engineering services available in the state. As was pointed out in the previous testimony, there's no practice restriction. I, I, myself, as a, am a professional civil engineer who practices structural design here in Nebraska, so I don't believe our opinion would have any impact on what the board wants to achieve. To continue, the MBEA has stated that they currently accept comity applications from SEs who have taken the exam early in states that have adopted decoupling, and that not decoupling the SE Exam for in-state candidates would be unfair. In my opinion, that concern is misplaced, given that Nebraska does not have a structural practice restriction. I am confident that we can compete for engineering work on our home turf with or without decoupling. There are some other points that, that I believe can be dealt with, should decoupling be adopted, that are-- that the statistics can be tracked to, to monitor, to see if these have any ill effects on the statute. Continuing education requirements for design professionals has become the norm. Unfortunately, decoupling will create a time lag of unknown duration between passing the exam and the enforcement of continuing education requirements. The NBEA can enforce the CEU rules on licensees, but not on those who have passed the exam but are not yet licensed. Lastly, the advantages to decoupling that have been cited by the NBEA should be scrutinized with greater convenience and flexibility offered by decoupling and the potential reduction of unfairness toward women engineers are valid. They would not be impacted if the work experience requirement remains for the SE Exam. Our engineers, more likely to pass the-- who pass the exam early, are more likely to get licensed. The evidence regarding an increase in exam applications and licenses granted that I requested from the NBEA show a temporary increase in the number of applications that did not include any evidence as to the increase in number of licensees. Will decoupling encourage licensing of engineers in exempt settings? Any encouragement offered by decoupling will need to be-- will need to overcome the unwillingness of many parties in exempt settings to accept sub, substantial financial liability associated with engineering services and the cost of professional liability insurance. The effect of decoupling, in the face of such opposition,

will likely be very small. Does a greater number of professional engineers improve public safety? I find this very flattering as an engineer. I think a greater number of professional engineers better indicates a more robust professional service sector for our economy. And with that, I'll take any of your questions. Thank you very much for your time.

HOWARD: Thank you. Are there questions?

WALZ: Oh, go ahead. Maybe you'll answer mine.

WILLIAMS: Thank you.

HOWARD: Senator Williams.

WILLIAMS: Thank you, Senator Howard, and thank you for being here. So your concern is with the decoupling, only of the SE portion, not anything else?

JEFF STEVENS: That--

WILLIAMS: I want, I want to be sure that I 'm understanding.

JEFF STEVENS: That, that is correct. If, if a candidate takes the SE Exam here early, not knowing what's required in other states, those other states that do have practice restrictions on the West Coast do require you to get the civil license first and then additional structural work experience. So you could find yourself in a situation where you would satisfy work experience here in Nebraska for your structural, that you take first after you've taken the exam, but then come to find out that you need to get the civil, at which point you'd have to get additional work experience for that, that you won't, you can't double dip on your work experience for two titles. Once you get the civil, you have to take a third-- three-year period of work experience in California, not sure what it is and the other West Coast states. So it would create a situation where you have three components of work experience, rather than two, in order to get the title in those West Coast states.

WILLIAMS: Thank you.

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

JEFF STEVENS: Thank you.

HOWARD: Our next opponent testifier for LB834? Anyone else wishing to testify in opposition to LB834? Is there anyone wishing to testify in a neutral capacity for LB834? Seeing none, Senator Arch, you are welcome to close. Oh, and while you're coming up, we have two proponent letters: one from Alexa Metcalf, representing herself; and one from Jan Bostelman from Bostelman Engineering, vice chair, Nebraska Board of Engineers and Architects.

ARCH: Thank you. I think we've heard good testimony today. And I, and I think we understand that this is really a matter of this decoupling of the like-- the taking of the exam from, from the experience required. I don't think it-- it does not lower the qualifications in any way for licensure for architects or professional engineers. The three legs of the license stool, where you've got education, experience, and examination, remain intact; they're not changing. And it will give engineering license candidates the ability to determine when it's the best time for them to take the PE or the SE Exam. It's simply eliminating unnecessary barriers. So I would encourage your support of this bill.

HOWARD: Thank you--

ARCH: And I'd be--

HOWARD: Are there any questions? Seeing none, thank you for your closing.

ARCH: Thank you.

HOWARD: This will close the hearing for LB834 and open the hearing for LB772, Senator Williams' bill, to change the scope of practice for physician assistants. I ask, if you're leaving, please do so quietly. Welcome, Senator Williams.

WILLIAMS: Good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. My name is Matt Williams, M-a-t-t W-i-l-l-i-a-m-s. And happy scope week. Thank you, Madam Chairman, for scheduling these today. I am here to open on LB772, a bill to update and modernize the scope of practice for PAs in Nebraska. We all know, when you become a senator, the first rule is don't carry a scope bill. I'm carrying this bill for two very specific reasons: one, I believe it will positively impact the access to high quality care across the

entire state of Nebraska; and I have been told and have experienced that, as many of the bills we have heard over the last few days, the details have been worked out on this one. I want to make it clear from the start that the changes proposed in LB772 have, in fact, run the 407 gantlet and have been approved by the medical director. It has also achieved the grand compromise that includes: the Hospital Association; the Nebraska Medical Association; the Department of Health and Human Services; and others that support this scope change. In general, LB772 allows PAs to continue to provide high quality patient care as part of a healthcare team, while also reducing administrative burdens and removing statutory confusion that currently surrounds the statutes regarding a PA's scope of practice. A very important tenet of this bill is to ensure that the physician/PA relationship is appropriately designed-- or defined, excuse me-- in Nebraska statutes. Under LB772, PAs are allowed to engage in practice, under a collaborative agreement, with the supervision of a physician, and are allowed to practice as part of a healthcare team. The bill redefines "supervising physician," in Section 38-2017, to include a licensed physician who supervises a physician assistants under a collaborative agreement, and redefines "supervision," as defined in Section 38-2018, to mean the ready availability of the supervising physician for consultation and collaboration on the activities of a physician assistant. Secondly, LB772 updates sections 38-2047, found on page 3 of the bill, to state that a PA may perform those tasks for which a PA has been prepared by their education, training, experience, and is competent to perform, as long as those tasks are supported by physicians in the practice and a part of the scope of practice of the supervising physician or another physician in the practice group. Current law limits the PA's scope of practice to the scope of practice of the supervising physician only, and does not take into account multidisciplinary teams in a practice or a multi-employer career that PAs may have in order to serve as Nebraska's-- in Nebraska's more rural areas. This modernization is further clarified in the proposed amendment, which has been handed out to you at the beginning of my testimony. You will note on--- that, on pages 4 and 5 of the bill, most of the action comes from striking sections of statute. This is done to lessen the statutory mandates related to PA/physician in employment relationships and the practice of PAs. LB772 removes specific requirements for a PA to practice in a hospital setting that are currently contained in 38-2047(5). Repealing this section of statute allows hospitals that are employing PAs, or otherwise allowing PAs to practice in their facilities, to decide, at their own facility, how to manage this relationship. LB772 also removes the sections of

statute mandating the provisions that must be included in the PA/physician practice agreement, currently outlined in Section 38-2050(2). An agreement is still required. Let me be very clear that physician assistants will still be practicing with the specific agreement of a physician, but what must be included in the agreement is best left to the physician, and the PA, and their unique practice. As an example, if a PA is in an orthopedic practice and has a supervising agreement with a foot and ankle specialist, LB772 would allow the PA to be called upon, from time to time, to take calls or assist in surgeries with a hand and wrist surgeon in the same orthopedic practice group, if the PA has the education, training, and experience. Using our example, we want to ensure that our law clearly allows a PA to protect-- provide care and assistance in hand and wrist care, even though hand and wrist care is not the scope of the practice of the primary supervising physician, but is within the scope of practice of a physician within the practice, again, as the PA has-- if the PA has the education, training, experience, and is competent to provide this assistance. LB772 also updates PA prescribing position-- provisions, under Section 38-2055, to include nonpharmaceutical-- pharmacological, excuse me-- interventions such as leg braces, wheelchairs and the like, and also allowing healthcare providers to furnish medications to patients in certain cases applies to PAs. Finally, LB772 seeks to change the governance of the PA Committee set forth in Section 38-2056. LB772 gives the Board of Medicine and Surgery physicians a representative on the PA Committee to act in a nonvoting advisory role. When PA Committee recommendations are passed along to the Board of Medicine and Surgery, the board's nonvoting representative sitting on the PA Committee retains an active role on the board of the medicine and surgery physicians with the ability to vote on any PA recommendations under review. I appreciate the committee's careful consideration of this bill. There are several people that will be testifying behind me, that know more about the details than I have been able to provide. But I will be happy to stay and close. Thank you.

HOWARD: Thank you. Are there questions for Senator Williams? Just so I'm clear--and there may be somebody coming behind you-- so essentially they're-- the PAs would be allowed to do whatever their supervisor is able to do, as long as they're supervised?

WILLIAMS: They can have a practice agreement with, with a physician like they do now. But this scope of practice could change because that could match any of the members of that physician group's scope of

practice, as long as the physician assistant had the training, education, and experience, and competency in those areas,

HOWARD: As long as the physician had the training?

WILLIAMS: And the PA would also have to have the training to provide those services.

HOWARD: OK.

WILLIAMS: Yeah.

HOWARD: Thank you. Thank you. All right. Our first proponent testifier for LB772?

KURT SCHMECKPEPER: Good afternoon,

HOWARD: Good afternoon.

KURT SCHMECKPEPER: Chairman Howard and members of the Health and Human Service Committee, my name is Kurt Schmeckpeper, K-u-r-t S-c-h-m-e-c-k-p-e-p-e-r. I am a PA practicing family medicine in Crete and Wilber, Nebraska. I am the legislative chair and immediate past president of the Nebraska Academy of Physician Assistants, or otherwise known as NAPA, the applicant group that brought forward the 407 application seeking to modernize the Nebraska statutes regulating our practice. It has been a long journey that has brought us to this hearing today, and we're very grateful to the many stakeholders who have been a part of what has been an incredible collaborative process. Thank you to Senator Williams in bringing forward this bill that reflects all these efforts, which are aimed at enhancing quality healthcare in Nebraska. In 1967, the first PA class, which was three formal-- former Navy corpsmen, graduated from Duke University. They went on to define an entirely new profession. They were determined to improve patient care and to address the huge shortage of clinic, clinical, clinic, clinical healthcare providers that existed at that time. They were out to change healthcare forever, and they succeeded. Today there are approximately 1,300 PAs practicing in Nebraska. More than 35 percent of PAs in Nebraska specialize in primary care. A typical Nebraska PA completes over 70 patient visits per week, and more than 41 percent of all Nebraska PAs serve in rural areas of this state. As you can imagine, a lot of the change-- a lot has changed in the five decades that the PAs have been in healthcare scene in Nebraska, and it's important that our laws reflect these changes.

Patients in the healthcare system, as a whole, benefit most when clinicians can provide the care they are competent and qualified to provide, without unnecessary state law barriers. Simply put, we want to ensure that PAs are able to work to the fullest extent of their education and experience, to provide the best access for quality care in Nebraska. The changes proposed in LB772 will allow PAs to continue to provide high quality patient care as a part of the healthcare team, while also reducing the administrative burdens or statutory confusions currently experienced by PAs, administrators, and the physicians with whom they practice. Allowing flexibility in the PA/physician professional relationship increases patient access to healthcare by giving PAs greater ability to practice in separate locations, including, including rural and underserved areas. It is also-- frees up the physician's time, letting them focus on their patients' needs, rather than meeting restrict-- strict administrative requirements. Perhaps, most importantly, the proposed changes will reflect the true nature of PA practice, in which PAs, physicians, and other practitioners work together to assure quality patient care. First-- excuse me-- I am going to talk through the three changes proposed by this bill and have my colleague, Tami, walk you through the remainder. First, NAPA is seeking to eliminate the statutory mandates relate, related to PAs' ability to practice in the hospital setting. NAPA believes that removing the hospital-specific provisions will place all PAs on an even playing field and remove any unnecessary confusion about what the statute may require for hospitals wishing to hire a PA or simply letting one have privileges. Hospitals are able to decide, at their own facilities, how to manage these employment relationships. The bill also seeks to remove the overlooked-- overly restrictive sections at statute mandatings the provisions that must be included in PA/physician practice agreement, currently outlined in Section 38-2050(2). These are decisions best left to the physician and the PA, and governed by the specific agreement, tailored to their practice. The third change is an amendment of statutory language to more accurately, accurately reflect the current state of physician/PA relationships. Under our application, PAs are allowed to engage in practice under a collaborative agreement with the supervision of a physician and are allowed to practice at that part of the healthcare team. These changes include: redefining supervising physician, as defined in Section 38-2017, to a "licensed physician who supervises a physician assistant under a collaborative agreement;" and redefining supervision, as defined in Section 38-2018, to mean: the readily availability of the supervising physician for consultation and collaboration on the activities of a physician assistant. My colleague

will be covering the parts of our bill related to scope, prescribing provisions, and the PA Committee. With that, I conclude my testimony and welcome any questions. Thank you very much.

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

CAVANAUGH: Thank you. Thank you for being here today. And I wanted to just ask a clarifying question about the-- when you're entering into the contract, the supervising contract with the physician. This changes the require-- the like basic requirements. But if the physician wanted to have in the contract what's currently in statute, it doesn't prohibit that from happening, correct?

KURT SCHMECKPEPER: Well, to clarify, it's not a contract.

CAVANAUGH: OK.

KURT SCHMECKPEPER: It's an agreement.

CAVANAUGH: Sorry.

KURT SCHMECKPEPER: And, and thus in lies why we need this-- some clarification--

CAVANAUGH: Sure.

KURT SCHMECKPEPER: --in some of our statute language. Because of the way that medicine is changing, that no longer is a standalone physician clinic available, this will allow this agreement that, I believe, Senator Howard was asking Senator Williams to clarify a little bit, now with the larger physicians' group, each-- all within one discipline of medicine, but have their subspecialties, this would allow the opportunity to utilize the PA for all the physicians in that group.

CAVANAUGH: OK.

KURT SCHMECKPEPER: Does that--

CAVANAUGH: Yeah.

KURT SCHMECKPEPER: --does that help clarify--

CAVANAUGH: It does; thank you.

KURT SCHMECKPEPER: --that agreement?

CAVANAUGH: Yeah, so thanks.

KURT SCHMECKPEPER: Thank you.

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

KURT SCHMECKPEPER: Thank you; appreciate it.

HOWARD: Our next opponent for LB772? Good afternoon.

TAMARA DOLPHENS: Good afternoon, senators. My name is Tamara Dolphens, T-a-m-a-r-a D-o-l-p-h-e-n-s, and I'm a physician assistant, practicing in pediatrics in Omaha, Nebraska. I also serve as an adjunct faculty member at the Creighton University, currently in the area of health administration and policy. I serve as the chair of the Physician Assistant Committee that is created under the Uniform Credentialing Act. In that committee, our duties include providing recommendations related to the issuance or denial of credentials, disciplinary action, and providing the department with recommendations on regulations related to our practice act. I'm going to pick up where Kurt left off with our bill. An important part of the bill is updating PA scope of practice provisions that are contained in 38-2047, that allow a PA scope of practice to reflect legal medical services for which a AP has been prepared by their education, training, and experience, and is competent to perform, rather than defining the PA scope of practice only by the scope of practice by that one specific supervising physician. Again, we work to come to a compromise with the NMA in this area, agreeing that a PA scope of practice should be based on the education, training, and experience of the PA, as long as those skills are supported also by the PA's current practice setting, either as a component of the supervising physician's scope of practice or as a component of the scope of practice of other physicians working with the PA in the same practice. So to provide an example similar to Senator Williams' orthopedic example that he opened with, one example that the 407 Technical Committee-- Technical Review Committee deliberated on is one from my previous practice experience where I worked in a pediatric specialty of pediatric cardiology at Children's Hospital. In this very specialized field, I was trained to read and and interpret pediatric echocardiograms by one of the physicians in my practice who was not technically my supervising physician, not the one I had the agreement with. The supervising physician that I had the

agreement with did not actually interpret echocardiograms; he had a different scope of practice. So therefore, this proposed bill helps to clarify an allowance of PAs, who are similarly, similarly situated, to perform or interpret studies that they are trained and competent to do, even if it's not in that one specific physician's scope of practice. This section will be further refined in the committee amendment to reflect the agreement NAPA reached with COPIC. The committee amendment specifies that a PA shall have at least one supervising physician for each employer. If the employer is a multispecialty practice, the PA shall have a supervising physician for each specialty practice area in which the PA performs medical services. The fifth point in the bill seeks to update PA prescribing provisions, under Section 38-2055, to include nonpharmacologic interventions and clarifying that provisions allowing the healthcare providers to furnish medications to patients, in certain cases, that applies to PAs. Prescribing is a part of the scope of practice that will remain limited by the provisions that have just been discussed. The PA will only be prescribing based on their education, training, and experience, as supported by the supervising physician or other doctors who work with the PA in that specific practice setting. Finally, our application does seek to change the governance of the PA Committee; and this is the committee that I personally chair. This proposal also reflects a compromise with the NMA. Our original application aimed to change the makeup of the PA Committee, but under the bill, we are asking to instead change only the voting provisions of the committee. The suggested change in this area would be to give the Board of Medicine and Surgery physician representative an advisory role on the PA Committee that would not be a voting role. When the PA Committee recommendations are passed along then, to the Board of Medicine and Surgery, that physician member will still have a vote at that time, as a member of that board. The second physician representative who currently sits on the PA Committee will continue to have a vote on all PA matters. We really appreciate your consideration of the proposal we are bringing forward today. Thank you for your time, and your attention, and all the work that you've done to improve the healthcare of our patients across Nebraska. Take any questions.

HOWARD: Thank you. Are there questions? I, I have a question.

TAMARA DOLPHENS: Sure.

HOWARD: On page three, line 23, you say, "the practice of a physician working in the same physician group." What's a physician group?

TAMARA DOLPHENS: So I'll use the example of my previous work experience, working in a pediatric cardiology group. I worked with eight physicians at Children's Hospital. I was the only physician assistant working with that group of eight physicians. Within that specialty area, each of the physicians had their own independent area of expertise or specialty. Being the only PA, I had a document that was my written agreement, that was with one specific supervising physician who had one single area of expertise. But I was utilized across the entire group. So that would be an example of a, of a physician group.

HOWARD: Do we have a definition in statute of what a physician group is?

TAMARA DOLPHENS: I don't believe that we do. I don't believe that we have physician group defined. And that is because when the doc-- when these statutes were originally written, it was a physician, a single physician, single PA. Like what Kurt discussed, you know, early on when this was written, it was idealized as far as a physician and a PA working together one on one. But now practice has changed, and we have physician groups. We have large medical organizations that hire multiple physicians, multiple PAs. So to answer that question, I don't believe that we have that defined, a physician group.

HOWARD: So that may be something that you'll want to consider as the com, as the committee considers this language, because a physician group, I believe, is a term of art in the medical community. I don't want somebody to look at this and say a physician group is 100 physicians with very broad scopes, and one PA gets to have the scope of every single physician in a 100-physician group. And so I think you may need to have some clarity on what that is.

TAMARA DOLPHENS: Sure.

HOWARD: Senator Arch.

ARCH: Thank you. I have a, I have a very related question to that.

TAMARA DOLPHENS: Yes.

ARCH: I was thinking along the same lines. And it's related to the special, the specialty practice area--

TAMARA DOLPHENS: Um-hum.

ARCH: --and whether that's defined. The example that Senator Williams provided here could be argued that that really is the specialty practice of orthopedics--

TAMARA DOLPHENS: Um-hum.

ARCH: --with subspecialties in foot and ankle--

TAMARA DOLPHENS: Um-hum.

ARCH: --and wrist and that. And so perhaps some definition as to what a specialty practice area would also be beneficial--

TAMARA DOLPHENS: Yeah.

ARCH: --if it's, if it's not currently here.

TAMARA DOLPHENS: OK. OK. That's definitely something to, to take into account. And much of what we refer to as physician assistants' education, training and experience, because physician assistants are trained in the broad, broad area of medicine, to cover all general medicine and really primary care in our training, so.

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

TAMARA DOLPHENS: Thank you.

HOWARD: Our next proponent testified for LB772? Good afternoon.

ROBERT WERGIN: Senator Howard and committee members, thank you for letting me share my thoughts with you today. My name is Robert Wergin, MD, R-o-b-e-r-t W-e-r-g-i-n. I'm a practicing rural family physician in southeast Nebraska, in the community of Seward. I also serve on the board of directors of the Nebraska Medical Association. And I'll be speaking on behalf of myself and the Nebraska Medical Association, in support of LB772. I've been a practicing physician for almost 40 years, and during this time, I've worked closely with physicians' assistants in my practice, in a team-based, whole person model of care. I've worked at a rural health clinic since 1995, which by statute requires a physician assistant or a midlevel provider to work with me during half the open hours that my clinic is open. This bill, as it was developed, was-- it was worked on collaboratively over this past year. And the NMA truly values the commitment of the physicians' assistants to this team-based model of care, and we're confident that

the changes requested in LB772 will maintain a high level of safe and quality care delivered to the citizens of the state of Nebraska. In my practice, the physicians' assistants I've worked with over the years, we've developed a whole-person approach to care, meaning just not in any one silo or problem area. The physicians' assistants I've worked with often have sought my input when patients present with complex medical problems that require other medications, as we developed treatment plans and medications for the problems they presented with. This process has worked well for me personally over the years, and also my partners who work in practice with me and working with our physicians' assistants. Over the years, I've had many instances where the physician assistants and I have collaborated and developed this team approach, particularly in patients with complex, multisystem problems, as we develop treatment plans, which include medications that may alter our approach to that specific problem. And I can give you instances where we have avoided certain adverse or possible serious outcomes related to that collaborative process where we've worked together. So it's, it's worked well in my practice. And I would say I highlighted my experience. It's my experience and expertise is the boots on the ground working on a day to day basis, in my clinic, with physicians' assistants. When we first developed discussion in this 407 process, which began last year, I'll admit there were changes requested by the physicians' assistants that we, as physician leaders of a team-based care team model, were not really very comfortable with. However, due to the nature of the 407 process, the Nebraska Medical Association was able to maintain an open dialogue with the Nebraska Association of Physicians' Assistants [SIC] and work together on what these desired changes were, what their goals were, what in terms of providing care and competing in the open job market. And that was very eye-opening for both groups. We feel that this LB772 407 process should be a reflection of how scope expansion bills should be approached. And others should follow that collaborative model with this open dialogue. For these reasons, I would ask the committee to support and vote to advance LB772 to the General File, and I would be glad to answer any questions regarding the process we went through to arrive at this day.

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

B. HANSEN: Something I just noticed now-- thank you for coming and testifying, sorry. Something I just noticed now. Were physician assistants able to prescribe drug samples before? And if so, why now?

ROBERT WERGIN: In my practice, they were, under my supervision, meaning dispense samples within the clinic, if we had-- or my current practice does not have drug samples. But yes, they were.

B. HANSEN: Under your, under your direction?

ROBERT WERGIN: Under my direction, yeah. So if they were going to hand out, if we had a sample cabinet, which we don't have in my practice any longer, they could do that with my--

B. HANSEN: OK. All right. I might ask the question again later with--

ROBERT WERGIN: OK.

B. HANSEN: --somebody else. All right, thanks.

ROBERT WERGIN: All right.

HOWARD: Other questions? I'm looking at Senator Hansen's language here on page 7. It says, "A physician assistant may distribute drug samples." Is it , is it meant to be dispensed? Is that the appropriate statutory term?

ROBERT WERGIN: Well, technically, it's by the definition of a drug sample. It's a, it's a-- in the days I had drug samples-- we don't see drug representatives anymore. It is to give-- if we-- as a physician assistant, often we've-- and myself have arrived at a treatment plan. And we say, gee, you have these three other problems. We think this medication may benefit this specific problem, but we're not sure if you'll tolerate it. Here's eight pills. I happen to have samples so you don't go out and buy an expensive copay prescription. Let's see how this goes, and then, if it's tolerated, we'll go on. And that was my approach to that. So when I said it was a collaborative arrangement, usually it was on these complex patients where we wanted to change or to find a specific treatment program in the milieu of the whole patient and say, here, here's a brief number of pills, so you don't get 30 or 90 pills and say, I can't take these. It interacts with some of the other medicines I'm on or I can't tolerate them.

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

ROBERT WERGIN: Thank you.

HOWARD: Our next proponent testifier for LB772?

ADAM KUENNING: Good afternoon. My name is Adam Kuenning, A-d-a-m K-u-e-n-n-i-n-g. I'm the corporate legal counsel for a company called Immanuel. And a letter was submitted by our president and CEO yesterday, which I'd basically like to read and answer any questions that may result from that. And I'll also try to address a couple of the questions who have come up here. I also serve as an adjunct professor of health law at the Creighton University School of Law and may be able to help with some of the interpretation issues. "Immanuel has been a nonprofit provider of senior housing and services in Nebraska for over 130 years. Immanuel provides affordable housing, independent living, assisted living, memory support, nursing homes, and the Program of All-Inclusive Care for the Elderly-- PACE-- for Nebraska and Iowa seniors. Immanuel communities are located in Omaha and Lincoln, Nebraska, and Council Bluffs and Des Moines, Iowa." And "I am honored to serve as Immanuel's president and chief executive officer." This is, again, a letter from our president. "As you know, Nebraska is facing a potential shortage of healthcare providers, particularly in rural communities. In order to address this shortage, Nebraska must retain and attract healthcare providers of all types. Senator Williams' amendments to the Nebraska Medicine and Surgery Practice Act, which expand the scope of practice for physician assistants in Nebraska, will help with this shortage. The shortage of healthcare providers in Nebraska will have an immense impact on seniors living in rural communities. In rural Nebraska, almost 20 percent of the population is over age 65, compared to just 10 percent in large urban areas. Additionally, chronic diseases are more prevalent in rural communities. Accordingly, rural populations have a higher incidence of obesity and hypertension. Furthermore, the lack of public transportation limits the ability of some residents to access healthcare. As the utilization of healthcare grows," especially in Nebraska's population-- "especially as Nebraska's population ages, the need for healthcare providers will continue to increase. The United States Health Resource and Services Administration has projected that the supply of primary healthcare providers, including physicians' assistance, will not meet the demand. Further, the Robert Graham Center has projected that Nebraska will require an additional 133 primary care physicians, an 11 percent increase, to prevent loss of access. In 2015, the Nebraska Legislature recognized the shortage of healthcare providers in amending the Nurse Practitioner Practice Act, to remove certain barriers to practice. Similarly in 2019, the United States Health and Human Services Department updated the Code of

Federal Regulations regarding PACE, to allow for physician assistants to act as primary care provider within the interdisciplinary team. Through this change, it was noted that the expansion of healthcare providers who could fill the role of a primary care provider was driven, in part, to ease burdens in providing healthcare services in rural areas. Immanuel supports this change to the scope of practice for physicians' assistants, with a hope that this will help ensure access to healthcare throughout Nebraska. The Nebraska Legislature and the federal government have already passed measures to reduce the shortage of healthcare providers, particularly in rural communities. LB772 continues this push and will help to attract physician assistants to Nebraska to help fulfill this need." Senator Cavanaugh, to address your question, a provider group, physician group, as we discussed, or a hospital system or something that chooses to utilize the old requirements of the collaboration agreement or something, may still do so. Practically speaking, they may not become the employer of choice for more progressive physician assistants or something like that, but they are absolutely still free to do so. I also think that the discussion about specialty practices and the definitions of provider groups that have been had here are spot on. Excellent observations. Any questions?

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

ADAM KUENNING: Thank you.

HOWARD: Our next proponent testifier for LB772. Seeing none, is there anyone wishing to testify in opposition to LB772? Anyone wishing to testify in a neutral capacity? All right. Seeing none, while Senator Williams comes up, we do have some letters. Proponent letters include: Joni Cover of the Nebraska Pharmacists Association; Beth Nelsen, the Nebraska Hospice and Palliative Care Association; Dr. Gary Anthone, the Department of Health and Human Services; Todd Stubbendieck, AARP Nebraska; Laura Ebke, the Platte Institute; Andy Hale and David Slattery, the Nebraska Hospital Association; and Eric Gurley, Immanuel. No Opponent letters. One neutral letter from Dr. Stephen Williams, Dr. Joseph Gutierrez, and Dr. Brett Wergin, from the Nebraska Academy of Family Physicians. Welcome back, Senator Williams.

WILLIAMS: Thank you, Senator Howard and members of the committee. When we're dealing with this, these issues, patient safety is the top priority for each one of us to think about. And broadening any kind of scope is serious business, and we need to take that seriously. I want

to emphasize that nothing in LB772 or the amendment allows a PA to provide services outside their education, their training, and their experience. What it's changing is matching the scope with the physician group, specifically, as you heard in this discussion. Again, the 407 gantlet was run fully in this case, with the approval of the medical director. And you've heard from the various providers and the disciplines, and the cooperation, and the compatibility, and the working together of that nature. So with that, I would encourage the advancement of LB772, as amended by AM2108, to General File. Thank you.

HOWARD: Thank you. Are there any final questions for Senator Williams? Seeing none, thank you for visiting with us today. This will close the hearing for LB772. And the committee will take a five minute break, and we'll reconvene at 3:00 p.m.

[BREAK]

HOWARD: [RECORDER MALFUNCTION]-- LB817, Senator Stinner's bill to adopt the Prescribing Psychologist Practice Act. Welcome, Senator Stinner.

STINNER: Welcome, thank you. Good afternoon, Chairperson Howard and members of the Health and Human Service Committee. For the record, my name is John, J-o-h-n, Stinner, S-t-i-n-n-e-r, and I represent the 48th District, which is all of Scotts Bluff County. LB817 would authorize prescribing privileges for psychologists in the treatment of mental health and substance use disorders in Nebraska. Passage of LB817 would provide more access to mental and behavioral health services for our state, especially in rural Nebraska. I believe this committee is abundantly aware of the need to expand access to mental and behavioral health services, particularly in rural Nebraska. Additionally, all of us are concerned with patient safety. I believe LB817 protects the public while also increasing access to a critical tool needed for the treatment of mental illness. Please note the chart I have distributed to the committee, showing the years of training and the education for a potential prescribing psychologist, compared to an MD in psychiatry, a psychiatric nurse practitioner, and a physicians' assistant. In addition to extensive education and training for a current Ph.D psychologist,, the bill requires additional education and training for prescribing psychologists, as well as two years of physician supervision. The United States Military has had the same prescriptive authority for psychologists for over 20 years. It has worked and it has expanded the treatment of our service members and

vet, and veterans. You will hear today from prescribing psychologists in that arena. In 2016, the Iowa legislature passed a psych-- psychologist prescription privilege bill and the regulations were implemented last year. After legislator understood the extensive training and education that would be required, the primary issue became not patient safety, but the need for these services in rural areas of Iowa. These issues will be discussed further today by psychologists from my district. We also know that there are psychologists interested in getting prescriptive privileges that are being recruited by Iowa healthcare facilities. Nebraska can't afford to lose more highly trained healthcare workers. There is a critical need in our state to expand behavioral health service access. I brought you a bill that won't solve all the access problems, but certainly will take the next step in the right direction. I appreciate your consideration of LB817, and would be happy to take any questions. Thank you.

HOWARD: Thank you. Thank you, Senator Stinner; I apologize. Are there questions for Senator Stinner? Seeing none, will you be staying to close?

STINNER: I will stay to close. Yes.

HOWARD: Wonderful. Thank you, Senator Stinner.

STINNER: Thank you.

HOWARD: We'll invite our first proponent up for LB817. Good afternoon.

DANIEL ULLMAN: I'm Daniel Ullman, D-a-n-i-e-l U-l-l-m-a-n, a licensed psychologist, and I'm testifying on behalf of the Nebraska Psychological Association. Terms of my background: I worked 30 years at the Lincoln Regional Center, and now I'm semiretired. Patients with disabling mental conditions are facing long delays getting their mental health medications. You'll hear testimony about the length of those delays and the impact on Nebraskans. Licensed psychologists with a postdoctoral medical training could reduce those delays. After LB817 has passed, a patient could see a prescribing psychologist for their diagnostic assessment, their psychotherapy, and management of their mental health medications. The patient would not have to see multiple providers, reducing patient copays and travel, which is very important. Because psychologists see their patients frequently, a prescribing psychologist could closely monitor the effects and side effects of the medications and take patients off medications that are

not needed or harmful. What you hear a lot in New Mexico and Louisiana is they spend half their time getting people off medications. The opposition will assert that passing LB817 will not increase the number of providers or improve access to care. I think the facts dispute this. Here is a map, coded green, where you can see where the psychologists are located-- mailing addresses. There's been a 34 percent increase in the number of licensed psychologists. In 2006, there were 449. Now there's 601. Now they all don't live in Nebraska, but the ones that are represented on here, some live in surrounding states and work at-- work in both states or three states. You can see we have about eleven and the panhandle highly motivated group to act on this bill once. It's an act, once it's enacted, hopefully. And then we have interests throughout the state. We badly, badly need more psychiatrists, whatever can be done to get more across the state. So for comparison and with the references at the bottom, you can see how we're hurting for psychiatry in this state. Currently, we have five psychologists taking the advanced training. Imagine how many psychologists would enter if we actually had a bill and a way for them to get credentialed. And as it was mentioned earlier by the, by the senator, they're looking to Iowa now and actually going there. So you will hear about that. The opposition will assert that the training and practice of prescribing psychologists is substandard. The facts refute this assertion. Of course, we went through the 407, the technical review committee members' five-, six-month review-- an unbiased group in my, in my opinion. Five out of six recommended approval of the application and moving it forward. We got through a subcommittee, the Board of Health, but we couldn't get enough votes in the Board of Health. There were some recommendations from the technical review committee, and we made those-- we followed those recommendations; and those are represented in the bill before you. This has already been handed out to you. This is the checklist, the training requirements. And very important you keep your psychology license; that is fundamental. And most of what you're doing is continuing to practice as a psychologist. This is how-- we do this as a [INAUDIBLE]. And you need to continue to get your continuing education. You have to get a postdoctoral master's degree. There's two practica, physician-supervised, and you have a national proficiency examination, and you need to have a two-year transitional supervised practice, once you get a, a, a provisional certificate to prescribe. And then, to keep the prescription certificate, you need it-- you need to complete 40 hours if you're taking the competency, as well as your 24 to keep your psychology license. The opposition will assert the practice psychology is unsafe. We refute this assertion. The military, and the Department

of Defense, and the government are using prescribing psychologists across the country. New Mexico and Louisiana have the most experience. New Mexico started in 2002, and Louisiana in 2004. What are they-- what did they do? In Louisiana, they expanded it. The legislature and the governor signed it-- a bill in 2009, to have advanced medical psychologists with more autonomy. What did New Mexico do? In 2018, they've added nurse practitioners as supervisors, to speed the training along so that they can have more prescribing psychologists. I see my time's up. The malpractice insurance-- 15 percent higher-- it stayed the same. And I'm very familiar with New Mexico. I'm a member of their state association down there, and I go down there twice a year to carefully track how this is working for the state. I'm not a prescribing psychologist. It probably won't happen. I'm 62 years old. It's just-- I'm semiretired, but I see this as important. I'm sorry I exceeded the time.

HOWARD: No worries, thank you.

DANIEL ULLMAN: Sure.

HOWARD: Are there questions? Senator Arch.

ARCH: Thank you. And thank you for testifying today. I, I have a, I have a question. We talk about access,

DANIEL ULLMAN: Right.

ARCH: How do you factor in primary care physicians in prescribing? My guess, my general understanding is, due to a shortage of psychiatrists, primary care physicians probably prescribe more-- I mean, just given the number--

DANIEL ULLMAN: Right.

ARCH: More psychotropic medications than even psychiatrists.

DANIEL ULLMAN: Right. Yes.

ARCH: So as far as access goes, they are in the communities, as well, prescribing.

DANIEL ULLMAN: Right.

ARCH: Have you factored that into--

DANIEL ULLMAN: Yes.

ARCH: --to that issue?

DANIEL ULLMAN: Yeah, it's-- they're at the frontlines. And when you look at the pharmacy databases, you see those like where your [INAUDIBLE] 70, 80 percent of the psychotropics are there. In New Mexico-- I know more about that-- and they're-- and I've been out and traveled out to the rural areas where these prescribing psychologists are located. Their referrals are coming from the primary care and from the physicians, because they-- what is it-- the 20 percent that take up 80 percent of your time kind of thing? You have somebody that needs very intensive services. They need the psychotherapy; they need like case management. They have a crisis, you know, one week after the other. They may need a mental health board commitment. They may need hospitalization. How are you going to manage that in a primary care practice? And they need very close monitoring of their medications. So I'm not saying just every month or every three months-- on a weekly basis, until you get them stabilized enough, and they're saying, I get them on a maintenance dose and then we spread out the sessions. So how this has turned out is that over the years, what the prescribing psychologists say, I get most of my referrals from the docs. And they like it because we get back with them; they know what we're, what they're doing. You have to have that collaboration. And in our bill, it's even a higher standard; it is concurrence. When you check back with that person's PCP, with the medication plan-- and you'll hear about this from the people that are actually doing this-- is that they look at it and they go, I'm fine with this. Now I want to talk to you about this. And they appreciate having that communication, and everybody's on the same page. And I've kind of expanded--

ARCH: OK.

DANIEL ULLMAN: --beyond what you asked, so I apologize.

ARCH: All right. But thank you. Thank you for your answer.

DANIEL ULLMAN: OK.

HOWARD: OK. Senator Walz.

WALZ: Thank you. Thanks for coming today.

DANIEL ULLMAN: Um-hum.

WALZ: In your testimony, you talked a little bit about, you know, not only having the ability to prescribe--

DANIEL ULLMAN: Right.

WALZ: --medication, but also the importance and the goal of getting people off of medication.

DANIEL ULLMAN: If it's not needed.

WALZ: IIf it's not needed, right. Could you expand a little bit on that and maybe in conjunction with your role as far as the programing?

DANIEL ULLMAN: Right, right. Let me give you an example. And there's plenty examples from the prescribing psychologists in New Mexico. They're seeing somebody and they're on a medication for attention deficit disorder. They've been on it for years, and they were put on it many years ago. So they're taking it dutifully. And then the person says, I don't know that I have the, this disorder. And so the psychologist goes, I test for that. I've got psychological tests, and we'll do like a differential diagnosis. And they find out it's anxiety. So they've been taking an ADHD medication for a long period of time that, really, they didn't have the disorder. So as clinicians, we always go back to, what are the diagnoses? What are the issues going on? We need to understand what's driving these behaviors, kind of the root cause. So the treatment was, you don't need the med. The med-- you, you-- they worked with the primary care on-- we're looking at maybe [INAUDIBLE] trading them off. What are you comfortable with? And getting them off that end and treating the anxiety.

WALZ: Um-hum.

DANIEL ULLMAN: And in this case, it wasn't medication. It was behavioral things, mindfulness training. You work that out with your patient. What are they most comfortable with? What do they want to try? What are they motivated for? What options are out there? And there's many options other than medications. The controlled substances are a very important issue to keep your eye on. And the prescribing psychologists I see, they take this prescription drug monitoring program very seriously. So they're checking to see what people are on, and if they need to be on these medications, and that how they stack up with other prescribers, in terms to what degree they're prescribing ADHD medications or these benzodiazepines; that can be a problem. There's no prescribing of opiates in this bill. We cannot prescribe

opiates. And the prescribing psychologists have basically said we want nothing to do with that. So does that help--

WALZ: Yeah, yeah.

DANIEL ULLMAN: --answer your question about that?

WALZ: It's a good example. Thank you.

DANIEL ULLMAN: Thank you.

HOWARD: OK. Other questions? Senator Hansen.

B. HANSEN: Thank you. So I'm trying to read the tea leaves over here, right?

DANIEL ULLMAN: Yes.

B. HANSEN: So what happens if this bill passes, and now psychologists, clinical psychologists, practicing psychologists now have prescriptive authority?

DANIEL ULLMAN: Right.

B. HANSEN: And maybe the philosophy of patient care-- like what happens now?

DANIEL ULLMAN: Right.

B. HANSEN: In your opinion, do you see, perhaps now with prescriptive authority--

DANIEL ULLMAN: Right.

B. HANSEN: --for psychologists, we-- that we might see a concern that we might be turning more now to psychotropic medication--

DANIEL ULLMAN: Right.

B. HANSEN: --as opposed to nonprescriptive--

DANIEL ULLMAN: Right.

B. HANSEN: --methods? Like you said, there's a lot of different ways we can help take care of some of these issues,--

DANIEL ULLMAN: Right.

B. HANSEN: --such as anxiety and other kinds of things-- I-- 'cause a growing concern--

DANIEL ULLMAN: Right.

B. HANSEN: --not just for myself, but I think also in the public is the-- is sometimes now the, the growing use or sometimes overuse of psychotropic medications to help deal with our problems.

DANIEL ULLMAN: Yes.

B. HANSEN: And I think we're seeing that, especially in America--

DANIEL ULLMAN: Yes.

B. HANSEN: And we deal with medications versus nonprescriptive methods.

DANIEL ULLMAN: Right.

B. HANSEN: So now we're allowing psychologists who, in my opinion,--

DANIEL ULLMAN: Right.

B. HANSEN: --are like the people who go to, the experts, when it comes to--

DANIEL ULLMAN: Right.

B. HANSEN: --nonprescription medic-- methods for dealing with our problems.

DANIEL ULLMAN: Right.

B. HANSEN: Do you see an issue, like I mentioned before, that now we might start turning to medications more instead of like, why don't we talk to this some more? Let's just put you on this little thing first, and we'll keep talking through it, as opposed to, let's just keep working, let's push it a little bit more, let's try some different, other kinds of methods first. Is that a concern at all if, like, this bill passes?

DANIEL ULLMAN: Right. I appreciate that question a lot. Although I'm here as a proponent, I was not a proponent starting off. I was, I was

in college in the '70s and the '80s before this stuff come along, and a lot of our discussion was, you know, we don't want to turn into a profession where you're giving just out medications. And at the-- the psychosocial interventions are very powerful and useful. So I basically read, I went to debates about this, I got to know these prescribing psychologists I thought, I'm going to start going to some of these training and see what happens there. Of course, we found out a lot from the military. And how does this change a practice? So the, there's-- psychologists do studies. So there's been some studies about this. How has this changed your practice? And one of them that I saw is that they couldn't find evidence of a shift to bias towards using medication. They were still using the psychosocial. Now, there's a caveat in here. If you're in a very rural area in New Mexico and you're getting the most severely mentally ill people, that's going to change your-- the patient profile that you have, and you're going to be using medications more. I work at the Lincoln Regional Center. We should be very thankful that we have the psychotropic medications that we have for these people that are released. That's my job, actually, to help prepare them to go back to the community. In a couple weeks, if they're off their medications, then to get to the Regional Center, usually have to go through the courts or the mental health board, and it's usually something very serious. So for somebody like me, if I came out of retirement and called back to Lincoln Regional Center, I will be doing-- there'll be a lot of overlap with the psychiatrists. Support-- they-- I would support them, they would support me. This is very-- the-- this is, this is the way I had it balanced in my mind, is, I think this is what you do. You train somebody as a psychologist first, so that they deal with the anxiety of dealing with people's problems without a prescription pad, without a prescription pad 'cause, if you can just write a script and send them along, it might reduce your anxiety. That may not be good for them. So you need to learn all these psychosocial interventions that master's level people-- we're all learning and, by the way, psychologists develop. And then when somebody comes in, they go, geez, I've had a lot of experience dealing with anxiety. You have PTSD and medications have a kind of a limited role in here, and you look at evidence-based practice, it's kind of lower down. You try cognitive behavioral therapy, exposure therapy, and these [INAUDIBLE]. I think, really, the evidence weighs towards not so much medication, but it might be helpful, particularly if you're doing psychotherapy. And it is difficult for them. It's very difficult. They may have a lot of anxiety, they're having problems learning, picking up the skills, and a little medication for a period of time would be helpful. I-- the

people that are following me are, are well trained. They're, they're, they are in school getting this training, one has been a prescribing psychologist for eight years, can answer this much better than me. But I just wanted to share with my own personal story, 'cause I would not have brought this unless I had thoroughly studied it. And going to New Mexico twice a year and talking to them has really had me thinking this could do great stuff. Now are there people out there? Are there people out there that it's going to make this in some kind of moneymaking thing? And I think the prescribing psychologists police each other and keep an eye on each other. And I think that's also a part of it. Prescription Drug Monitoring Program-- I think you could do a lot, checking to see if somebody is-- there'd still have to be a psychologist. They're still accountable to function as a psychologist. You cannot do this without your psychology license. I think that will help, also, balance it out. But I greatly appreciate your question. Thank you, Senator.

B. HANSEN: Yep, thank you.

DANIEL ULLMAN: Am I going too long? I'm sorry.

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

DANIEL ULLMAN: OK, thank you very much.

HOWARD: Our next proponent testifier for LB817? Good afternoon.

MIKEL MERRITT: Good afternoon. Senator Howard and members of the Health and Human Services Committee, my name is Mikel Merritt, M-i-k-e-l M-e-r-r-i-t-t. I was born and raised in Nebraska, graduated from North Platte Senior High and, ultimately, from UNO with a Ph.D in psychology. I've used that degree in my training to serve the past 14 and a half years as a psychologist in the United States Air Force, working in mental health clinics at six permanent duty stations, as well as multiple forward operating bases and outposts while deployed to Afghanistan. It is my intention to return to Nebraska to practice here as a psychologist after my military career. In 2008, I began the multiple years of postdoctoral training, practica, national exams, and supervision in psychopharmacology. My training involved learning hands-on physical assessments, in-depth training on classes of medications, their impact on body systems, and interactions with other medicines. Along with those courses was an advanced study of ethics, and the impact that prescribing could have on ethical concerns. I was

also required to complete a practicum, working in primary care clinic, demonstrating assessment capabilities, and a practicum for focusing on treating mental health patients with psychotropic medications or determining that medications were not the appropriate warranted treatment. I've been independently prescribing since 2011, treating members of the armed forces, members who carry weapons, work on military aircraft, work with sensitive projects, work with munitions including nuclear munitions-- in short, members with whom there is very little room for error. Unsafe or erroneous prescribing practices could end a career, cost taxpayers millions of dollars in equipment damage and costs to train replacements, and could potentially cost lives. The most striking thing that I can tell you about working in the military is the high level of collegial support and partnerships. I was supervised by a psychiatrist, and since I began independently prescribing, I have had outstanding professional relationships with psychiatrists, including supervisory relationships of both directions. When we, as mental health provide-- professionals are paid based on our rank and years of service, not our units of service or how distinguished our professional appointments are, there's no resistance to psychologists prescribing. I've experienced countless physicians calling me to consult on prescription questions and referring members to me for the benefit of treatment from a provider with mental health specialty. The same has been true of prescribing psychologists throughout the Department of Defense and in states where prescribing psychologists have existed for over a decade, New Mexico since 2002 and Louisiana since 2004. In talking with my patients, what I hear most frequently is how much they appreciate the fact that there are fewer providers they have to see to get care. This is most striking when dealing with victims of trauma, vulnerable patients who are asked to recount their trauma multiple times to multiple providers. When seeing me, they're able to access the full range of care with greater ease. In addition, having fewer providers averts the patient questioning which provider they told what. Did they mention sleep difficulties to their prescriber, their therapist, or both? Is it a symptom of needed, of a new tree, of a new disorder in need of a new treatment or a side effect from the current medication regimen? Adding to that, the bill before you requires prescribing psychologists to interact with a patient's primary care provider. No other provision of mental healthcare carries that requirement, a requirement that the care team at least all be aware of the diagnoses and treatments involved in a member's care. This, too, closes a gap in care and increases the safety afforded to our patients. Throughout today's testimony, you'll hear opponents tell you that it's unsafe. Some may

be so audacious as to say that additional mental health prescribers are unneeded. None of them will point to objective evidence of safety concerns. The training is focused, rigorous, and only available once a person has completed not only a Ph.D or Psy.D in psychology, but also a one-year internship in the practice of psychology, a national examination in the practice of psychology, a state-administered exam on the practice of psychology, and a one years of-- one year of supervised experience in the practice of psychology. Only then can they commence training of an additional three years, including practicum requirements in general medicine, prescribing mental health medications, and seeing mental health patients, another national exam, another period of supervised practice, all to practice with an extremely narrow subset of medications for a defined set of dysfunctions. This concludes my testimony. I'd be happy to answer any questions.

HOWARD: Thank you.

MIKEL MERRITT: Thank you.

HOWARD: Are there questions? Senator Hansen.

B. HANSEN: Thank you. Thanks for your testimony.

MIKEL MERRITT: Certainly.

B. HANSEN: More of an opinion question. I've always viewed psychologists and psychiatrists-- not, not one was really better than the other.

MIKEL MERRITT: Sure.

B. HANSEN: They both kind of work collaboratively together as a team. So not counting the prescriptive authority now with this, with this bill passing, potentially passing, what's the difference now between a psychologist with prescriptives, you know, with authority, psychologist versus psychiatrist then? What would be the difference?

MIKEL MERRITT: Between a psychologist with prescriptive authority and a psychiatrist?

B. HANSEN: Yes.

MIKEL MERRITT: So certainly in the training and background. My bachelor's degree was in psychology, my master's and Ph.D were in

psychology, and then all of my training in psychopharmacology was focused primarily on psychotropic medications and how they interact with other medications in other systems within the body. So training-wise, an MD completes medical school and then gets additional specialized training in, in psychiatry. Functionally, when we see patients, my experience has been, while it will vary from school to school, I have more training in traditional therapy and traditional behavioral modification strategies to use in conjunction with, with psychotropic medications. Functionally, for the patients we see-- so our psychiatrists will typically serve as the medical director for like our substance use subclinic. Again, this is within the military system, within the Air Force. So there are some slight differences in that regard. Most of the patients that the psychiatrist sees are in therapy with someone else within the clinic. So they're doing just kind of medication monitoring, and I do that for my own patients. So our, our patient load profiles are different because I'm typically seeing patients that I'm doing therapy with.

B. HANSEN: Um-hum. OK, thanks.

MIKEL MERRITT: Did that help? OK.

B. HANSEN: Yes, I think so.

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

MIKEL MERRITT: Thank you.

HOWARD: Our next proponent testifier for LB817? Good afternoon.

MARILOU REYES: Good afternoon. My name is Marilou Reyes, M-a-r-i-l-o-u R-e-y-e-s. Good afternoon, Senator Howard and members of the Health and Human Services Committee. I'm a pediatrician, practicing in Beatrice for the last 10 years, and have worked in psychologists-- with psychologists throughout my medical training and in my pediatric practice. It wasn't until I practiced in rural America that I realized the value of working with psychologists and their expertise in behavioral health. Prior to coming to Beatrice, I worked in a slightly larger city with greater mental health resources. The shortage of mental and behavioral health services is magnified in a rural setting. This is seen in my daily office visit from patients, requesting-- from parents requesting help with their child who is anxious, depressed, hyperactive, autistic, bullied, or just not listening. When our

clinical doctorate psychologist, Dr. Kimberly Hill, joined our practice, it provided our families the much needed education and proximity of care. My relationship with Dr. Hill is one of collaboration in medicine and in mental health, since she often sees them more than I do. We share a common philosophy, as she aptly says: skills before pills. When I refer to my-- when I refer my families to her practice, I receive frequent feedbacks. When I-- when there is a crisis in a family, I am immediately contacted. In 2017, I was approached regarding the proposal to allow licensed doctorate psychologists to obtain postdoctoral training in psychopharmacology, to earn privileges to prescribe psychiatric medications. The purpose was to address the shortage of behavioral health prescribers in Nebraska, especially in rural health. Knowing firsthand this shortage, reading their plan, and reading the arguments, I wrote a letter in support of this proposal. LB817 is a well thought out bill, which I have read-- all 32 pages-- with the goal to increase mental health prescribers in Nebraska. It is designed to have those already dedicated to mental and behavioral health to have more tools to provide a more comprehensive care for patients. This could be cost-effective for families and organizations. There are guardrails built in which restrict what they can prescribe, their extensive training that they are required, and their partnership with the primary care physician providing oversight, and continued competency requirements throughout their career. Although this bill does not solve all the mental health problems, it does address a glaring need of more mental health prescribers. I'm asking you to look at this bill closely, and ask your support because it affects thousands of Nebraskans. Thank you.

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

MARILOU REYES: Thank you.

HOWARD: Our next proponent testifier for LB817? Good afternoon.

TRAVIS GROFT: Hello. I'm Travis Groft, T-r-a-v-i-s G-r-o-f-t. I'm the senior director of neuropsychology at Madonna Rehabilitation Hospitals, which has facilities in both Lincoln and Omaha. Madonna is a freestanding physical and medical rehabilitation hospital, serving persons with a variety of neurological and medical conditions, including brain injury, stroke, spinal cord injury, and pediatrics. Madonna is-- has over 2,000 employees between the two campuses, and is among the top ten employers in Lincoln. Last year, Madonna served over

2,400 patients, many of whom were highly medically complex. I've been employed for Madonna for nearly 27 years. I'm representing Madonna Rehabilitation Hospitals today, and Madonna supports this bill. Madonna's patient population includes individuals struggling with severe mood and behavioral problems due to the direct effects of their injuries or problems in adjustment to their condition. These disorders include: depression; suicidal thoughts and behaviors; intense anxiety; agitation; confusion; psychosis; and physical aggression. Madonna adopts a holistic approach to treatment, including: psychotherapy; environmental management; nonviolent crisis intervention techniques; and treatments with psychotropic medications that are most often administered by physicians and psychiatrists. Across my 27 years at Madonna, we have consistently struggled to enlist the services of psychiatrists, who are the physicians most comfortable in-- at administering psychotropic medications. Numerous local psychologists-- psychiatrists-- have performed part-time work at Madonna over the years. But frequently their engagement with Madonna has been short-term and interspersed with periods of time with no psychiatric support. In fact, our Omaha facility has been unable to find psychiatry support in the three years since its opening. Because of the nature of our business, there's typically no need for a full-time psychiatrist on staff. Our needs in this area are relatively infrequent, but when the needs arise, they call for prompt and often intensive involvement of a prescribing practitioner with close, ongoing monitoring and, preferably, team-- treatment team integration. Although the psychiatrists who have worked with Madonna have been excellent practitioners who have worked hard to meet our needs, it is our impression that their many other commitments make it impractical to provide the level of support that we desire. On a personal level, I've enjoyed warm and respectful relationships with many psychiatrists across my career, and I respect their contributions, including the current Madonna-Lincoln consulting psychiatrist, who is an excellent practitioner. However, Madonna would strongly consider hiring a prescribing psychologist to meet our needs. Madonna already has an active psychology department at both facilities. Psychologists are trained in behavioral management and psychotherapy. And in addition-- and the addition of prescribing privileges would allow us to hire a full-time prescriber who could be immediately available, integrated into our interdisciplinary treatment teams, and able to monitor ongoing treatment response close, closely and frequently. We believe this would be to the benefit of our patients who need careful, ongoing, and integrated prescribing professionals to manage their psychological and behavioral needs in a safe and effective manner. For

this reason, Madonna supports this bill, to give limited progressed prescription privileges to psychologists who undergo the intensive additional training outlined here. In closing, I would like to mention that this bill appears to have the support of service providers for a variety of underserved populations, underserved both because those populations may be difficult to serve, and they may struggle with geographical barriers, such as in the western part of Nebraska. The prescription privileges in this bill will supplement the services provided by psychiatric partition-- practitioners in a number of ways: First, psychologists are simply more numerous and can provide more enhanced coverage to the entire state, in a more cost-efficient manner in some cases; Second, the psychologist practitioner represents a new and innovative type of practitioner, one that is well-trained to seamlessly provide both pharmacological and nonpharmacological interventions, such as psychotherapy, family therapy, and psychological assessment. To my knowledge, this model has proven safe and effective for years in other states and contexts, and will place Nebraska on the leading edge of an innovation to meet the challenges of rural areas and complex populations. Thank you, and I would be happy to answer any questions,

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

TRAVIS GROFT: Thank you.

HOWARD: Our next proponent testifier for LB817?

RYAN ERNST: Is this community water up here? Good afternoon, Senator Howard and the committee. My name is Dr. Ryan Ernst; it's spelled R-y-a-n E-r-n-s-t. I'm a Nebraska licensed psychologist. I grew up in Hastings and attended college at UNL. Here in Lincoln, I've worked in private practice, I have worked for the state of Nebraska, and I spent just over eight years at Madonna Rehabilitation Hospital. In 2019, when Iowa enacted their prescribing psychologist law, I readily located a rural hospital in Iowa that agreed to provide the physician supervision needed for licensure. The hospital saw the value in the comprehensive services a psychologist could provide and additionally offered a full-time position. I accepted. I accepted, and as a Nebraskan-- so I accepted the position and, as a Nebraskan, I became the first psychologist in Iowa to begin active training under their new law. Though I was very happy with my employment here in Lincoln, the professional and personal benefits of becoming a prescribing psychologist in Iowa were great, despite the 800 to 1,000 miles now

that I drive every week. I left Madonna and I had to close the private practice that I had started in Grand Island, where I was the only board-certified neuropsychologist west of Lincoln for the entire state. I was now a magnet for young and talented psychologists, and I don't claim to be either one of those. There are several Nebraska psychologists who are either currently pursuing or already completed training in psychopharmacology. Many of these psychologists also pursue opportunities. Many of these psychologists will also pursue opportunities in Iowa and other states, just as I did. I urge the committee to carefully consider how not passing LB817 will cause a problem of retention and recruitment of psychologists in this state. And conversely, passing LB817 will give Nebraska a competitive edge for recruiting new psychologists to our state and retaining the excellent ones that we already have. The committee will hear opposition today from a small number of medical providers and possibly some organizations. However, I can tell you, from my interaction with physicians and midlevel providers in Iowa and Nebraska, the vast majority do not oppose the idea of prescribing psychologists who work from a narrow formulary, exclusive of narcotics, and only with the consultation and collaboration with a patient's primary care provider. During my time so far in Iowa, I have received referrals from nearly all of the physicians and nurse practitioners in the hospital and for medical providers in the greater rural community. I have had physicians defer ongoing care of their patients to me, including the prescription of psychotropic medications. So my point is, there is a trusting relationship among us. You may not get that in this forum today, but I can tell you, when you're in the clinics and hospitals in Nebraska, the sentiment is much different. There is a trusting and collaborative relationship that we have, and medical providers do, to a great extent, appreciate our knowledge of psychiatric medication management and psychopathology. The committee will hear today that allowing psychologists to prescribe is not a safe option. What you will not hear are facts to substantiate this tattered argument. If, during the 20-plus years of psychologists prescribing medications, unsafe practices actually occurred, those instances would be highlighted by the opposition today. To the contrary, psychologists tend to be conscientious and judicious practitioners with an excellent safety record. There are-- competent practice is a direct result of the comprehensive training. The committee will hear today, in general reference, that our master's degree medical training is lesser than the master's degree training earned by nurse practitioners and physicians' assistants. You will not hear valid and convincing specifics of what our training lacks because, in actuality, all of

these programs are much more similar in content and duration than they are different. Thank you very much for your time today. Are there any questions?

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

RYAN ERNST: OK, thank you.

HOWARD: Our next proponent testifier for LB817?

TYLER NEWTON: [INAUDIBLE], senators.

HOWARD: Good afternoon.

TYLER NEWTON: My name is Dr. Tyler Newton, T-y-l-e-r N-e-w-t-o-n. I'm a provisional psychologist with the Nebraska Department of Correctional Services. And today I speak on behalf of my personal experience as a professional psychologist, and not on behalf of NDCS. I hope my testimony today will provide insight into how LB817 could benefit Nebraska's ability to improve mental health services. I think it would be beneficial for me to explain my professional and educational background. I am, first and foremost, a native Nebraskan. My ancestors were pioneers who settled land in Bayard and Bridgeport. I was born in Scottsbluff and I graduated from Western Nebraska Community College with my first [INAUDIBLE] college degree. I obtained my bachelor's and first master's in community counseling from Chadron State. My first license was as a mental health practitioner in Nebraska. My first employment, as a therapist, was in Lincoln in 2008. In 2010, I moved to Arizona and began acquiring my second master's and a doctoral degree in clinical and forensic neuropsychology, from the Arizona School of Professional Psychology in Phoenix. Currently, I've completed my third master's in clinical psychopharmacology from the Chicago School of Professional Psychology. I moved home to Nebraska in January of 2013, to complete my postdoctoral hours required for licensure requirements as a psychologist. I began my position at NDCS in January, 2018, to earn these on super-- these supervised hours. I have since completed over 2,300 hours, which exceeds the licensure requirements anywhere in the United States. I am at the point where I only need to complete the EPPP in an effort to meet licensure requirements fully as a psychologist. I am at a crossroads in my career where I must do that which is best for my family of six children and my amazing wife, who nurtures them all. I can either continue my career here in Nebraska for NDCS or move to Iowa and

accept a job offer where I could prescribe for their Civil Commitment Center [SIC] for Sex Offenders. Nothing is more shameful to a Nebraskan than moving to Iowa [LAUGHTER]. However, I'd be forced to, if it benefited my family in a meaningful manner. I work as part of sex offender services for NDCS. I generally perform LB1199 Sex Offender Commitment Act evaluations. I also assist in many other mental health related duties for NSP-- the State Penitentiary. I believe expressing the views of the frontline professional convey cleaner message to the Senate committee. I walk through the gates of a prison every day to provide mental health services. It has been my experience, over the last two years, that these professionals perform their duties, serving a population of individuals who mirror that of a psychiatric facility. I say this because I've worked in both settings and I can compare. I watch as these professionals carry workloads that are, in my perception, incomprehensible. They do so without complaining, and they do so with the utmost of professionalism. Regardless, these professionals cannot be expected to do the impossible. I can only express what I witness as that of a military triage tent during battle. The beds fill up and you can only perform at your optimal best. However, you cannot save everyone. Does that make you heroic, a failure, or human? I don't know, but I would imagine it would make you eventually feel overwhelmed and hopeless. What I do know definitively is that I see a staff of mental health professionals who I would support any time of the day or week, thus bringing me to why I'm here today, senators. I'm asking you to consider passing LB817 to bring in more support. I have heard, during my experience, that the cavalry was supposed to arrive. It has been two years on my watch, and that has never come to fruition. In fact, I've watched the numbers of mental health professionals dwindle at what I would consider an alarming rate. LB817 more assist in supplying that cavalry of highly experienced and educated professionals who can assess, treat, and prescribe, not only to the environment in which I work, but also every hospital, rural area, underrepresented population, veteran and treatment facility in the state. Every day I walk through the prison gate and through a prison yard. I watch as prescribing professionals become overburdened and inundated with ongoing clinical "crisises" that often involve prescriptive necessity. I watch mental health staff work hard to stay afloat with inmates who are psychotic, delusional, disruptive or violent. This requires an immediate need for psychiatric support to stabilize crisis situations or prevent them. I am forced to stand down and not perform what I know I am capable of doing. By having the ability to provide prescriptive privileges, I can provide much needed relief, support, and guidance. I

can assist in improving quality of care, security, and safety. I believe I could increase the likelihood of an inmate's continued mood stability and assessment of mental health issues to reduce their recidivism. I could assist with stabilization of some of the severely mentally ill and improve the likelihood of a chance of reaching a parole date versus staying until their tentative release date, thus decreasing overall population. Without LB817, I'm just a dreamer who stands on the side and watches the current struggles of my coworkers. I've spoken to many psychologists, psychiatrists, and supervisors that I work with about their feelings considering prescriptive authority. Not one was against LB817. The feedback I've received has been extremely supportive. I've heard a lot about Nebraska values in politics. It's an all too common theme to hear someone quote "Nebraska values" and never define what they mean by that statement. What are Nebraska values, after all? Well, as a Nebraskan who grew up driving a tractor and setting irrigation tubes, with blistered hands at 12 years old, for no pay, and only because it was to help an aging grandfather, I was taught this Nebraska value: We do not stand by with our hands in our pockets and watch someone else struggle to complete a job. We jump in and help. By telling me to stand by and watch as my fellow coworkers struggle, is asking me to defy that which is at the very fabric of my Nebraska roots. Please consider this when deciding on LB817. I speak as one of the many professionals who are qualified and ready to step in and fill the gap in mental healthcare. Thank you

HOWARD: Thank you. Are there questions? All right. Thank you, Dr. Newton, and--

MURMAN: I, I've got one.

HOWARD: --thank you for working to correct-- oh, Senator Murman. Thank you.

MURMAN: So thank you for coming in. So in your work at the Nebraska Penitentiary, I assume you work with psych-- psychiatrists also?

TYLER NEWTON: We have very few, but yes.

MURMAN: OK. So that's, that's what I'm-- my question is trying to get at. You know, if you're working with psychiatrists, couldn't they do the prescribing, rather than the psychologists?

TYLER NEWTON: We have so many different institutions, and we don't always have a psychiatrist available at our institution. So the waits

are very long and often they use things like telehealth. And if we're on a lockdown situation, they're missing those appointments. The psychiatrists that I know, two that are full-time, are generally tied to LCC, where we have the mental health unit. And their caseloads are so overwhelming, they're not able to put out the fires that grow at every single institution. Having somebody like myself who's there, readily available and immediate, it really does help take that burden away. Otherwise, you're just triaging the most severe cases, and they're the ones that rise to the top and get seen; the other ones are left to the wayside.

MURMAN: OK, thank you.

HOWARD: Sorry for forgetting, Senator Murman. Do you want to talk about-- how many, how many prescribers do you have in that correctional facility that you work in?

TYLER NEWTON: I can think of two psychiatrists and maybe two part-time APRNs.

HOWARD: Who prescribe?

TYLER NEWTON: And we don't always have a prescribing physician at our facility.

HOWARD: And what's your census?

TYLER NEWTON: At NSP, I know we're right around 1,500, I believe total right around 5,500 with all institutions and facilities.

HOWARD: OK. But for, for where you're at--

TYLER NEWTON: At least 1,500. We have a restrictive housing, as well.

HOWARD: OK, so 1,500 and then four prescribers?

TYLER NEWTON: Nobody there on a full-time basis.

HOWARD: OK.

TYLER NEWTON: LCC is where I know the psychiatrist is mainly housed, and that there they have a mental health unit. What we have at an NSP is like a secure, secured nursing facility with very minimal beds. Typically, you're looking at the restrictive housing population, you know, as a holding area.

HOWARD: OK. And I know you're testifying on behalf of yourself, but--

TYLER NEWTON: Yeah.

HOWARD: --did you need to get--

TYLER NEWTON: This is my experience, and--

HOWARD: DId you need to get per--

TYLER NEWTON: I have to make that clear to all the senators--

HOWARD: Yes.

TYLER NEWTON: --that I'm on my own behalf, not theirs.

HOWARD: Did you need to get permission to come visit us today?

TYLER NEWTON: I asked for permission.

HOWARD: OK.

TYLER NEWTON: Yeah, long story.

HOWARD: -OK.

TYLER NEWTON: But on my own behalf, not theirs.

HOWARD: All right. Any other questions? Seeing none, thank you for visiting with us today.

TYLER NEWTON: Thank you.

HOWARD: All right, our next proponent testifier? Good afternoon.

ANNE TALBOT: Good afternoon. Thank you for allowing me to testify. And my name is Dr. Anne Talbot, from Scottsbluff; and that's A-n-n-e T-a-l-b-o-t. The testimony I'm here to give you pertains directly to the desperate need in western Nebraska and what we can do to help address that problem, including numbers of young or early-career psychologists in Scottsbluff alone, already poised to take the postdoctoral master's degree in psychopharmacology and obtain training to obtain a prescriptive authority. Since 1984, when I first moved to Scottsbluff, I've seen more than 30 psychiatrists come and go, beginning with my own father-in-law, who retired early due to health problems brought on by the stress of failed recruitment efforts and

work overload. Most of the time, we've had no more than two psychiatrists for the entire western half of the state. So I'm not talking just about the Nebraska Panhandle or Scotts Bluff County. Nebraska Panhandle alone has something like 80,000 residents. And so we are now down to one psychiatrist employed full-time at Regional West Medical Center. While I strongly support efforts to increase providers across specialties, you can-- will hear from our psychiatry colleagues about their efforts to address that problem. But I'm here to tell you, those efforts are not enough. They haven't solved the problem. And we have multiple heart-wrenching examples of how these aren't working. In other testimony I tried-- I was working on, I have a list of really gut-wrenching examples of desperate situations. I can tell you one incident, earlier this week, where a client of mine was in tears, learning that the second psychiatrist was moving to a part-time practice, and her elderly mother was told she had a four-month wait for her next appointment, and she's an, an existing patient. Not only that, my client had been in treatment with, not only with me, but with that leaving psychiatrist for 15 years. And she was desperately terrified how she would get her medication managed from here on, because she couldn't get an appointment with the other psychiatrist or the nurse practitioner in that office. And this is medication that had kept her out of the hospital for ten years and had allowed her to continue working full-time. This led to suicidal ideation. She had thoughts of wanting to drive in front of a train, and she almost required hospitalization. That's only one example, and I have many others. In general terms, what this shortage means, for our vastly underserved rural residents, is wait times of a minimum of two to three months on average, not only for initial appointment, but for follow-up, with further delays in scheduling or rescheduling due to cancelations-- unfortunate, nobody's fault-- from inclement weather, childcare obligations, or lost transportation, all of which can, can lead to more delays of up to, or upwards of, six months. And although, just to add a note in here, although people still have to travel long distance to see a prescribing psychologist, I would add a more efficient system of delivery, both psychotherapy and medication management makes that process less time consuming and more efficient. But back to the issues. The destabilized and worsening symptoms due to this lack of follow-up or running out of medication, leading to crisis situations that place these patients and others in jeopardy, and result in unnecessary and costly ER visits for psychiatric emergencies that could have been prevented with appropriate medication management. People of all ages with unnecessary symptoms that impede their function and their well-being, sometimes on multiple medications they

might not need, as a result of fragmented and uncoordinated care that harms their ability to comply with treatment recommendations and allows them to function academically, in the workplace, or in their general community functions. And to address your question, also, Senator Hansen, about the issues with overprescription, this is where we prescribing psycho-- psychologists would really take a look at the range of medication that's not needed. We start with accurate diagnosis, as well as looking at medication management. And prescribing psychologists also have the option to unprescribe unnecessary medications. That's a standard that prescribing psychologists follow. Increased-- back to the other issues, if I can plow through that so I can keep your attention on this-- increased attention of parents and others wanting to know, struggling whether to agree to a medication in-- is appropriate, with a 15-minute time limit-- that is all they have, that they've waited three months for-- to determine whether they have the recommendation that is right for themselves or their children. Numerous clinicians of all disciplines in a daily struggle, struggle to obtain appropriate complex psychotropic medication management for their patients, who can tell you about desperate situations in which they have been on call with complicated, high-risk patients in crisis who have no access to psychiatric consultation. So I can talk quickly about the solution if I still have some time.

HOWARD: We're going to ask you to wrap up your final thoughts; you have a red light.

ANNE TALBOT: Yes. Can I keep going? Or--

HOWARD: Finish-- finish your final thoughts and then--

ANNE TALBOT: OK.

HOWARD: --we'll see if there are questions.

ANNE TALBOT: So I've got in-- I've got data in the-- at the end of this testimony that includes consumer survey data on the benefits. I also want you to tell-- to tell you that as I'm a-- as a-- part of the solution is, I'm training faculty with the High Plains Internship Consortium, with-- which is located, partly located in my clinic. And we, and we have, we have a, an ongoing pipeline of eager psychologists. We had 43 applicants for four different slots, including six, applying to my clinic alone, of young graduate students who want to complete a doctoral psychology internship in rural and

frontier settings. And they are eager and ready to go through that training. We have, you have written testimony from four psychologists-- or two at least-- who are in Scottsbluff alone, who are willing to take the, who are prepared to take the training. And if I could say one last thing, if I have permission--

HOWARD: Sure.

ANNE TALBOT: Thank you. As an experienced psychologist, but also as a nurse with a master's degree in mental health nursing, and I was a former ER-ICU critical care nurse, I have no tolerance for marginal, unsafe, or unnecessary medical practice that harms the people and the communities for which I am passionately advocating. From that background. I can tell you the training and practice for psychologists with prescriptive authority is safe, effective, and help-- meets a desperate need. And that's why I much appreciate you giving me a chance to plow forth with all the things I really am eager to tell you, to see how this would be a part of the solution if you would consider supporting this bill, so these specially trained psychologists can join with other colleagues in addressing the problem. Thank you so much.

HOWARD: Thank you. Are there questions from the committee? Seeing none, thank you for traveling so far to visit with us.

ANNE TALBOT: Thank you; much appreciate that.

HOWARD: Our next proponent testifier for LB817?

BRETT SAMSON: Hello.

HOWARD: Good afternoon.

BRETT SAMSON: Good afternoon. My name is Brett Samson, B-r-e-t-t S-a-m-s-o-n. I might be the only person up here that's not a doctor, so it's a little intimidating. Thank you for the opportunity to speak to you on this subject. I'm the CEO and president of the Autism Center of Nebraska. We are a licensed developmental disabilities provider that provides residential and day services to adults and children in Omaha, Lincoln, and Fremont, also surrounding areas such as Blair, Valley. I've worked with people with developmental disabilities for over 21 years in Nebraska and Iowa. But I am a Nebraskan; I'm from Valley. I've seen countless people and their families live a more fulfilling life due to quality support and programs provided by

companies like the Autism Center. However, the importance of appropriate and safe use of psychotropic medications, for many people we work with, cannot be understated. For many people we work with, the absence of appropriately prescribed medication does affect their safety and ability to meet their desired goals. Not enough medication or too much medication can result in increased police calls, hospital stays, violent and self-abusive behavior. The shortage of specialists who can prescribe and, and, just as importantly, unprescribe psychotropic medication can and does present real challenges for the people we support. Waitlists for new patients are sometimes longer than a month, sometimes two months, maybe longer. A person begins displaying behavior that can be unsafe or unhealthy to themselves, it can take weeks to get into a specialist who can adjust that medication. Within this time frame, there can be, again, multiple incidents that put people at risk or create police calls that could have potentially been avoided. Please keep in mind that the company that I work for operates in Nebraska's two largest cities and in Fremont. So we have the most prescribing specialists in the state in our areas of operation; and, and it still seems inadequate. There have been several instances where we began to support a person that's moved to Omaha or Lincoln from different cities around the state. Due to waitlists, we will drive them as far away as Norfolk, Grand Island, and other cities hours away, just to be seen and have their medications adjusted, or sometimes just their meds refilled. Furthermore, it is common for psychologists to see the people we support just more frequently, sometimes weekly, twice a month. They have great knowledge of the strategies and the programs that we, as providers, are implementing to help the person live a safer and more fulfilling life. They are aware of the day-to-day struggles and challenges that that person is facing and how the current medications are affecting them. I'm in support of this bill, and I have a couple of real-life scenarios I'd like to share with you. Nearly two years ago, I received a call from APS, Adult Protective Services, and Omaha Public Schools about a young man who was 18 years old, with autism and developmental disabilities, who was dropped off at a homeless shelter by his parents because they could not keep the rest of his family safe from his violent outbursts or him safe, due to him trying to jump out of moving cars on Highway 75. We picked him up and we agreed to support him 'cause that was the right thing to do. We didn't know much about him at all, other than just what was described to us. This young man began to almost immediately see a psychologist who not only suggested a new diagnosis of what he was previously diagnosed with, but also several medication changes that would hopefully help him stay

safe. Due to wait times to get him in, it took, it took a month, month and a half, actually, for him to get those medications prescribed. The psychiatrist did, did change the diagnosis, as well. So this young man began living quite a different life after that change. He's gone over five months without a single interaction with the police, where he was averaging more than two a week. When he used to physically attack the staff and attempt to run into traffic, he's now coping with these emotions and communicating in a safe way. He's excelling in his education transition program. And I actually got to see him attend prom; he had a great time. Had his psychologists had the ability to prescribe earlier, this young man most likely would have been displaying this productive and safe behavior much earlier, and we would have avoided many of those near misses. I'm in support of this bill. I have another example, but I see I'm on a yellow, so I'll close. I'm in support of this bill and I've seen the negative consequences of the shortage of prescribing specialists and long wait times, also the consequences of meds being prescribed with limited, limited-- they don't see them very often, so they just don't know them very, very well sometimes. Psychologists, like I said earlier, they'll, they'll see somebody much more often-- very interactive with us. And that day-to-day struggles, that communication, it just seems to work. And I think somebody else mentioned, you know, when you have so many people involved, sometimes medications don't get changed fast enough, several instances where we've had too many people on too many prescriptions. And once that was changed, we saw an immediate change-- well, not immediate, but after a week or so, saw a change for the better. So I'm in support of this bill. 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. Our next proponent testifier for LB817? Good afternoon.

JERRY WALKER III: Good afternoon, Senator Howard, members of the Human Health and Human Services Committee. I'm Jerry Walker, J-e-r-r-y W-a-l-k-e-r, and I'm the 3rd, if that matters. I'm a licensed and board-certified counseling psychologist. Recently moved to Nebraska about seven months ago. I previously served in this capacity for six years in the United States Air Force, both stateside and in the Middle East. And I worked alongside several prescribing psychologists during this time. Currently, I'm the manager of psychology services at Nebraska Medicine in Omaha. And in this role, I oversee the operations of all clinical psychologists in our enterprise, partner with

physician leaders throughout the institution, and represent our interest in the larger Omaha healthcare environment. I believe this position has provided me with a unique insight into the mental health treatment needs of Omahans and, to some extent, Nebraskans. Last year, one of my patients, a Vietnam veteran with severe and chronic PTSD, was facing a six-month wait time to see a psychiatrist at the Omaha VA. I worked to have him seen by a Nebraska Medicine psychiatrist, but it was still two months before he could get in for an appointment. This is, unfortunately, a common occurrence. Two to three month wait times for prescribers of psychotropic medication is the norm. There are simply not enough trained and credentialed prescribers of psychotropic medication to meet the current needs of our population. And this problem is gradually becoming worse. I wish I could have managed this patient's medications and advised him which of his nine different prescriptions to continue taking and which ones to stop. I had the knowledge to help them, but I did not have the legal capacity to do so. So he had to wait and continue to suffer with debilitating anxiety and nightmares for two months. LB817 would change that. The opposition will tell you it's dangerous for psychologists to prescribe even the small scope of medication. They will ignore the fact that our training to prescribe includes courses in anatomy and physiology, pathophysiology, neuroscience, two courses in pharmacology and four courses focused exclusively on psychotropic medications. They will ignore the fact that our training involves conducting health and physical examinations, consideration of drug interactions, and the influence of physical illnesses and other conditions, tailoring a medication to the demographics of the patient, years of supervision by other physicians, and a collaborative care model. They'll dismiss the fact that peer-reviewed research findings from 2012, and just last year, have demonstrated, by physicians no less, that the postdoctoral training for prescribing psychologists has been deemed, deemed more rigorous, more rigorous than that which is required for nurse practitioners and physician assistants to prescribe the same scope of medication. And you will hear hypothetical scenarios of risk to patients, ignoring the fact that psychologists have been safely prescribing in the military and two states for nearly 20 years. The opposition will tell you that primary care, primary care physicians are in a better position to prescribe psychotropic medication than postdoctorally-trained psychologists. However, I can tell you that, in my experience working in multiple primary care settings, these same physicians frequently have asked me, a psychologist, what medication they should prescribe and at what dosage. It would seem that the preparation of nonpsychiatrist, nonpsychiatrist physicians to

prescribe psychiatric medication is, in fact, comparatively lacking for what we are proposing. The opposition will tell you their solution is to encourage partnerships between psychiatrists and primary care physicians, something psychologists already do, and something that would continue under the provisions of this bill. I come to you also selfishly, as I'm currently taking the final courses in an approved postdoctoral Master's [SIC] of Science program in clinical psychopharmacology. And my hope is that I will, I may be able to use that knowledge to, to continue to practice here and serve Nebraskans. Therefore, I urge you to strongly pass LB817. Thank you for your time and consideration.

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

WILLIAMS: Thank you, Senator Howard. And thank you, Dr. Walker, for be, being here. I just wanted to be sure of one thing with your description of your testimony and the-- using the letterhead of Nebraska Medicine. Is your testimony on behalf of Nebraska Medicine?

JERRY WALKER III: Thank you for that question. It is on behalf of the clinical psychologists who I supervise at Nebraska Medicine, not on behalf of the larger institution.

WILLIAMS: Thank you.

HOWARD: Senator Hansen.

B. HANSEN: Thank you again for coming to testify. I've just got a couple questions. You said you moved here, right? Did you move from Iowa [LAUGHTER]?

JERRY WALKER III: No, from Virginia. I lived there the past six years when I was working in the United States Air Force.

B. HANSEN: OK. Wanted to make sure I didn't have to apologize from the state of Nebraska. One other thing. I don't know what the current state of like malpractice insurance would be or-- for you guys if it ever comes to the fact that we have to start prescribing medications. Is-- would you even be able, be able to get malpractice insurance for that? Or-- because that's [INAUDIBLE]-- you know, we're talking about a totally different scope and different kinds of issues that can arise. I don't know if malpractice insurance for psychologists--

JERRY WALKER III: Um-hum.

B. HANSEN: --have kept up with some legislation in other states, or if that would affect how your ability to prescribe 'cause if you don't have the malpractice insurance to prescribe--

JERRY WALKER III: Um-hum.

B. HANSEN: --you probably won't, you know. So I didn't know for sure if there's-- if, if you've been up to date on that at all or noticed anything like that.

JERRY WALKER III: That's a great question. I actually am-- I can't answer that off the top of my head. I will tell you, at the institutional level, psychologists are covered under a Nebraska medicine policy. But I also have my own insurance outside of that, because I have a telehealth practice in addition to my role at Nebraska Medicine. So there are national companies that do cover prescribing psychologists. I'm just not aware of those right now.

B. HANSEN: OK. That's fine.

JERRY WALKER III: Yeah.

B. HANSEN: Thanks, appreciate it.

HOWARD: Other questions? Seeing none, thank you for your testimony today. Our next proponent testifier for LB817? Seeing none, is there anyone wishing to testify in opposition? Good afternoon.

TODD HLAVATY: Good afternoon, Senator Howard and members of the committee. My name is Dr. Todd Hlavaty, MD. I'm the current president of the Nebraska Medical Association. So I rep--

HOWARD: Could you spell your name for us?

TODD HLAVATY: It's Todd, T-o-d-d; last name is H-l-a-v-a-t-y.

HOWARD: Thank you.

TODD HLAVATY: I'm currently president of the Nebraska Medical Association and represent over 2,500 physicians in the state, and I'm testifying on their behalf, as well as my own, in opposition to LB817. I passed out letters of opposition that I received from our various members and they're enclosed. Personally, I'm an oncologist, I'm a cancer specialist, localized in North Platte, Nebraska. I run two cancer centers: the Anderson Cancer Center in McCook and the Callahan

Cancer Center in North Platte. I encounter this problem quite oftenly, in that a majority of my-- about 10 to 15 percent of my patients who have two conditions, both a psychiatric condition, as well as a cancer condition, require complex interaction between cancer drugs and psychotropic drugs. That interaction is a very testy interaction to actually experience because both those drugs have side effects that can cause considerable harm and, in some cases, death to the patient. Today, we will hear several test of-- testimonies on the risks to patient safety, LB817, that could potentially bring harm to Nebraskans, from the lack of comprehensive medication to a division of patient care, to alternatives to the bill, such as telepsych services, and even how the physicians' supervisory requirements within the bill do not rise to the level of our secondary providers, namely, nurse practitioners and physician assistants. The previous 407 process from 2017 will be mentioned today, and that's where I'd like to focus my comments to you. So this is not a new thing. In 2017, both the Board of Health and the chief medical officer voted against an extremely similar proposal to authorize psychologists prescriptive authority. Just over two years later, this decision should still carry significant weight with you all, considering no other state has adopted these prescriptive authorities since that time. We should all be concerned by the confidence expressed by the proponents in straying away from the traditional model of healthcare education. And we must remember healthcare professionals evaluated this proposal previously with a resounding rejection. I can tell you from a personal perspective, the traditional medical education includes four years of undergraduate, four years of medical school, in my case five years of residency and some fellowship time. In that time, we were asked to take a series of three eight-hour exams for board to, to pass our basic medical education licensing exams. And then I was asked to take a special exam that listed eight hours of written for my given residency, as well as an eight-hour oral examination. During all those examinations, pharmacology was, was a prime focus of those. Many experts highlight that psychologist prescriptive authority has a high potential for abuse of the profession by managed care, pressures to prescribe, and the desire to seek an easy solution. All of us are subject to that. But what you're seeing now is a movement to get that prescribing authority because healthcare is-- for the mentally ill is taking a side-- a highlight of our medical economy and more money is being focused in that area. With so many intricate issues that play within this bill, it's imperative that proposals as this one follow and gain approval through the 407 process. The process was designed for healthcare professionals with the utmost knowledge of these

intricate issues be subject for mat-- as matter experts. To stray from this process puts Nebraska patient safety at risk and establishes a dangerous precedent. Remember, you heard testimony earlier in the day about how we worked in the 407 process with the PAs, and we have done everything we can to try to meet the 407 process with the psychologists. The thing that sticks in this bill is the independence of their ability to prescribe drugs. So I'm asking you, for these reasons, in conjunction with the testimonies you'll hear throughout the course of our today, that the NNA respectfully asks you to reject the proposal and to keep the LB817 process in committee.

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

WILLIAMS: Thank you, Chairperson Howard. And thank you, Doctor, for being here. And thank you for being here from North Platte.

TODD HLAVATY: And that's true. In constant-- I guess, in refute, I do represent half of western Nebraska.

WILLIAMS: Well, we live right in the middle, don't we? So--

TODD HLAVATY: I know.

WILLIAMS: I have no doubt everybody that has testified today is concerned about patient safety. I have no doubt of that. I have some questions just to give you an opportunity to respond to some testimony that we've heard, just so I can get a broader feeling for that. Dr. Merritt testified that nobody that is in opposition to this bill will be able to give any objective evidence about the safety concerns, concerning the length of time that the military has been doing this and, also, the, the two states that have been mentioned. Have you got a response to the--

TODD HLAVATY: And you'll hear testimony from our psychiatrists into that-- respond--

WILLIAMS: OK.

TODD HLAVATY: --into that response. I want them--

WILLIAMS: And these--

TODD HLAVATY: --to go into that.

WILLIAMS: --questions that I'm asking, if, if, if anybody following you--

TODD HLAVATY: Yes.

WILLIAMS: --would be [INAUDIBLE]--

TODD HLAVATY: We have a-- we have a--

WILLIAMS: --would be--

TODD HLAVATY: We have a litany of people that actually, that--

WILLIAMS: Yeah, we have a time limit [LAUGHTER].

TODD HLAVATY: And so-- and I'm actually moving as fast as I can to avoid that.

WILLIAMS: My, my second question relates around. the, the-- well, it was actually a comment by Dr. Ryan Ernst, that he made, that in his interaction with physicians and midlevel providers in Iowa and Nebraska, he says, "the vast majority do not oppose the idea of prescribe-- prescribing psychologists." Would, would you agree with that statement?

TODD HLAVATY: I would not agree with that statement.

WILLIAMS: OK. And my last question that I would like to have you, as a medical doctor, address is the-- and you mentioned this in your testimony-- is the prescribing of PAs and nurse practitioners of these same lists of medication. And of course, that's been through a 407.

TODD HLAVATY: Right.

WILLIAMS: Has to do that. I understand that. Are, are you comfortable with that? And if that is the case, why would you not be comfortable with someone that would be a psychologist that might have more specific training in this area doing that, same thing?

TODD HLAVATY: I think it's the drug-drug interaction with other medical conditions. So a lot of the testimony we heard today with normal, healthy, young military. But that's not always the case of our patient population. We deal with patients who have cancer. We deal with patients-- one in three people at age 60 of hypertension, congestive heart failure. And you'll hear testimony later today on

that interaction, of how we are providing direct supervision to that. I mean, there's certain-- I mean, there's certain drugs that, if you don't know what you're doing, you will kill patients. There's no question about it.

WILLIAMS: Thank you for your testimony.

HOWARD: Do you know of any-- excuse me.

WILLIAMS: We're not [INAUDIBLE].

TODD HLAVATY: I'm sorry.

HOWARD: Do you know of any patients who have been killed?

TODD HLAVATY: Oh, absolutely.

HOWARD: By the military and--

TODD HLAVATY: No, no.

HOWARD: --the two states?

TODD HLAVATY: In my own clinic that, that, that were not closely monitored.

HOWARD: No, I'm sorry. I, I mean to clarify. Do you know of any patients who have been killed by a prescribing psychologist in the two states where they're allowed to do it?

TODD HLAVATY: Not personally.

HOWARD: And by the military at all, those who were practicing there?

TODD HLAVATY: I don't know of any cases.

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

TODD HLAVATY: All right.

HOWARD: Our next opponent testifier? Good afternoon.

NATASHA HONGSERMEIER-GRAVES: Good afternoon. My name is Natasha Hongsermeier Graves, spelled N-a-t-a-s-h-a H-o-n-g-s-e-r-m-e-i-e-r-hyphen-G-r-a-v-e-s. I am a second year medical

student at the University of Nebraska Medical Center, and I am testifying today on behalf of myself and the Nebraska Medical Association. I would be failing Nebraska, UNMC, and myself, as a medical student, if I did not advocate for our state's legislation to uphold critical patient safety and quality standards in the regulation of prescribing psychotropic medications, especially to our most vulnerable patient populations. I'm one of two medical students at UNMC who operates our student-run free clinics for the uninsured and the poor. So I work, partic-- with particularly vulnerable patient populations who present with very complicated comorbidities, as in they have many, many different medical problems at the same time, and psychiatric illnesses are commonly among these. I cannot bear the thought of an adverse drug reaction affecting one of my very dear patients because they are prescribed to by someone with less extensive training than should be required. Additionally, as a medical student, I am closely supervised in these clinics with a practicing physician in the room to guide me. I cannot imagine having to make complicated treatment decisions without that close supervision. Never prescribe something for which you do not understand the mechanism of action. This was a recent piece of advice I received from a teaching physician. As a medical student, I have to learn all the mechanisms of action, treatment uses, side effects, contraindications, and drug interactions for every drug in the book. But I am not convinced that the training kind of vaguely laid out in LB817 will ensure that same education for prescribing psychologists. We medical students receive this training so that we do not blindly follow guidelines, but actually think about how this medication, in the setting of our patients' past medical history, current comorbidities and concurrent medications, could affect them in terms of how well the drug will work, its side effects, and its drug-drug interactions. I am continually amazed by the complexity of the decision-making process regarding patient care, even with the critical thinking skills that I started acquiring seven years ago, and my rigorous undergraduate-- and now medical-- training. Even seven years into my training, I can't imagine having to be on my own, prescribing psychotropic medications right now. It is an incredibly complex process. In any advocacy work, evidence-based policy should be the goal. Unfortunately, there is no current evidence that allowing psychologists to have prescription authority will address the public health issue of lack of access to mental healthcare. And what is worse, there is no current evidence that this, that this will not bring unintended harm to patients. Patients with psychiatric illnesses and their families deserve the same safety and quality standards as all other patients. And so for--

and so I urge you, for the health of all Nebraskans, please do not support this bill. Any questions?

HOWARD: I just had a question about the-- you mentioned that the, the treat-- the, the training is loosely laid out. And I just wanted-- I was hoping you could tell us a little bit about that.

NATASHA HONGSERMEIER-GRAVES: Yeah. So when I was reading, I did my best to carefully scrutinize all the pages of this bill. But granted, I don't have the expertise that people who may follow me may. But when I was reading through, especially Section 20, I just-- there are many places, when I was reading, that I was like, what does that mean or why, why is this not defined? It just seemed vague, and many terms are undefined. Like what exactly does it mean that you're gonna take a national exam? Oh, it's always going to be set by a board who's going to determine the rules of this exam. It's like, it's not laid out ahead of time, which is kind of concerning because, as the previous testifier mentioned, we take three eight-hour exams to become, at the minimum, doctors. And like I'm preparing for one of those that I take on February 29. So--

HOWARD: Thank you.

NATASHA HONGSERMEIER-TRAVIS: Yeah.

HOWARD: All right. Other-- Senator Hansen,

B. HANSEN: Thanks for coming to testify. I know sometimes, as a student, you know, you're already embroiled in all this kind of stuff with school. And to come here and pay attention to this kind of stuff, I commend you for actually coming here and, and talking on this subject.

NATASHA HONGSERMEIER-TRAVIS: Thank you,

B. HANSEN: Chairperson Howard stole my question.

HOWARD: Oh.

B. HANSEN: But I have one more question.

HOWARD: Sorry.

B. HANSEN: Do you-- be, because of you were talking about the training of a psychol-- you know, prescriptive authority of a psychologist now,

not having the training or your trust, maybe, about prescribing medications, psycho, psychotropic medications. Do you have that same feeling-- as we just had a previous discussion of the previous bill here about having physician assistants having prescriptive authority now, do you trust a physician assistant to do the same, to, to, you know, prescribe psychotropic medications that a psychologist would?

NATASHA HONGSERMEIER-TRAVIS: I do, but again, it's under the very close supervision in working with physicians. So all of their training programs have-- like everything is very clinic clearly delineated and how much supervision will-- like what that will entail, and what all of their exams will entail, and what the practicum will entail. I think everything is just far more, very much more specific than what I'm seeing in this bill.

B. HANSEN: OK. Thank you.

NATASHA HONGSERMEIER-TRAVIS: Thank you.

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

NATASHA HONGSERMEIER-TRAVIS: Thank you.

HOWARD: Our next opponent testified for LB817? Good afternoon.

MARTIN WETZEL: Good afternoon. Senator Howard,and members of the committee, thank you for the opportunity to testify in opposition to LB817. My name is Martin Wetzel, M-a-r-t-i-n W-e-t-z-e-l. I'm a psychiatrist, practicing in Nebraska since 1992, currently I'm the behavioral health medical director for WellCare of Nebraska, president-elect of the Nebraska Psychiatric Society, and a teaching faculty at both Creighton and UNMC Medical Schools. I'm also the former chief of psychiatry at the Nebraska Department of Corrections. I oppose LB817 because LB817 would allow psychologists to perform physical examinations, order and interpret laboratory tests, prescribe medications, store and dispense medication samples, and obtain a pharmacy license to sell medications. LB817 removes medical education from independent accreditation standards and substitutes it with cursory programs developed and regulated by the American Psychological Association, which is a political organization, and an advisory committee appointed by the Board of Psychology. Not either these groups are medical organizations, and it allows any clinical psychologist-- any clinical psychologist-- to enroll, regardless of

their ability, and any psychologist in the Interjurisdictional Compact. And furthermore, any psychologist from another state, such as New Mexico or Louisiana, with a 10-year-old certificate, would be able to practice, regardless if they ever even use that certificate, and with no entrance exam or interview to our state. This is unprecedented access to licensure. And I want to emphasize, this is not U.S. Defense Department education or supervision. LB817 would remove patients who fall into an arbitrary list of mental health diagnoses, and segregate their treatment to the psychologists who have the substandard training. And then those patients would also have an equally limited access to medications. A patient could well ask in that situation: because I've been given this diagnosis, I'm being lumped in with other patients with nothing else in common with me, offered a limited list of medications, and treated by a psychologist whose training is completely different than anyone else? Better access to care-- the idea is noble and one we all agree on, and we are doing fantastic initiatives in this state to improve access. It's the standards in LB817 that are so incredibly low, as to be alarming. Even worse, in the name of access, LB817 says people living in rural areas of Nebraska, such as where I was born and raised in Curtis, somehow deserve substandard care. The opposite is true. In those areas with limited resources, people need the best possible care because medical mistakes made in rural communities are even more costly. LB817 is not new. It has failed the 407 process, but it returns as poorly constructed as before. It's needlessly confusing and very vague. When a malpractice case or class action lawsuit occurs-- and unfortunately in our business, tragedies always occur, whether it be a suicide, overdose or other tragedy-- all the details lacking in LB817 will be made excruciatingly clear in court during discovery and testimony. This sets medicine back to its darkest days of for-profit medical schools and private accreditation, and segregating people with mental health disorders from the medical community. The stakes are way too high to allow this risk to public safety. Thank you

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

SHARON HAMMER: Good afternoon. I'm Sharon Hammer, S-h-a-r-o-n; last name, H-a-m-m-e-r. And I'm a medical doctor and practicing psychiatrist in Nebraska. I've been practicing for 28 years. I'm currently an assistant professor at UNMC, where I'm the director of Medical Student Education in Psychiatry, and I'm responsible for training all UNMC students in psychiatry, as that is required of all

medical schools. I'm testifying with my own opinion, but with the knowledge of the psychiatry chair and the vice chair of UNMC. Allowing nonmedically trained psychologists a shortcut to becoming medical providers is bad for patients, and it's unnecessary when there are multiple accredited paths to becoming a medical provider. Simply because psychologists are able to make psychiatric diagnoses, that does not mean they are capable of practicing medicine without participating in standardized training. This is one of the faulty premises on which LB817 is based. Another is that training in psychology inherently prepares an individual in any meaningful way to become a medical provider, well not being asked to participate in standard medical training. Psych-- psychiatric medical care cannot and should not be segregated and cut off from the rest of medical care. LB817 allows psychologists to become quasi-medical providers and allows non medically trained individuals to establish and supervise their own training program rather than utilizing longstanding and proven medical education organizations. This is a dangerous proposal for the development of medical professionals, and it flies in the face of nearly 100 years of established and continuously refined accreditation and medical education. And believe me, I attend a monthly 7 a.m. meeting to continuously refine the accreditation, as it applies to our students at UNMC. We have to ask ourselves honestly, really honestly, whether we would allow this route to medical practice for the treatment of any other groups of patients other than those suffering with medical, with mental illness. That's a serious question for all of us to ask ourselves. Some of the striking differences in standard medical training between what is proposed in LB817 are: the lack of prerequisite basic science training; open access to training, regardless of academic aptitude, leading tend to that point; lack of an integrated medical training curriculum, and lack of robust direct supervision of trainees. A key concern that I have, as the person responsible for psychiatric training for our state, is the weak direct supervision that LB817 requires. During medical training, no matter what that medical training is, students are directly observed, interviewing and examining patients over a period of many years. Patients are examined independently by a supervising physician who often is observing these trainees, and then the patient is reexamined by the physician in front of the trainee, showing them and teaching them, through action and a real-time interaction with patients. This is time consuming, but nothing can replace this process. This is the heart of medical training. And the bill proposed does not come anywhere close to the quality and quantity of this type of supervision, needed in order to practice medicine. Supporters of LB817

imply that primary care physicians are not capable or willing or able to diagnose and treat psychiatric illnesses. I am personally responsible for the psychiatric education of most of the future primary care physicians practicing in our state, because most of these primary care physicians have graduated from UNMC, and I can assure you this is not the case. Psychiatric training at UNMC is intentionally focused on the primary care physician. The required psych-- psychiatry training at UNMC is consistently ranked by students as among the top two of all the specialty training they receive while in medical school. And this is asked of the students every single year, and we have ranked in the top two for the last five years. In addition, the medical school graduation questionnaire, which was established in 1978, is given to all U.S. medical grads when they are practicing physicians, to assess the adequacy of the medical training they received in medical school. This is done to constantly improve and refine the quality of medical school education. UNMC's most recent results show that we are currently ranked in the top 11 percent, of all medical schools in the United States, for quality of psychiatric training. I ask that Nebraska not adopt a new, risky protocol for training medical professionals and, instead, utilize the excellent training programs that already exist and have been developed for and invested in by our state. Please don't legislate by anecdote. All I heard this morning from the psychologists supporting this bill were anecdotes. Accepted medical training, including medical school, nursing school, and advanced practice endorsement, and physicians' assistant training programs are all acceptable routes. Any psychologist or mental health therapist of any type can become a medical provider by completing one of these well-established programs. I have a sister-in-law who went to PA school at age 40. She is now a practicing ER PA, and I have a niece who had an undergraduate degree and then did an accelerated nursing program afterwards. in one year, and is now going through advanced practice to go into cardiology. These routes are proven, they're tested, they're accredited, they're available.

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

WILLIAMS: Thank you, Senator Howard. And thank you, Doctor, for being here. I don't think it's anecdotal that we have a shortage of medical providers in our state.

SHARON HAMMER: That is not.

WILLIAMS: And it gets more difficult, the further west we go, in particular in the mental health area. I understand your concerns about LB815 [SIC]. I share many of those same concerns. As a person in charge of this training at our state's number one-- I better be careful what I say with another medical school, and I'll stop there. What, what is the solution?

SHARON HAMMER: Yeah. The solution is going to be multifaceted, but what I don't want to see is a poor solution. And right now, UNMC, as you probably know, has many areas. One is through BHECN, and BHECN has been successful. Their whole goal and funding is to increase behavioral health work force, and that includes people who are medically trained and people who are trained in psychotherapy. There has been a 17 percent increase in nurse practitioners that are specializing in behavioral health, over the last several years, through the efforts of BHECN. We have psychiatry interest groups. Two years ago, we had the largest number of students going into psychiatry. That was 14, which is fantastic. Average nationwide is about five to six medical students per class. That's going to take time to see that investment. A lot of the students go and train in their residencies outside. We maintain a relationship with them to get them to come back to the state. The other are telehealth-- and you're going to hear about telehealth. UNMC, my department, the outpatient clinic has started piloting, this week, telehealth that will be able to be done in patients' homes. I did telehealth to Albion, Nebraska, for years. Unfortunately, patients had to drive to their clinic to do it. Now we're going to be doing telehealth that patients are in their home on a smart device, on phone, on an iPad or on their laptop. That's going to be absolutely fantastic. My speciality is reproductive psychiatry, treating pregnant/postpartum women. We tend to start telehealth services for those women. They won't need to leave their house with a newborn. So there are answers, and I want to reassure you that we are working on them. We have just developed a consultation model at UNMC where, instead of seeing a new patient and keeping them indefinitely in our practice, we're developing tight relations with primary care, trying to stabilize them in three to four visits and, when appropriate, referring them back to primary care. I just emailed our office manager. Our wait time is down to three and a half weeks for a new patient, adult outpatient clinic.

WILLIAMS: Thank you.

SHARON HAMMER: A year ago it was six months.

WILLIAMS: Thank you.

SHARON HAMMER: Thanks.

HOWARD: Actually--

SHARON HAMMER: Oh, sorry.

HOWARD: A previous testifier mentioned Section 20. And I just had a question because I've heard the word "supervision" quite a bit.

SHARON HAMMER: Yeah.

HOWARD: And when they're talking about the practicum, they have to be supervised by a supervising physician. Can you tell me a little bit more about that? Or is that also concerning to you?

SHARON HAMMER: In what way concerning?

HOWARD: Well, you mentioned that they're not medically trained and then there's no supervision. But here in the language of the statute, that's proposed?

SHARON HAMMER: And let me be clear. I mean, wholly inadequate supervision. So part of it is we don't know who these supervisors are, what is their quality versus going to an accredited medical training program--

HOWARD: Oh.

SHARON HAMMER: --or, you know, and potential, these could be community level. The other question is the number of hours.

HOWARD: This says a physician.

SHARON HAMMER: OK, that's fine. But I would say, what's the quality of that physician--

HOWARD: Oh, OK.

SHARON HAMMER: --who is providing this service? Are they specially trained and have adequate training to do that level of supervision, as compared to someone who is working in an accredited medical training program?

HOWARD: Oh.

SHARON HAMMER: The numbers, just the sheer amount of it and then the number-- the other question I have and I think, as Dr. Wetzel mentioned, there's a lot of vagueness in this. Required by medical training is direct supervision. We are sitting next to that trainee. In this training, it's very unclear to me what that means by training. Could this be, you know, done remotely? Could it be done tele? Could it be? I don't know.

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

SHARON HAMMER: Um-hum.

HOWARD: Our next opponent testifier? Good afternoon.

CHELSEA CHESEN: Good afternoon. It's a big chair. My name is Chelsea Chesen, C-h-e-l-s-e-a; last name C-h-e-s-e-n. I think I have the honor of being, maybe, the only second-generation Nebraska psychiatrist here. I am a former president of the Nebraska Psychiatric Society, and I am currently in solo, private, outpatient practice in Omaha. And a significant portion of my practice is performed via telepsychiatry. I see patients in 16 rural communities, as well as some other places. I'm a former academic psychiatrist, and I have worked in just about every single setting you can possibly imagine, including the criminal justice system setting, the VA setting, with the Indian Health Service, at every level of care. And I, I say that just so that it gives you guys some idea, just like who I am and why I'm invested in this. I'm very invested in Nebraska. And I guess I had a whole bunch of things that I was going to specifically say. However, I think it's better for me to actually, maybe, try to provide a little bit more information about some of the questions that have been asked, especially a couple of the questions that were asked to Dr. Merritt, whose service we all appreciate. There was a question about, well, then, if prescribing psychologists, if that becomes a thing here, then what is the difference between a prescribing psychologist and a psychiatrist? I believe it was Senator Hansen's question. Yes. And I guess I felt like maybe Dr. Merritt hadn't had a chance to think through that question. I had a whole lot, whole lot of time to sit and think about that question. The first difference between a prescribing psychologist and a psychiatrist is that a psychiatrist is a physician; we're a physician first. We take an oath to do no harm. We've spent years and years in higher education and continuing education to become

the, the physician-- healer that, that we strive to be. In terms of everyday practice, psychiatrists do a lot more than prescribe medications. Psychiatrists are trained in multiple different types of psychotherapy. Many of us do integrated psychotherapy and psychopharmacology, like the prescribing psychologists talk about doing. That's already being done by psychiatrists everywhere, every day. It's done in my office every day. We do not just see people for 15 minutes every three to six months; that is absolutely inaccurate. We also do procedures that are medical procedures. We're trained to do electroconvulsive therapy, we're trained to do transmagnetic cranial stimulation [SIC] therapy, we do IV and intranasal ketamine therapy. We do a lot of different kinds of treatments that-- not all of us do all of those treatments in every setting that we work in, but we are trained to do those kinds of things, which-- all of which would be out of the scope of what the prescribing psychologists are talking about. I think it's important to point these things out because we are not the same. I also don't think that any of the prescribing psychologists have probably delivered any babies, but I can guarantee you that every psychiatrist here has. The second thing that I wanted to bring up is that, you know, there's this section of the bill that lists different types of patients that would not be cared for by a prescribing psychologist, specifically in Section 34 on page 26. In my pocket-- in my practice, I do not have patients that walk in the door with a sign on their forehand that says that they have multiple chronic medical conditions. I assume every woman of childbearing age who walks into my office is pregnant or could be pregnant, even when she claims that that would be impossible. I've seen lots of virgin pregnancies in my time. I think that it is very dangerous to assume that the average Nebraskan, that is seeking psychiatric medication treatment, is going to automatically meet the very narrow kind of criteria that the prescribing psychologists feel safe addressing the needs of. We don't have that kind of privilege to get to choose how healthy, otherwise, our patients are. The majority of our patients with psychiatric problems have multiple medical comorbidities and many are very complex. I see the red light, so I will hush. But if you have questions, I'm happy to take them.

HOWARD: OK, let's see if there are questions. Any questions? Seeing none, thank you for your testimony today.

CHELSEA CHESEN: Thank you.

HOWARD: Our next opponent testifier for LB817. Just by a show of hands, how many folks are still wishing to testify? One, two, three, four, five, six-- all right. After this testifier, we'll take a quick five-minute break. Welcome.

KARL GOODKIN: Hello, Chair Senator Howard and members of the committee. My name is Karl Goodkin, K-a-r-l G-o-o-d-k-i-n. I'm a physician, board certified in psychiatry, with over 30 years of experience since my training at Stanford University. I also completed Ph.D training in clinical psychology. I'm testifying today as the medical director for behavioral health at Nebraska Total Care, a Medicaid-managed care organization, and I speak in opposition to LB817. The language of LB817 is clear, well-written, and would lead the reader to believe that this expansion of scope of practice is straightforward documentation of existing skill sets, when, in fact, this is not the case. As a psychiatrist and a psychologist, my entire career has been devoted to the realm of behavioral health. I know firsthand the implications of psychiatrist versus psychologist prescribing psychotropic medications. There are many factors that contribute to the physician's choice. These factors are imbued by the extensive training of psychiatrists. Psychiatrists are required to complete four years of medical school and four additional years of training in the practice of psychiatry as an intern and resident; and some may go on to do fellowships. The combination of coursework and the test that is required of a psychologist who can potentially prescribe psychotropic medications, together with a prac-- practicum, does not equal the eight years of specialized medical training required of a psychiatrist. Numerous psychotropic medications are associated with significant side effects, some of which are severe and even lethal. In recent years, considerable gains have been made in the practice of medicine in terms of reducing prescription errors and improving patient safety. Patient safety must be maintained as a primary concern. Working with psychologists over the years and being trained as one myself, I am aware to be sure of the limitations of the clinical psychopharmacology knowledge of psychologists, as it might be applied to clinical cases. One psychotropic medication suggested by a psychologist would fail when another chosen by a psychiatrist would work. I am also aware of limitations in which one psychotropic medication suggested by a psychologist could cause major toxicities when another chosen by a psychiatrist would not. This is not an unusual circumstance. Legislating this expansion of scope of practice could lead to a decrease in efficacy and, potentially, an increase in toxicity of psych-- psychotropic medications prescribed to patients.

Psychologists themselves, which hasn't been mentioned at this point, openly debate the value of seeking prescription privileges and the associated risks. Many believe that gaining this privilege will damage psychology's credibility and distinctiveness from psychiatry. Based on data accumulated where psychologists have been given prescription privileges, opinions of the value of this change remain mixed on follow-up. Physicians and selected nonphysician medical providers are best suited, through their training, to determine appropriate clinical psychopharmacological treatment for their patients. The case for psychologists to join the ranks of the selected nonphysician prescribing providers remains lacking. LB817 will likely negatively impact psychotropic medication efficacy for patients, as well as increasing the side effects these patients experience. In the Medicaid program, there also may be additional expenses related to longer treatment time if new medication medication trials are undertaken or if supplementary treatments are required for medication toxicities. As the committee debates LB817, I respectfully request consideration of the concerns heard today in opposition of the bill. For the sake of quality of behavioral healthcare and patient safety for Nebraska's Medicaid population, LB817 should not be advanced out of committee. Thank you for your time and attention. And I'm open to any questions you might have.

HOWARD: Thank you. Are there questions? Seeing none, thank you for your testimony today. The committee will take a five-minute break, and we will reconvene at 5:03.

[BREAK]

HOWARD: All right. The committee will reconvene, and we'll invite our next opponent testifier up for LB817.

JOAN DAUGHTON: Hello. My name is Dr. Joan Daughton, J-o-a-n D-a-u-g-h-t-o-n. I'm a practicing child and adolescent psychiatrist in Omaha, Nebraska. I'm speaking on behalf of myself and the Nebraska Regional Council of the American Academy of Child and Adolescent Psychiatry, in opposition to LB817. You also received a letter from the president of our national organization, the American Academy of Child and Adolescent Psychiatry, not from me, but it was sent. I will be addressing concerns of having psychologists prescribe to children, about which I have heard very little so far today. Child and adolescent psychiatrists are physicians with at least five years of additional training beyond medical school. At a minimum, we receive 10,000 to 12,000 hours of training and pharmacology in order to treat

mental health disorders. This enables us to understand a patient's complete medical history, perform a medical exam, prescribe the appropriate medication at a safe dosage level, and avoid potentially fatal drug interactions. This is especially important when prescribing for children and adolescents. I see nothing in LB817 that addresses adequate medical training and education to have the knowledge and experience necessary to safely prescribe medications, specifically to our youth. Child psychiatrists are also highly trained in therapeutic techniques and are able to provide therapy in the exact same way as psychologists. I spend 60 minutes or more on every new patient that I see, and 30 minutes or more on every follow-up appointment. Children's bodies metabolize medications differently than adults, and formulations and dosages must be individually adjusted to their needs. Even adult psychiatrists, with their own extensive medical training beyond medical school, refer children, adolescents, and transitional-aged youth to a child and adolescent psychiatrist to treat their complex needs. A Ph.D or Psy.D psychologist has extensive training in social behaviors. An MD or DO physician has years of biomedical training. The depth and breadth of medical education and clinical training cannot be replicated if psychologists are granted prescribing authority. And consider further, physician subspecialists, such as child and adolescent psychiatrists, who have additional specialized training to understand the developing brain. I will highlight three well-researched ways to improve access to quality child mental healthcare: number one, increase funding for the overall mental health system, especially programs serving youth and adolescents-- we can prevent so many negative outcomes this way; provide incentives for medical students to become child and adolescent psychiatrists; and lastly, support integrated care programs between child and adolescent psychiatrists, primary caregivers, and other mental health providers. I have been involved in three different models of this for several years and can account personally for the effectiveness. I have been providing care in clinics, in school-based health centers, in eight OPS schools, and-- I'm sorry-- in four OPS schools, eight hours per week for nine years. I have also taught the primary care providers in those clinics, who are there Monday through Friday, to assess and treat mental health needs in children and adolescents. I've been providing care in the Dundee Children's primary care office for five years, where I have also taught primary care providers to assess and treat mental health needs in children and adolescents. Dr. Jennifer McWilliams and I have started an e-consult program at Children's Hospital, which allows access to our consultation during business hours, for any questions from any

provider related to mental health needs of any patients seen within the Children's system. And our plan is to expand that statewide, once we have more data. Thank you for your time.

HOWARD: OK, thank you. Are there questions? Senator Hansen.

B. HANSEN: Thank you. Just a quick question because I'm, I'm a little unfamiliar. How many child and adolescent psychiatrists are there in the state of Nebraska? Do you know? And especially, I mean, out in western Nebraska?

JOAN DAUGHTON: We have 60 in the state of Nebraska. To, to reduce that to how many are in like the Omaha and Lincoln area, the majority are clearly in Omaha and Lincoln areas.

B. HANSEN: Yeah.

JOAN DAUGHTON: But I can't, I can't give you the exact number.

B. HANSEN: OK. Just curious. You know, a lot of this bill pertains to like trying to deal with the--

JOAN DAUGHTON: Absolutely.

B. HANSEN: --access. And we were talking about referring to a child and adolescent psychologist. You know, in some areas in Nebraska, it's just a little difficult. So I'm just kind of curious about your--

JOAN DAUGHTON: And the hope would be that we could train our primary care providers in those settings much better. Right now, there's no requirement for pediatricians to have mental health training during their residency training. And so we need to get those approaches changed so that our primary care providers are well-prepared to treat these kids.

HOWARD: OK.

B. HANSEN: Thank you.

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

KURT SCHMECKPEPER: Good afternoon.

HOWARD: Good afternoon.

KURT SCHMECKPEPER: Senators, my name is Kurt Schmeckpeper, K-u-r-t S-c-h-m-e-c-k-p-e-p-e-r. On the behalf of Nebraska Academy of Physician Assistants, the body that advocates for physician assistants' practice rights, I am here to oppose LB817. The ability for psychologists to prescribe medication is concerning to the safety of the general population. This proposal has failed in the process that was placed in Nebraska to present scope of practice changes. As we PAs know well from the efforts bring change, bringing changes to our own practice statutes, scope of changes are generally presented in the 407 application that is given serious vetting by a technical review committee, followed by a review of the Board of Health, and, if approved, review by the chief medical officer. And that is all before a bill is presented. When a version of this proposal was presented in 2017, it failed to gain support by the Board of Health and the chief medical officer. Importantly, the stakeholders' groups expressed important patient safety concerns that were never addressed and still remain. The bill would allow psychologists to prescribe psychotropic medications, and order and interpret lab tests and other medical diagnostic procedures. This is concerning because psychologists receive little to no actual medical education or training. It is important for patients to receive treatment from a practitioner who is trained and understands the complexity, dangers, and side effects of such medications and other interactions with different patients and conditions. The training for all health professions currently maintaining prescribing rights in Nebraska is vastly more extensive than what is proposed in the NPA's application. Physicians, PAs, and nurse practitioners all spend at least six to seven years studying biology, chemistry, physiology, pharmacology, and clinical medicine, prior to being able to prescribe pharmacological therapy. Training encompasses all aspects of the human body. Even cardiologists or neurologists who practice focus on the one body system are thoroughly educated and all symptom-- centum-- systems. The choice to specialize and, therefore, to prescribe and only treat one body system comes after an arduous and thorough education and training in all aspects of the human body and clinical medicine. There are no health professions currently in Nebraska who are able to prescribe medications who do not undergo this type of comprehensive training. Dentists, podiatrists, and veterinarians are also held to this standard. NAPA would like to encourage NPA's clinical psychologists to continue to promote their strength of their training, and find alternative methods to reach more patients. My personal experience, while practicing in a rural health clinic, is there is a long wait for new patients to receive cognitive therapy. In metropolitan areas, this wait could generally be two to

three months. In rural areas, this could be doubled. Telehealth is an option; however, it's in its infancy in regarding the impact it has in underserved areas. Thank you for your consideration and work to improve on healthcare delivery in Nebraska while keeping patient safety at the forefront.

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

JASON OURADA: Hello.

HOWARD: Good afternoon.

JASON OURADA: My name is Jason Ourada. I'm a physician/psychiatrist. My name is spelled J.-a-s-o-n; last name O-u-r-a-d-a, and I'm here speaking in opposition to LB817, on behalf of myself; these are my opinions. I'm also involved in the Nebraska Psychiatric Society. So a little bit about me. I'm from Holdrege, Nebraska. I'm a physician graduate of Creighton University, and I trained in psychiatry in Massachusetts and lived there for over ten years. And I trained in general psychiatry and am board certified in general addiction and forensic psychiatry. My current work has been involved in working in a rural setting in Fremont, and now I'm doing some forensic work for the courts. Many of the points I was going to make have been stated, and I appreciate the testimony from both sides and the passion on this topic, as well as your patience, in hearing all the testimony. I'm going to skip some of the points and make this short. I would like to just make a couple of points from the perspective of an addiction psychiatrist. It has been mentioned, regarding some vague terminology in LB817. When I read it, it was similar to reading the similar bill in 2017, during the 407 process, I found it to be vague, to have vague language, to be all encompassing and very unrestrained. And the one recent speaker spoke about child psychiatry as a subspecialty. I'm going to speak about substance use disorders as a subspecialty, specifically with regards to the opioid crisis, which is much heavier in some parts of the country. And here we have a methamphetamine epidemic, as well as other substances. I was concerned when I saw an unrestrained approach to training and being able to treat kids, elderly people, but also people with substance use disorders, in a very compact curriculum, relatively speaking. These subspecialties take years of training and supervision. And to kind of skip over some of the years that are at the heart of building that knowledge is a big concern. I have concerns about the terminology regarding controlled substances and the definition of psychotropic medications. And from

what I can recall, there is a very broad definition of a psychotropic medication to not include opiates. I brought up a concern in my letter about the words opiate-- "opioid narcotic." The statute uses the word "opiate" and 'narcotic," and it's very difficult to follow some of that regarding controlled substances, even from a experienced clinician point of view. But this-- when I read this bill, I was wondering, would there be a, the opportunity for a prescribing psychologist to prescribe buprenorphine, which is also known as Suboxone? It is a treatment used for opioid use disorder. Similarly, methadone is a medication used to treat opioid use disorder. I did hear testimony from the psychologists regarding that they want nothing to do with opiates. I just found the language confusing and vague, and not specific. And I would have wanted to see something in the bill that said we do not want to prescribe buprenorphine. We specifically will not prescribe any opioid, including these, and come up with a list, not to mention lack of specificity regarding general psychotropic medications. But along that same line, schedules 2 through 5 would be wide open for use. But again, the terminology of opioids, buprenorphine being a Schedule 3 opioid, it was confusing to me. So I'm probably going to stop at that point there. If anybody has any questions--

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

JASON OURADA: Thank you.

BETH ANN BROOKS: Good afternoon.

HOWARD: Good afternoon.

BETH ANN BROOKS: A long one. I am Beth, B-e-t-h, Ann, A-n-n, Brooks, B-r-o-o-k-s. I'm a Nebraska licensed physician and board certified psychiatrist and child and adolescent psychiatrist from Lincoln, who is today representing the Nebraska Psychiatric Society, the Nebraska Medical Association, and the regional organization of Child and Adolescent Psychiatry, in opposition to LB817. I testified before the technical review committee and Board of Health in 2017, during the 407 process for psychologists prescribing. That proposal failed to gain support in the last two of the three-step process. I would refer you to the opinion letter from Dr. Tom Williams, and this was distributed by Dr. Hlatavy, who conducted an in-depth analysis as the third step of the 407, where he could not endorse psychologists prescribing. I've worked as a member of mental health teams for more than 40 years and

never worked on a team that didn't include at least one psychologist. And I do hold psychologists in high regard for their assessment and psychotherapy skills. And as one of the earlier testifiers opined, we sorely need psychologists who are skilled in providing evidence-based therapies, cognitive behavioral, dialectical behavioral, multisystemic, and parent management training, to name a few. Nebraska already has medical professionals who can prescribe for patients with psychiatric disorders. The bill describes access problems, but it seems to ignore that primary care physicians, nurse practitioners practicing in both primary care and mental health, and certified physician assistants are dispersed all across Nebraska. These medical professionals possess the requisite medical background and physical examination differential diagnosis of physical health versus psychiatric disorders, ordering and interpreting laboratory tests, and recognition of medication interactions and side effects, which are imperative before deciding whether to prescribe psychotropic medication. They already are addressing access issues without the risks to patients and the administrative costs to develop a program for prescribing psychologists. The contemporary emphasis on collaborative care, as Dr. Daughton referred to, telepsychiatry, and regular consultation with other prescribers is addressing the need for access to qualified medical professionals who can treat mental disorders across Nebraska. I distributed to you a list of 88 widely dispersed locations throughout the entire state that are served by telepsychiatry providers who practice in Nebraska. Admittedly, it is not a complete list, but it does include the larger health systems of Avera in northeast Nebraska, Catholic Health Initiatives, also known as CHI, Children's Hospital, and UNMC. As an example of modern technology, the UNMC psychiatry department just launched a universal access platform for statewide telepsychiatry available by smartphone, tablet, or laptop, as Dr. Hammer alluded to. It uses an app that is integrated with the UNMC electronic medical record, and the program includes medication management. It should be obvious that geography is no barrier to telehealth, and it is important to note that, since 2017, insurers are required to reimburse telehealth at the same rate as face-to-face services. Time will not allow me to give a history, and it would not be as comprehensive as it should be over the last 30-some years. But psychologist prescribing started with a Department of Defense pilot program that, at the end of time, they sunsetted and did not train any more prescribing psychologists, even though the DOD allows those who are already trained and have passed the necessary exams to continue to prescribe. I have some information regarding lawsuits filed in Louisiana in 2012 and 2013, which were cited during

testimony when a 2017 psychologist prescribing bill failed in Oregon. I thank you for the opportunity to comment why LB817 should not advance. It does not protect some of our most vulnerable citizens, and there are alternatives already in place from medical professional, professionals to address access. Thank you.

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

BETH ANN BROOKS: Thank you.

HOWARD: --testimony today.

BETH ANN BROOKS: And have a good evening.

HOWARD: Good afternoon.

PHILIP BOUCHER: Good afternoon-- good evening. I am Philip Boucher, P-h-i-l-i-p B-o-u-c-h-e-r. I'm a pediatrician here in Lincoln, Nebraska, at Lincoln Pediatric Group. I grew up here in Lincoln and attended my undergrad and graduate and residency training all in Nebraska, and I--here representing the NMA, the-- my practice, Lincoln Pediatric Group, our competitors, Complete Children's Health in Lincoln, and myself. My partners and I, along with our competitor, Complete Children's Health in Lincoln, rep-- see over 40,000 children in southeast Nebraska. And we are in opposition to this bill. I think the challenge for everyone is that it's difficult to make the correct diagnosis and direct the treatment plan of pediatric patients, in particular. As a primary care physician, I am usually the first person to talk with parents, and talk through those issues, and come up with a treatment plan. We face evaluating not just the patient, but looking at the developmental progress of the patient, the past medical history, the past surgical history, the medications the patient is on, and the family history, all when taking those together to try and come up with a cohesive diagnosis and management plan. There's a lot of underlying pathophysiology, and pharmacological-- pharmacology, and pharmacokinetics that goes into selecting psychotropic medicines for children. And it requires a deep understanding of biochemistry, endocrinology, cardiovascular systems, all the systems of the body that can be affected by these drugs in children, especially as they go through, develop, grow, gain weight, and all the other things that go along with childhood. These medications that we use, and use very judiciously, and try to avoid as much as we can, impact not just the brain and the psyche, but all of the body systems and the developing

body systems as the child grows. I feel very fortunate to work side-by-side with psychologists, and I find that the working relationship is very strong. I'm able to help coordinate care and provide medications in some cases, while the psychologist is able to address the behavioral issues, the family dynamics, deal with parenting issues, and help in that capacity. And we work very well in concert together and often talk and collaborate. But we have two different realms of knowledge, training, and expertise. I believe that, without a deep understanding and training that goes into the medical education, without understanding how the past medical history, surgical history, medications, and family history impact the choice of medication, that that puts the child at risk. And there's always the risk of overmedication of children that we, we see in practice. And so having more, having more providers only increases that risk rather than allowing for brakes to be put in place by myself, by the psychologist, to do what's best for the child. I agree with others that there's a great need for mental health services in our state for our children. But I, I and the organizations that I represent do not feel that the risks of allowing this prescriptive authority outweigh the benefits to our state's children. And I'm happy to answer any questions.

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

PHILIP BOUCHER: Thank you.

HOWARD: Good afternoon.

ROBERT WERGIN: Senator Howard, committee members, thank you for allowing me to share my thoughts again today. I guess I'm thinking I might be the closer. I hope I bring this all together. My name is Robert Wergin, R-o-b-e-r-t W-e-r-g-i-n. As I stated before, I am a practicing rural family physician in southeast Nebraska, in the community of Seward, and I'm also a board member of the Nebraska Medical Association. And I'm speaking on behalf of myself and the Nebraska Medical Association, in opposition of LB817. I've been in practice for over 30 years and have supervised physicians' assistants, and that'll be the direction of my remarks regarding supervision and what it entails for me over these years. I think in-- this bill attempts to create the kind of supervisory relationship that physicians have with physicians' assistants, but we feel that it falls flat, or a little bit short from accomplishing this. The physician assistants and I that have worked together in a team, manage to

deliver high quality, evidence-based, whole-person care. A physician's assistant receives this whole-person allopathic education in a medical school setting, often sitting right by me in classes, and on clinical rotations with medical students during their training. They sit in classes such as: medicine, surgery, pediatrics, obstetrics, and gynecology, and psychiatry, and also rotate on clinical services, being directly supervised. They also get pharmacology education during their academic and clinical years that emphasizes interactions between different interventions, and particularly other medications, and particularly in regards to prescribing psychotropic medications, how they may inter, may interact with other medical issues, including other medications that these patients may be on. In my practice, the physician's assistants have worked collaboratively and together in this whole-person approach on multiple occasions over those 30 years. They, the physician assistants, as I said earlier, often with these complex patients, seek my input and advice regarding these complicated patients as we develop treatment plans. This process, as I stated, has worked well for me and my physician colleagues over the years. And there have been instances where medications and other patient illnesses have precipitated our recommendation of changing our treatment plan, including medication and the approach to taking care of patients. This team-based approach has worked, and working together has avoided possible serious interactions and adverse outcomes regarding those patients. As an aside, I will say, as a past-president of the American Academy of Family Physicians for the United States, I traveled across the country. I can tell you, with some degree of certainty, that most psychotropic meds are prescribed by primary care physicians, not by a psychiatrist or a psychologist or whatever. So we do have the training and background, but don't operate in a, in a silo of just one thing, often get advice for, again, many of these complex patients. Another concern, COPIC is-- who's one of the major malpractice carriers in this state, contacted us regarding LB817, in how primary care physicians could potentially be drawn into a supervisory relationship with a psychologist with which they have no prior relationship with, and that this is unlike what we have with our physicians' assistants. And it's not a true team-based approach to care. They had stated that may increase our malpractice premiums and our medical liability exposure. The bill then would place the burden on that physician to ensure patient safety without that supervisory relationship. This is not something that is necessary when working with psychiatrists. This type of loose supervisory relationship provided in LB817 would also increase the primary care physicians' malpractice liability premiums, as I stated before. Working together

and not in a silo is the answer to healthcare delivery, in my opinion. And addressing the serious medical interventions with a colleague,-with a whole-person, allopathic education, has served my patients well. These team-based discussions with a team member with similar, but more limited training than myself, and experience has also avoided adverse outcomes when prescribing medications to patients in a healthcare setting, even those with psychiatric problems. I believe this collaborative approach is the answer. It has worked well in my practice to deliver high quality, safe care to my patients. I do not think that the more limited background and training of psychology colleagues would serve them as well. And I speak in opposition, as well as the Nebraska Medical Association, to LB817.

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

ROBERT WERGIN: Thank you.

HOWARD: Is there anyone else wishing to speak in opposition to LB817? Is there anyone wishing to speak in a neutral capacity on LB817? Seeing none, Senator Stinner, you are welcome to close. And while you're coming up to close, I will do the letters. OK, letters from proponents: Dr. Elizabeth Lonning, Psychology Health Group; Kim Hill, Beatrice Women and Clinton-- Children's Clinic; Dr. Sarah King, Behavioral Wellness Clinic; Dr. Glenda Cottam, self; Dr. Rebecca Schroeder, self; Lori Rodriquez-Fletcher, self; Dr. Casey McDougall, self; Dr. James Haley, self; Dr. Katherine Carrizales, president-elect, Nebraska Psychological Association; Carmen Skare, self; Garrett Blankenship, self; Laura Ebke, Platte Institute; Dr. Laura Reardon, Nebraska. Medicine; Dr. Adam Mills, Nebraska Medicine. Letters for-- in the opposition: Dr. John Massey and Dr. Liane Donovan, NE Pain; Dr. Aleh Bobri, University of Nebraska Medical Center; Dr. Geoffrey Allison, Creighton University Medical Center, Center; Dr. Katherine Rue, Nebraska Methodist Health Care System; Dr. Kyle Myers, self; Dr. Steve Gogela, Neurological and Spinal Surgery, LLC; Dr. Steven Williams, Dr. Josue Gutierrez, and Dr. Brett Wergin, Nebraska, Academy of Family Physicians; Dr. Merlin Wehling, President of Sonno Anesthesia; Dr. James Madara, American Medical Association; Dr. Kelly Caverzagie, Metro Omaha Medical Associate-- Medical Society; Dr. Kai Wicker-Brown, self; Drs. Steve--Stephen Nagen-- Nagengast, John Fallick, Brad Olberding, and Clinton Rathje, General Surgery Associates; Dr. Jason Ourada, self; Dr. Alyssa Lucker, self; Dr. Sharon Hammer, UNMC; Dr. Laura Kendall, self; Dr. Ruben Solis, self;

Dr. Anthony Akainda, self; Dr. Martin Wetzel, self; Dr. Arun Sharma, CHI Health Clinic; Dr. Cindy Ellis, Nebraska Chapter of the American Academy of Pediatrics; Natalie Sitvak, self; Dr. Michael Sedlacek, Psychiatric Services, PC; Dr. Stephanie Sutton, self; Dr. Gabrielle Carlson, American Academy of Child and Adolescent Psych-- Psychiatry; Dr. Sian Jones-Jobst, Complete Children's Health; Dr. Rashmi Ojha, self; Dr. Saul Levin, American Psychiatric Association; Dr. Cynthia Paul, Nebraska Psychiatric Society; Dr. Daniel Gih, Nebraska Regional Council of the American Academy of Child and Adolescent Psychiatry. One letter in the neutral position: Dr.-- Doctor, duh-- just Darrell Klein, Nebraska Department of Health and Human Services. Thank you. Senator Stinner, you are welcome to close.

STINNER: Thank you. I'm going to be as short and as blunt as I can possibly be. How's that?

HOWARD: Great.

STINNER: Uncharacteristic, right?

HOWARD: Yeah.

STINNER: Well, the first thing I want to say is I have no interest in turf wars. I just have no interest in it. I've been a problem solver my entire business career, adult life. We got a problem, folks, in western Nebraska. We got a problem in rural Nebraska. I'm trying to get it solved. I'm trying to move the ball forward. And why am I doing that? I've been involved with superintendents, police departments, judges. Everybody says, hey, we've got a problem and we've got a work force problem. We've got a mental health behavioral problem. And I'm trying to come up with some solution. Now if I need to tighten up the legislation to satisfy some of these people, as I want them to go through as rigorous a training as they possibly can. Safety is the uppermost in my mind. But I'll tell you, the map I passed out said two psychiatrists in western Nebraska. Those are slots at Regional West. Right now we got one. It's been a revolving door. We go times-- years without having a psychiatrist there. It's time we started to take this a lot more serious and take a look at it. The profession needs to take a hard look at it and do some positive things. What I'm trying to do, and I'm-- here's, here's the body of information that I went to. Prescribing psychologists meet the need. And I went back to looking at testimony in New Mexico and trying to get up to date on what happened there, because they've been in it; 2002, they've been in, what, 17 years now. But I got a-- I got some letters and things I'll share with

you. May 8th, 2016: Prescribing psychologists, in general, have improved the access to care in New Mexico. We just did some research on prescribing psychologists. 80 percent are serving in underserved areas or with severely underserved populations, such as: severely mentally disturbed children; homeless; and community mental health centers. Almost all of us take Medicaid. Another, another letter that is put in here, many of them, many of them, meaning patients, will say they really like having the therapy and medication management by the same person. They feel that the medication is being more closely watched. Yeah, this is quality of care. This is a need to care. We all know; I, I'm preaching to the choir here. You guys know; you've been involved in it for a period of time. I know the-- Chairwoman Howard has been a concerned person. But let me talk about going back to safety. I wouldn't recommend something if I thought this was a reckless idea. I'm taken back-- 1990, Department of Defense started the program, right? 1999, the General Accounting Office report to the Committee on Armed Forces [SIC], U.S. Senate-- at that time, no adverse patient outcomes. OK, I'll go then to New Mexico again. They've been in it, what, 14 years, 15 years, whatever your accounting is? And this is a letter from a psychiatrist: May 6, 2016-- in 14 years, there's been about 55 psychologists who have a license. And there are not-- there has not been a single action taken against a psychologist for unsafe practices-- none is what he said. In New Mexico, since people started prescribing, and these-- and those people being psychologists, started prescribing, there had been no difficulties in terms of complaints of unsafe practices. I'm on the board. I can tell you there has been none. So to those critics I would say, listen. I understand, theoretically, what your concerns might be but, actually, that's not a problem. And that's from a psychiatrist. And that was a letter that he also addressed. So far in Louisiana, ten years into the program, no license board disciplined for unsafe prescribing practices by psychologists. These people-- the rigor that they have to go through to become a prescribing psychologist, I can work with people to get that rigor in there. I need a work force, and it's time that we got a little bit serious about that. With that, I'll conclude. Thank you. Sorry about the sermon.

HOWARD: Thank you. Are there any last questions for Senator Stinner? All right. Seeing none, thank you, Senator Stinner. This will close the hearing for LB817, and we are done for the day.