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ARCH: John Arch. I represent the 14th Legislative District in Sarpy County and I serve as Chair of the HHS Committee. I'd like to invite Senator Cavanaugh to introduce herself, please.

M. CAVANAUGH: Good morning. I'm Senator Cavanaugh, District 6, west-central Omaha, Douglas County.

ARCH: And I'm sure we'll be having other members join us. We, we got a little bit of a late release from the floor this morning, so they'll be coming down. Also assisting the committee is one of our legal counsels, Paul Henderson, our committee clerk, Geri Williams, and our committee pages, Jordon and Sophie. A few notes about our policies and procedures, please, please turn off or silence your cell phones. This morning, we will be-- have hearings on, I believe, seven, seven appointments, gubernatorial appointments, and taking them in the order listed on the agenda outside the room. The appointee will begin with an opening statement. After the opening statement, the committee members will have the opportunity to ask questions and we will hear from supporters of the appointment, then from those in opposition, followed by those speaking in a neutral capacity. If you plan on testifying, please fill out a green testifier sheet located on the table near the entrance to the hearing room and hand it to one of the pages when you come up to testify. 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. We request that you wear a face covering while in the hearing room. Testifiers may remove their face covering during testimony to assist committee members and transcribers in clearly hearing and understanding the testimony. Pages will sanitize the front table and chair between testifiers. This committee has a strict no-props policy and Senator Williams has joined us. I'll give him a chance to introduce himself as well.

WILLIAMS: Hi, I'm Matt Williams from Gothenburg, Legislative District 36. That's Dawson, Custer, and the north portions of Buffalo County.

ARCH: Senator Walz as well.

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

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ARCH: Great. And with that, we will begin today's gubernatorial, gubernatorial appointments with Dr. Russell Crotty for the State Board of Health. Welcome, Dr. Crotty, who's on the phone.

RUSSELL CROTTY: Yes, thank you. It's Dr. Russell Crotty, R-u-s-s-e-l-l C-r-o-t-t-y. I do want to thank everyone for allowing me to call in today, allowing me to see patients this morning. That is very helpful. I was honored to be recommended to serve on the State Board of Health as the optometry representative. My understanding is the position has been vacant for a little while and I am excited. I do have a lot to learn, but I, I have been very involved with the Nebraska Optometric Association. We have our legislative days each year that I've been involved with. I've made some good relationships with senators and my, my main focus is obviously protecting the safety and, and health of the public, while also offering my professional opinion on everything optometry related and eye related. So I have enjoyed my first meeting and I think there's a lot of talent and smart individuals on the Board of Health that I'm excited to work with and learn a lot from.

ARCH: Thank you, Dr. Crotty, very much. At this point, we want to open it up to any questions from the committee and you can respond to the questions. Are there any questions? Senator Walz.

WALZ: Good morning, thank you for being here today. What are you most excited about regarding serving on the board?

RUSSELL CROTTY: Well, I think it's just one of the best ways to both give back to my profession-- I also think that we've been a little bit underserved with not having a representative. Anything eye health related, I think it's very important to have that type of voice on the board. And I find it exciting just to be more involved in all-- I think all health professional-- all health professions have-- are greatly affected by legislation and to just be tuned into that a little bit more, I think is very, very important. I think a lot of people take that for granted, that this is all going on behind the scenes, but I, I want to be tuned into it and plugged in and have an idea of what's going on around me. And I want to make sure that not only optometry is set up for being in a good position, but again, the, the safety of the public. One example I can give from my first meeting that I've had so far, it was LB19 going right now regarding tattoo artists and body artists and I just put my voice of opinion in there that tattooing of the eyelids can, can have some long-term detrimental

effects and so just added that little note to a letter of support so that the, the general public can be protected on things like that.

WALZ: Thank you and thank you for visiting with us today.

RUSSELL CROTTY: Yeah, thank you for having me.

ARCH: Other questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and, and thank you, Mr. Crotty, for, for applying for this and doing this. A question that I would have relates to the scope of practice issues, which are, I will tell you, not a favorite of this committee and me--

ARCH: Or the Board of Health.

WILLIAMS: --or the Board of Health, probably. That's probably right, but how familiar are you with the 407 process and, and knowing that we have oftentimes-- we didn't have it this year, but we've oftentimes had the optometrist and the ophthalmologist lining up on different sides of that particular issue as it relates to your practice.

RUSSELL CROTTY: Yes, absolutely. I, I haven't been directly involved in, like, testifying or anything in the 407, but I have attended some of those meetings and been present to see arguments from both sides and I know that that, unfortunately, has created a lot of tension between ophthalmology and optometry. My hope is that going forward, both sides can learn to work together. I think that is a goal from, from optometry's side. We-- the scope is ever changing and so I, I won't say that there's, you know, not going to be a further attempt at scope expansion because in some ways, that's very important to the state of Nebraska because there's other states that are expanding scopes in a way that we may not be able to attract the talent of, you know, bright, young students who are graduating if our scope is too restrictive in some ways. So while I'm not going to sit here and say I-- you know, I, I have no plans of, of seeing our scope expand, I hope it can be done in a way that is a little more collaborative on both sides and finding ways to reach agreements that, that are less combative and less like what you've experienced in the past.

WILLIAMS: Thank you.

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ARCH: Are there any other questions? Seeing none, Dr. Crotty, thank you very much for your time this morning. The process will be that the committee will, will consider the appointment and if favorable, we will vote it out of committee and, and it will be heard on the floor. Thank you especially for volunteering to do this and applying your professional skills. We, we need, we need excellent people in the-- on the Board of Health, so thank you very much.

RUSSELL CROTTY: Yes, thank you for, for having me and I appreciate your, your time today and all of you serving on, on this board as well. You all have a great day.

ARCH: Thank you. Have a good day.

RUSSELL CROTTY: Thanks. Bye.

ARCH: So we will now be hearing from Dr. Timothy Tesmer and he's going to be calling in here. Oh, I'm sorry. Yeah, good. Are there any proponents for this last gubernatorial appointment, appointment? Are there any opponents? Is there anybody who would like to testify in a neutral capacity? Seeing none, that will close the hearing on Dr. Crotty. He's-- Dr. Tesmer is waiting for a text from us and so--- Dr. Tesmer?

TIMOTHY TESMER: Good morning, yes.

ARCH: Good morning. So we have the, we have the Health and Human Services Committee sitting here and thank you for calling in and--

TIMOTHY TESMER: Thank you.

ARCH: --we would maybe like you to just open up with a little bit of a, of a briefing on your background and then the, the question of why, why, why are you interested in serving on the Board of Health, so please, please proceed.

TIMOTHY TESMER: OK and-- OK, I'll, I'll make this introductory part brief. Born in Grand Island, college, I went to college at Nebraska Wesleyan, medical school at UNMC, my ear, nose, and throat residency was in Louisville, Kentucky, and that was from 1982 to '87. My first private practice opportunity was in Springfield, Missouri, and then in 1991, moved out to Colorado Springs, Colorado. And then in the mid 1990s, my wife and I felt-- my wife, also from Nebraska, felt that we

needed to get back to Nebraska to raise our family, which at that-- we had four children and so in 1998, had an opportunity and we jumped on it to move back to Nebraska in Lincoln and that-- I've been there, been there since and this will be our home. And throughout my career, I wanted to obviously be an advocate for the health of my patients, but at this point in my career, I feel a stronger tug and urge to take that to the next level, if-- hopefully, if possible, and advocate for the health of the citizens of the state of Nebraska. So that-- in, in a nutshell, I am very honored, very honored to have received the appointment and also would be honored to be certified or ratified or voted upon positively.

ARCH: All right, thank you. Thank you very much. Any questions from the committee? Dr.-- that's not a doctor-- Senator Murman.

MURMAN: Thank you, Senator Arch. This is Senator Dave Murman from the Glenvil-Hastings area.

TIMOTHY TESMER: Yes.

MURMAN: I'm wondering what were your motivations to move back to Nebraska other than your wife, of course?

TIMOTHY TESMER: Well, I tell you what, this sounds-- and please-- this sounds like a Chamber of Commerce statement, but I mean it from the bottom of my heart. We had four, we have four children and we wanted to raise our children in the state of Nebraska and that was, that was it because we-- both my wife and I were born and raised here, here in Nebraska and we know the quality of life there in Nebraska and that was the overriding reason for us to move back, so--

MURMAN: Thank you very much. Could you be more specific? Is it the good weather, schools?

TIMOTHY TESMER: Well, you know, with all due-- I am calling you right now, Senator, from the state of Arizona, where we have had a long, long planned vacation, so please don't hold that against me, but it, it was the quality of life insofar as the education and work ethic and-- well, other things. I mean, compared to Col-- cost of living. Again, it sounds like a sort of a Chamber of Commerce statement, but for us and our, and our strong faith that my wife and I have, we just

knew that we needed to get back home to Nebraska to raise our family and so we-- again, had the opportunity, so--

MURMAN: Thank you very much.

TIMOTHY TESMER: Yes.

ARCH: Thank you. Other questions? I, I have one in particular. You, you are an otolaryngologist. Any--

TIMOTHY TESMER: Yes.

ARCH: --any particular passions in that field that right now your practice is-- I mean, I, I have experience with otolaryngology, but any particular area in that, in that practice that you're most passionate about?

TIMOTHY TESMER: Well, the main-- the bulk of my practice right now is what we call just general ear, nose, and throat, so that's working with children, tubes in the ears, tonsils, a lot of nasal/sinus types of things. I currently am interested in some other aspects as far as nutrition, pain management, that type of thing, and so I want to be able to try to see if I can parlay that in, in my professional career to see if I could help out people in a, in a different, better way.

ARCH: Great. One, one follow-up question that I have.

TIMOTHY TESMER: Yeah.

ARCH: This is Senator Arch, by the way.

TIMOTHY TESMER: Yeah, sure.

ARCH: One question that I have that the committee may be interested in is what, what, what, what has changed in your practice during this time of COVID as far as what you see in infections-- ear infections, sinus infections in the general population?

TIMOTHY TESMER: That's a very interesting question and in conversations that I have had with a, a couple of pediatric-- pediatrician colleagues in length in, from my personal standpoint, for the last year, I have not seen as many children come into my office referred-- let's say with ear infections or tonsil infections and I

can even parlay that into adults with perhaps less sinus infections. The overriding thing-- the overriding reason to me has been the measures with masking and social distancing and hand hygiene. The pediatricians that I've talked to have said that they have not seen near as many children with upper-respiratory infections. Now partly, I'm sure it's due to the fact that parents are having their children wear masks and if, if the family situation would allow, they're not in a daycare setting as much or they're home being-- let's say, learning from home, that type of thing. So I think that there is a public health benefit to what has gone on insofar as a reduced number of upper-respiratory infections. Now I, I, I don't want to go so far as to say they're-- please-- not, not mandating for it, but I just think we've seen less referrals for upper-respiratory infections and I cannot help but think it's due to the COVID measures that most people have enacted, so--

ARCH: OK, thank you. Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Dr. Tesmer.

TIMOTHY TESMER: Yeah.

M. CAVANAUGH: You, you, you mentioned pain management as an area of interest for you.

TIMOTHY TESMER: Um-hum.

M. CAVANAUGH: Could you talk a little bit more about that? We, yesterday-- had some hearings here yesterday on medicinal marijuana and I know that a lot of the focus was that-- of that was on pain management.

TIMOTHY TESMER: Um-hum, um-hum.

M. CAVANAUGH: So I would just be interested to hear what, what your thoughts are on pain management and if you think something like that has a role to play.

TIMOTHY TESMER: OK. When I was talking-- my interest as far as pain management would be more so of the head and neck-- different treatments for, let's say, headaches, that type of thing, and there are other modalities for that not involving necessarily medicinal marijuana. And I-- I'm, I'm going to be honest with you, with you all.

And I've got to keep in mind that as a-- if, if voted upon as board of, board of health member, that, that's a hat that I have to wear accordingly. I have personally some reservations and, and some questions on how all that would work and the long-term side effects of that, of medicinal marijuana. I guess I would just-- I, I would have to look at it very critically and see if that would be in the best interest of the citizens of the state of Nebraska. There's a subset, I'm sure-- there may be a subset of people that that may benefit, but there would have to be, I think, some very tight, strict regulation. And I wouldn't want, I would not, would not want a bunch of-- an offshoot of medicinal marijuana fairly parlayed into more recreational use of marijuana. I just don't feel in favor of that at all.

M. CAVANAUGH: OK, thank you.

ARCH: Senator Murman.

MURMAN: Thank you, Senator Arch. Your comments on masks spiked my interest a little bit. You know, I-- you said there's less upper-respiratory problems that you've seen in recent weeks or months. And, you know, there's of course, as you mentioned, a lot of reasons for that. Kids aren't--

TIMOTHY TESMER: Yes.

MURMAN: --in daycare or schools or with other children as much possibly, more lockdown-type situations where people just aren't out as much. But, you know, I've heard specifically on masks that, you know, it's-- there's unhealthy things also about wearing masks. You know, you're, you're breathing in your own exhaust, for example. I'd just like to have you give some more comments on that and, and maybe it's just a good year-- that there's less flu and colds around also-- just your ideas on that?

TIMOTHY TESMER: Well, I-- I can tell you, as a, as-- in what I do in the operating room, wearing a mask a lot, you're, you are correct. I mean, probably tend to get a little bit more open-mouth breathing and tired and somewhat even a headache the longer that you wear a mask. I don't doubt any of that. I think that the quality of the mask probably plays a role in that. A good-quality mask will try to prevent outside pathogens, outside, offending things from reaching your respiratory tract and then you've got less chance to spew out germs. I, I just

think that from-- at least for this past year timeframe from my personal ear, nose, and throat public health perspective, I just have seen quite a bit less incidences of upper-respiratory induced infections to the point that statistically, from a surgical volume of what I do, just the ears, tonsils, nasal/sinus surgery, I've probably seen about a 30 percent de-- decrease in those types of related surgeries. So I-- there's got to be something to it. How long we will-- how long we should do it or we'll have to do it will remain to be seen, but I think within the last year, I think it has, I think it-- I think the masks have helped, I do.

MURMAN: Thank you.

ARCH: Seeing no other questions, Dr. Tesmer, thank you very much.

TIMOTHY TESMER: Thank you all.

ARCH: We'll-- at this time, we will take any proponents for the appointment. Seeing none, any opponents for the appointment? Seeing none, anyone want to testify in the neutral capacity? Seeing none, Dr. Tesmer, this will conclude your hearing and we will consider this in committee and, and if favorable, we will vote this out of committee and it will, and it will then go to the full floor for a vote.

TIMOTHY TESMER: OK.

ARCH: Thank you very much for volunteering to be part of the Board of Health and this will conclude your hearing.

TIMOTHY TESMER: Thank you all very much, appreciate it.

ARCH: Thank you. You have a good day.

TIMOTHY TESMER: Um-hum, bye-bye.

ARCH: And now we will open the hearing for Dr. Michael Kotopka for the Board of Health. I hope I pronounced your name correctly.

MICHAEL KOTOPKA: Yes, that's correct. You can say Katopka [PHONETIC], but--

ARCH: Kotopka? Thank you.

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MICHAEL KOTOPKA: Mr. Chairman--

ARCH: Welcome.

MICHAEL KOTOPKA: --senators and other committee members, very excited and honored to sit in front of you today for this hearing. I'll just, if it's OK with you, just give a little personal--

ARCH: Please, yes.

MICHAEL KOTOPKA: --introduction and then--

ARCH: Please do and if you could spell your name for the record as well?

MICHAEL KOTOPKA: Sure, it's Michael, M-i-c-h-a-e-l, Kotopka, K-o-t-o-p-k-a. So I personally have been married to my wife, Ann, for 30 years. We have seven children. I moved to Nebraska in 1983, attended UNL-- UNMC College of Dentistry. After graduating, I served in the Air Force and after my commitment was over, came back to Nebraska in 1997 and have been practicing in private practice general dentistry ever since. But why am I interested on-- being on the Board of Health as the one dental member? It's kind of a confluence of having more capacity to do it. For example, my children are getting older. I've always wanted to serve the public more. Now I'm having more time to do it, so a few months ago, I received a call from the Governor's Office and they indicated there is an opening for the dental member. Dr. Kevin Low was past his, his term and so they really needed to find a new member. After performing some due diligence, I determined that serving on the board would be something that I could do to give back to the state of Nebraska and I would be-- I feel like I can do it. And it's really quite an honor, so I'd really be honored to do it.

ARCH: Thank you. Thank you for volunteering to do that.

MICHAEL KOTOPKA: My pleasure.

ARCH: Questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for your service in the Air Force. Were you a dentist in the Air Force?

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MICHAEL KOTOPKA: I was, yes.

M. CAVANAUGH: We have oftentimes some hearings around dentistry that deal with Medicaid and reimbursements. I just was curious, as a practicing dentist, what is your experience in, in that area?

MICHAEL KOTOPKA: So we try to find a way-- so I'm in a group-- an owner of several practices and we try to find a way to serve the underserved, but we still need to keep our lights on and, and stay in practice and so there is a balance that, you know, needs to be taken care of. Fortunately, in Lincoln at least, there are many charitable organizations. For example, Clinic with a Heart sees the underserved. I volunteer there, but more needs to be done. I know for children, most of the pediatric dentists accept Medicaid patients up to-- and they're-- they have their own limitations for each office. It might be up to a certain age and then the adults, I think, is where some falls through the cracks. So we do serve some Medicaid adults, but we need to kind of limit-- put limits on how many-- we, we try to work them in and serve the public that way. There could be more done, I think.

M. CAVANAUGH: If our Medicaid expansion program didn't have two tiers, but just had the same benefits for everyone that included dental, would that be easier for dentists?

MICHAEL KOTOPKA: I think so, um-hum.

M. CAVANAUGH: OK, thank you.

MICHAEL KOTOPKA: You bet, it would be a lot easier.

ARCH: Other questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch and thank you, Doctor, for being here. My question relates to the 407 credentialing review process. Have you been involved with that at any level to date?

MICHAEL KOTOPKA: So far, I have not been involved in the credentialing process.

WILLIAMS: But that's something that I, I know is one of the relationships that we see that's, that's very important and, and I know you'll have an opportunity to be involved with that and appreciate your willingness to serve.

MICHAEL KOTOPKA: Well, thank you very much.

ARCH: Other questions? Do you, do you come to the Board of Health with any particular passion, agenda that you, that you would really like to see for citizens of Nebraska?

MICHAEL KOTOPKA: Yes, so the mission of the DHHS is helping people live better lives and I think as a board member or as board members of the Board of Health, we can all-- if we just focus on that mission from the health standpoint, we can help Nebraskans to live better lives and as a dentist, I want to do my part of that. You know, dentistry is a big part of health for an individual and a public health population and I just passionately want to help people live better lives.

ARCH: Thank you. Any other questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. What, what are some of the opportunities that you see through the Board of Health in, in doing that?

MICHAEL KOTOPKA: A couple of things, as you mentioned, so seeing ways that we can serve the underserved better. I think Nebraska does a pretty good job overall, but anywhere we can serve more people, more of the underserved, we would be-- that's something we can focus on. Another thing is public safety, so, for example, in dentistry, there's a lot of do-it-yourself products on the market as far as, like, orthodontic aligners, occlusal guards are being marketed, so it-- we just need to keep an eye and make sure these products are safe for the public to use, so-- anything in the future that comes up too, so--

M. CAVANAUGH: Thank you.

ARCH: Any other questions? Seeing none, thank you very much for volunteering and for coming today to testify. At this point, we'll take any proponents. Any opponents? Anybody in the neutral capacity? Seeing none, as I've said before, we will consider your appointment and if favorable, we'll vote it out of committee and move it to the full floor for confirmation.

MICHAEL KOTOPKA: Thank you so much, Senator Arch--

ARCH: Thank you.

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MICHAEL KOTOPKA: --and committee members.

ARCH: Thank you. That will close the hearing for Michael Kotopka and we will now open the hearing for Dr. Mark Patefield. Welcome, Dr. Patefield.

MARK PATEFIELD: Good morning. Good morning to all of you. So my name is Mark Patefield, M-a-r-k P-a-t-e-f-i-e-l-d. I am a pharmacist. I grew up in Laurel, Nebraska, and I attended undergrad here in Lincoln at the university and then Creighton for my pharmacy program. My wife is a pharmacist as well. We met at Creighton and together, we own pharmacies in Laurel and Wayne. We've got four kids ages five through 13 and I was asked to consider serving on the Board of Health. The timing was really good. I had just finished up my second term as the mayor of Laurel and so can't run again, so asked to serve on this board. I felt that with my history of, of doing that, along with-- there tends to be not a lot of pharmacy-- I, I work in retail pharmacy, so most retail pharmacists aren't necessarily involved in government or things like that. They're just busy working and so-- tends to be hospital pharmacists or academic pharmacists who tend to be more involved with things like this. So I felt my voice and being kind of on the front lines, working the bench, would be a benefit to the committee, just because I have a lot of interaction with patients, kind of see things on the front line, you know, deal with insurance directly all day, every day. So a lot of those aspects I thought would be beneficial to the, to the state board.

ARCH: Thank you. Questions for Dr. Patefield?

MARK PATEFIELD: Yeah.

ARCH: Senator Day.

DAY: Thank you, Chairman Arch. Thank you for being here today. Where exactly is Laurel?

MARK PATEFIELD: Laurel? Northeast corner, so if you made a triangle between Norfolk, Sioux City, and Yankton, it's basically right in the center of that.

DAY: OK, OK.

MARK PATEFIELD: And a lot of people hear Morrill with an "m," which is way out in the Panhandle, so--

DAY: OK.

MARK PATEFIELD: I definitely would be calling in from there.

DAY: And so this essentially would be a continuation of your public service. You were mayor of Laurel. What interested you in the area of public service? How did you--

MARK PATEFIELD: I think I've always just had that desire to, to give back. You know, I realized even coming out of high school how much I benefited from the things that had been done for me by people. You know, you look-- as mayor, you know, we tried to do things and I always think about the future. What does this mean for my kids? What does it mean for them to come back to the area? And public service is just all about that. How can I serve people, make their lives better, make, you know, Nebraska a place that attracts people that they want to live-- you know, that's been going on forever, the, the brain drain in Nebraska, you know. We raise the best kids and then they don't stay, so all the ways that we can help them stay here, see the, you know, the quality of life that we have.

DAY: That's wonderful, thank you.

ARCH: Thank you. Other questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thanks for being here. I see there's a, a lovely article about your family-- I don't-- it might be a couple of years old-- in the Community Foundation.

MARK PATEFIELD: Oh, yes, yes.

M. CAVANAUGH: And do you still have the old-fashioned soda fountain?

MARK PATEFIELD: We do, yes.

M. CAVANAUGH: I'll have to come visit. It sounds, it sounds really lovely. I did want to ask a similar question that I asked previously about pharmaceutical or medical-- medicinal marijuana. As a pharmacist, if Senator Wishart's bill were to be enacted into law-- and I don't know if you're familiar with the particulars-- I'm not

particularly familiar with the particulars, but how will that impact pharmacy-- pharmacology in Nebraska and, and what role do you see yourself playing in that as a member of the Board of Health?

MARK PATEFIELD: Right. That's the-- I think it's a pretty long bill, correct?

M. CAVANAUGH: Yes.

MARK PATEFIELD: Very, very detailed, yeah, I've-- I read all that one. So after reading it, I come away with a couple of questions. You know, there's synthetic THC, which is already available as a product that's available. And I don't know if people are-- I should say prescribers are somewhat resistant to prescribing it off label. I think it's just the on-- the labeled use is to increase appetite for certain, you know, chemotherapy, things like that. So yeah, my, my question reading through it is what is the benefit that is not already available? I've looked at CBD quite a bit over the last couple of years since that was made legal through the, the federal level a couple of years ago and there's a lot of benefits that I've seen from that as far as the CBD anti-inflammatory properties and so that is another route that, that is possible, you know, but that also has to be regulated because some of this stuff you see come in, you know, that's sold at a gas station or whatever is noneffective, you know, claims to be something that it's not. So to use that, you'd have to go through proper channels, kind of like pharmaceuticals, you know, where chemical assays are done to verify the quantity of product in there and things like that. And those are available and so yeah, that, that's kind of my question is-- as I see that bill is why this route, maybe, when other products are available that don't maybe have the negative implications, you know, the--

M. CAVANAUGH: So the synthetic THC, heard from a woman yesterday that her prescription for that is $3,000 a month.

MARK PATEFIELD: Wow.

M. CAVANAUGH: Has that been your experience?

MARK PATEFIELD: No, I-- it dep-- it would depend on how much they would use. I had-- I haven't used it in several years or I haven't dispensed it in several years. It actually just expired and I hesitate

to even say-- I want to say it's like-- it was a couple hundred dollars, the ones that we did.

M. CAVANAUGH: OK, so it wouldn't-- this person maybe needs it for a higher dosage.

MARK PATEFIELD: Right, that's, that's possible.

M. CAVANAUGH: OK, I didn't-- I, I'm not familiar, so I wasn't sure if it's cost prohibitive, so--

MARK PATEFIELD: Right and yeah, that's another complete issue with how insurance companies would pay for anything that's considered medical. You know, they're, they're very protective right now. So in my experience, the-- with the opioid crisis right now, all the insurance companies are putting limitations in place. How many-- if somebody gets a first-time prescription for, say, morphine, they can only get so many, last a week, you know, and then there has to be prior authorizations done. So if that bill was approved for insurance coverage, I think there would be several hurdles to overcome for payment.

M. CAVANAUGH: Thank you.

ARCH: Other questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and, and thank you for, for being here. We get into a lot of issues, in particular, issues, as you just mentioned, between insurance companies and pharmacists and pharmacy benefit managers and MAP pricing and auditing and all of those kind of things. I'm assuming you've experienced, from the pharmacy side, those kinds of things and could bring that expertise to the Board of Health to help them with looking at those also?

MARK PATEFIELD: I think so, yes. I, I actually testified on behalf of PBM legislation last year and I know there's one coming up with a hearing next week, but yeah, plenty of--

WILLIAMS: Yes, there is.

MARK PATEFIELD: Yes.

WILLIAMS: We'll see you next week.

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MARK PATEFIELD: Yeah. I don't know if I'll make it for that, but yes, just the experience because I think most people generally don't even know what a PBM is, you know, and-- but they are basically the force behind what's paid for, what's not, whether people can get things, whether they can't, whether pharmacies stay in business or, you know, close their doors, kind of like the previous was talking about, how they can only accept so many Medicaid patients. You know, those-- you want to help everybody you can, but if you have to close your doors, you're helping no one. So that balance, yes, I've definitely dealt with that a lot, so-- yeah, I, I've been trying to get a contract with one company of an employer in our area and they just say absolutely not, no. We have to drive to Sioux City or Norfolk or get a mail order, so--

WILLIAMS: Thank you.

ARCH: Any other questions? Seeing none, thank you for volunteering to do this. I really appreciate you coming down and, and testifying today as well. Are there any proponents? Are there any opponents? Is there anyone that would like to testify in a neutral capacity? Seeing none, again, we'll consider and if, if found favorable, we'll vote it out to the floor and there will be a discussion and a vote on the floor.

MARK PATEFIELD: All right, thank you all.

ARCH: Thank you. This will close the hearing for Dr. Patefield and we will now open the hearing for Dan Vehle and I hope I pronounced that name correctly.

DAN VEHLE: You did.

ARCH: Oh, great. All right.

DAN VEHLE: You're one of the few that has ever gotten that right. It should have been anglicized generations ago, but it is what it is.

ARCH: OK.

DAN VEHLE: I was instructed to perhaps bring something with me to familiarize the committee.

ARCH: Sure. If you just hand it to the page, they'll hand it out to us.

DAN VEHLE: Very good.

ARCH: And if you could state and spell your name to begin and then tell us a little bit about yourself?

DAN VEHLE: Yes, sir. Thanks again for this opportunity to come and address the committee today, Senator. My name is Dan, D-a-n, last name is spelled V-e-h-l-e. I've been a resident of Nebraska since 1988. I grew up in South Dakota. I'm native from there, graduated from the University of South Dakota and embarked on a career that has-- its amazing how sometimes the small decisions you make in your life can lead you down a path that you didn't expect. And as I was graduating from college, I made it a point to go and visit the secretary of the business school's dean. I didn't attend any classes in the business school because I was a political science major and had earlier been a biology major, so I didn't really have a solid plan as I was graduating in four years. So I went to speak with the secretary and I asked her, has anybody brought you a Coca-Cola today? And she said, no one has ever bought me a Coca-Cola ever. I made a friend and quickly found myself with a host of possibilities for job interviews and I took a position with a company called Burroughs Wellcome, which at first, I thought was Burroughs corporation, the business machines folks, and it turned out they were pharmaceuticals. And a small step led to an entire career, which now spans 43 years, and as I am now-- am approaching my 66th birthday, I was speaking with my wife about what it is that we do when we decide that our time in the occupations that we've served is, is coming to a close, but you feel like you are, you are not prepared to be unproductive. You have to find things to do that-- because you have much yet to contribute. And it turns out that my brother is a former state representative and then a term-limited state senator in South Dakota. I'm proud of him in the way that he was the first and only legislator to be honored in the hall of fame for the second-- for the Department of Transportation, as he was able to construct a bipartisan alliance in the legislature there to help fund a 30 to 40-year plan for roads and bridges in the state of South Dakota. And it took, as he explains to me, it, it took him years and his terms of serving in the Senate to find a coalition of people to gather together to bring this really bipartisan effort together. And so naturally, I said to him, well, I sure hope I can do something like that sometime. And he said, well, what does-- what is that you can provide for folks? I said well, I've spent a year-- I spent years-- my whole career-- in medical sales, but in that course of my time, I've

learned a lot about people and I've learned a lot about how to gather people together in an effort that we find the common good. As I was stating before, I was speaking with my wife about this. We've been married 28 years. We have two daughters, both are graduates-- one's from Creighton. She's a nurse now, presently at Children's Hospital. My other daughter graduated this May here from Lincoln and she immediately landed a job with LRS Healthcare as a talent acquisition specialist. So the whole family is involved in this in terms of being in healthcare and for myself, I've spent all these years-- while working with my career, I also spent a seven-year period where I served in the-- on the educational board for Concordia schools in Omaha and I spent there-- also one year as vice president, two years as president of the, the board. You know, as you probably know, parochial education is a wonderful thing and it doesn't have deep pockets. So when you are in a position like that, you're always looking to find consensus, find people to contribute to help. Sometimes it's not always monetary, sometimes it's finding ways that people can assist. And so as I approach my 66th birthday, I find myself in a position where I would like to be able to contribute in another way and serve the state of Nebraska. So it turned out that a member of my Bible study group had said, as I was speaking to her about the possibility, I'm probably going to retire here very, very soon. She said have you ever thought about a Board of Health? I know that they have public lay members on there and I thought to myself, perhaps, perhaps I could bring a different perspective in that public membership. Having served in industry and having served in this capacity for these years, sometimes industry can, can be a word that seems rather monolithic and-- not as caring. The truth is people are an industry and many times, you can-- with solid discussion and heartfelt statements, you can find ways to make industry move in, in efforts that help benefit society and that's what I'd like to bring. I'd like to bring that perspective to the board, if I can.

ARCH: Thank you. Thank you. Questions for Mr. Vehle? Senator Day.

DAY: Thank you, Chairman Arch, and thank you for being here today. So it looks like on your resume, you've been all over the United States. Are you-- this--

DAN VEHLE: The resume may reflect the companies I've worked for, but that-- I've lived in Nebraska.

DAY: OK, so you're working remotely or you're flying back and forth currently between--

DAN VEHLE: No, no, I really work a territory that would be centrally located out of Omaha and I'll cover locations in Lincoln, Kearney--

DAY: OK.

DAN VEHLE: --Norfolk, also Sioux City and Sioux Falls.

DAY: OK.

DAN VEHLE: So my time in-- living as a citizen here in Nebraska, having moved up here from South Dakota, has generally mostly been spent covering sales management perspectives from our companies based out of Omaha.

DAY: OK. OK, thank you. Yeah, that-- I was just going to ask what keeps you here in Nebraska, but it looks like-- and you have two daughters, so I'm assuming it's--

DAN VEHLE: And I'll be honest, you grow up in South Dakota, there's not a lot of people there and we didn't have any Division I team, so when Bob Devaney was taking us against Oklahoma that day-- on Thanksgiving, it was winter in South Dakota, we had friends who were visiting from Omaha. I became a lifelong fan and I'd always hoped that my kids would eventually go to Nebraska. Well, I got both. I got one at Creighton and at Nebraska, so it's a, it's a constant fight between blue and red in the house and it's-- but it's good.

DAY: Thank you, thank you.

ARCH: Thank you. Other questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thanks for being here. I have two questions.

DAN VEHLE: Yes.

M. CAVANAUGH: The first is where in South Dakota are you from?

DAN VEHLE: Chamberlain.

M. CAVANAUGH: Chamberlain.

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DAN VEHLE: Is a-- it's a small town.

M. CAVANAUGH: I know.

DAN VEHLE: You probably know-- it's right at the junction of the Missouri River and Interstate 90 and if you come over to the hill going west, Missouri River opens up into this beautiful-- you've been there?

M. CAVANAUGH: Yeah.

DAN VEHLE: Yes.

M. CAVANAUGH: My husband's from South Dakota.

DAN VEHLE: Where from?

M. CAVANAUGH: Big Stone City, booming--

DAN VEHLE: I'm sorry?

M. CAVANAUGH: Big Stone City.

DAN VEHLE: Way up north in-- oh, by, by [INAUDIBLE]--

M. CAVANAUGH: Grant County, Grant County.

DAN VEHLE: Yeah, yeah, cool up there.

M. CAVANAUGH: Booming metropolis.

DAN VEHLE: Cool and cold up there.

M. CAVANAUGH: The city is a misnomer in that one. What-- based on your experience and, and your interest in serving, what about the Board of Health-- what did-- what do you, what do you hope to accomplish as a member of the Board of Health?

DAN VEHLE: What I'd really like to do is determine if there are ways that I can be a liaison to various industries, wherever it may be an issue for the Board of Health, to, to have some kind of interaction. My hope is that having been in this position for 40-plus years, that I could serve the board in a way that might be a bridge, a bridge with industry executives and help them understand the positions that we

have or the-- better yet, some of the issues that the senators in the Unicameral might be jockeying and going back and forth about and see if we can't find a way that is-- we can provide some sort of assistance, some sort of direction, anything that could help in that terms for the state of Nebraska and the citizens of Nebraska.

M. CAVANAUGH: Thank you.

ARCH: Other questions? Seeing none, you have-- you do have a very interesting background.

DAN VEHLE: Oh, that's good.

ARCH: You would bring a-- it will bring an added perspective, I'm sure, to the Board of Health.

DAN VEHLE: Here's the problem you have, Senator Arch. You give a salesman a microphone and undivided attention, I've got, I've got a story that can last until the next door, you know, so I'll, I'll try to learn too.

ARCH: Well, thank you. I mean, thank you very much for volunteering, obviously and, and for your, your service even at Concordia and, and in other things that you've done. So with that, are there any proponents? Are there any opponents? Is there anybody that would like to testify in a neutral capacity? Seeing none, thank you, and we will consider that appointment and if favorable, we will vote it out of committee and to the floor.

DAN VEHLE: Very good. Thank you. Senator Arch, Senator Cavanaugh, Senator Day, thank you very much for your questions.

M. CAVANAUGH: Thank you.

ARCH: Thank you. That will close the hearing for Dan Vehle and we will now open the hearing for Bud Synhorst.

BUD SYNHORST: Good morning, Chairman Arch and members of Health and Human Services Committee. My name is Bud Synhorst, B-u-d S-y-n-h-o-r-s-t, appreciate your time and opportunity here today to be able to talk about joining the State Board of Health. I am a graduate of the University of Nebraska at Kearney with a degree in education. I have a master's degree from the University of Nebraska and I think as

you've probably seen in my career, I've done a lot of different things throughout the state of Nebraska in many different capacities and I absolutely love our state. I think as a lay member of the committee, I can bring a lot of different perspectives to the committee and I think one of the reasons that I was so interested in raising my hand and applying for this appointment was I've always been an advocate. I currently serve as the president and CEO of the Lincoln Independent Business Association and one of the things that I advocate to our members is always stand up and raise your hand and get involved. And every time the Governor's boards and commissions comes out, I put it out on our social media pages. I talk about it in communications to our members. And I decided, well, if I'm going to preach it, I better live it a little bit too, so I think it's a great opportunity to serve our, our community and our state. Having worked in the nonprofit sector, I think there's a lot of different perspectives that I can bring to the committee working in education, working-- having worked in healthcare, having worked in association management, I think there's a lot of different good perspectives that I can bring. I worked in healthcare at Mary Lanning out in Hastings for about three years where I was involved with the foundation and also did a lot of outreach throughout central and south-central Nebraska, southwest Nebraska. So I think there's a lot of different perspectives there that I can bring to the committee and I appreciate the opportunity to be here today.

ARCH: Thank you. Questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thanks for being here. Are you familiar with the 407 process?

BUD SYNHORST: I am not, Senator.

M. CAVANAUGH: OK.

BUD SYNHORST: I apologize.

M. CAVANAUGH: What, what issues with the Board of Health are you passionate about and, and what do you, what do you want to accomplish in that role?

BUD SYNHORST: I think as, as a member of the Board of Health, what was intriguing to me was, number one, the ability to get involved, but

also the ability to learn-- I think the outside perspective that I can bring. But also having been involved in the legislative process, I think that's an area where I can really help the, help the-- help talk about issues, look at issues, help put together testimony, those kind of things, so helping kind of on the legislative side. I'll be honest with you, Senator, when I, when I applied, I didn't have a specific item or agenda that I was mostly applying for, so I was-- there was no single issue.

M. CAVANAUGH: OK, thank you.

ARCH: Senator Williams.

WILLIAMS: Thank you, Chairman Arch. It took me all these years to find out that your real name is Robert.

BUD SYNHORST: It's a, it's a big secret, Senator.

WILLIAMS: Full disclosure, I've worked with Bud Synhorst on a lot of issues for many years in his life outside of this. COVID has dominated our lives for the last year. It's dominated healthcare. It's also had a great impact on the association that you are head of right now.

BUD SYNHORST: Yes, sir.

WILLIAMS: Do you see any of that, in maintaining your representation of LIBA, with the service on the Board of Health and with the COVID issues?

BUD SYNHORST: Are you asking if I'm seeing conflict, Senator? I'm not-- I guess I'm not understanding.

WILLIAMS: Well, I'm, I'm seeing-- the lessons that you have learned over the last year?

BUD SYNHORST: Oh, OK. Yeah, I think-- and I think, you know, over the course of the last year, who would have ever thought within the first year and a half on the job, I'd be helping lead an organization through a pandemic? But I think understanding the issues that businesses are seeing and how it's impacting our members, but also to be able to bring those perspectives to the board I think is valuable. I think it's interesting being a lay member of a Governor-appointed committee just because, you know, sometimes when you're not in the eye

of a hurricane, you see a little differently and, and I think that's one of the perspectives that I bring. Governor Ricketts also appointed me to the Judicial Nominating Commission and I'm not a lawyer either, so it, it was-- you know, to be able to bring and look at things from a different perspective. So I think it's, it's a great opportunity to, to be a voice for our members, but be an advocate and help understand what the issues are facing outside of the medical community and, and bring a wider, wider view, I would say.

WILLIAMS: Thank you.

BUD SYNHORST: Thank you, Senator.

ARCH: Thank you. Other questions? Senator Day.

DAY: Thank you, Chairman Arch, and thank you for being here today. You said you're the president and CEO of the Lincoln Independent Business Association. I've heard of the organization, but I'm a small business owner myself, so it's just interesting. I would like to hear more about exactly what--

BUD SYNHORST: Well, thank you for that, Senator.

DAY: Yeah.

BUD SYNHORST: We represent over 1,000 businesses here in Lincoln and mostly Lincoln and Lancaster County. Our primary focus is kind of twofold. We want to connect small business owners. You know, you never know when the plumber needs to know an, an auto-repair person or different things like that, but also to bring small businesses together and educate them on issues that come before this body, that come before our city and county boards. A lot of our members don't have the ability to hire a lobbyist or maybe they don't have someone in their business-- I'm, I'm guessing you don't have a lobbyist in your business--

DAY: I don't, no.

BUD SYNHORST: --if you're a small business owner and I'm guessing, I'm guessing you don't have a government affairs person.

DAY: You know, I don't have one of those either.

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BUD SYNHORST: And so we kind of serve that role to be able to watch the-- how the issues that come before, you know, the school board, county board, NRD board, we're monitoring all of those-- the Legislature, obviously, and our federal delegation-- the issues that come before them and how they might impact a small business owner and try to communicate to our members what's happening so that they know, so to provide a, a good education to our members of what's happening from the elected official, an elected body perspective, but also to advocate for small businesses and be their voice to bodies like the Legislature. We testify frequently in front of the Legislature. I've seen many of you in several different committees. If you've been around the Revenue Committee or General Affairs, you've probably seen me a few times. So that's kind of what the primary purpose of us is to educate both our members about what's happening on issues. Because a lot of times when you're a small business owner-- again, you're in the eye of the hurricane, you're running your business, you may not know that there's a regulation coming from city hall that's going to negatively affect your business where you might have to-- it might cost you tens of hundreds of thousands of dollars.

DAY: Right, right.

BUD SYNHORST: So we try to be that conduit for business owners, but also make that connection with our elected officials so they understand the--

DAY: Yeah--

BUD SYNHORST: --the plight of the small business owner and how things are affecting small businesses.

DAY: Yeah, I, I appreciate that. I think that's-- especially after going through the pandemic as a business owner, it's an important perspective to potentially have on the State Board of Health as well, so--

BUD SYNHORST: It's been a really tough year for our business owners.

DAY: It has, yes.

BUD SYNHORST: You know, I mean, as you probably have seen, there's, there's so many things that have happened to business owners not because of their actions.

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DAY: Right.

BUD SYNHORST: You know, we look at all the things and the regulations that kind of came down throughout this and how it impacted them and trying to help them find ways to pivot. I'm, I'm really proud that our organization was able to stay open every day. We never closed our offices. We modified our hours because to me, it was important for us to be there when that phone rang. When that business owner called and needed access to a resource, I, I felt it was important for us to be there. Nothing's worse than when you're trying to call for help and you can't get it.

DAY: Right.

BUD SYNHORST: You know, I think of people that have tried to call for a counselor and they can't get a counselor to call them back and those kind of things, so we really wanted to be there and be that voice for them and I, I feel like we've done a nice job of that this year.

DAY: That's great. Thank you so much.

BUD SYNHORST: Thank you.

ARCH: Other questions? Seeing none, thank you very much. Thanks for volunteering. Thanks for stepping up. Thanks for being an example to your members of the association.

BUD SYNHORST: Yes, thank you very much. I appreciate the opportunity to be here today.

ARCH: Thank you. Are there any proponents? Are there any opponents? Is there anyone that would like to testify in a neutral capacity? Seeing none, this will close the hearing for Bud Synhorst and we will now open the hearing for an appointment to the Commission for the Deaf and Hard of Hearing. Welcome.

JOSH SEVIER: Good morning, senators. I am Dr. Josh Sevier, J-o-s-h S-e-v-i-e-r. I am a cochlear implant audiologist at the University of Nebraska in Lincoln. I run the cochlear implant program there, as well as the one at the Children's Hospital of Omaha. I've been very involved with legislative affairs since I moved to Nebraska in 2016 for the Nebraska Speech-Language-Hearing Association and I'm currently trying to do anything we can to-- excuse me-- to continue to build our

cochlear implant program. I'm originally from Nashville, Tennessee, hence the accent. I came here to work at the cochlear implant program at Boys Town National Research Hospital in 2016 and I moved over to the University of Nebraska July of 2018, have been there ever since. I served -- was a Navy Hospital Corpsman right out of high school, served with the Marine infantry and went to college initially to be a trauma surgeon, oddly enough, because that's all I had done in the military. And then my last semester of college, I started working with the deaf and hard of hearing and it completely changed the scope of my career trajectory and I guess the rest is history.

ARCH: Interesting, thank you. Questions for Dr. Sevier? Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and, and thank you, Doctor, for your willingness to donate your time in a very busy schedule. You talked about one career path and then switching. What caused that to happen?

JOSH SEVIER: I noticed when I was working with the, the deaf group-- honestly, I got started working with the deaf because there was a chapter of my fraternity when I was in college that had a complete deaf chapter at Gallaudet University in Washington, D.C. When I met them, I became frustrated because I couldn't communicate with them and I started learning sign language and got pretty good at it, took a formal program in my hometown and started getting closer and closer. So I started researching health careers with the deaf because I wanted them to have all the same opportunities that we did. They would have to have an interpreter with literally every event that they went to and I can only imagine how frustrating that could be when you don't have access to communicate with people, so I wanted to do anything that I could to try to help in that process.

WILLIAMS: Thank you.

ARCH: Thank you. I, I have a question. The, the, the technology impact on the, on the deaf and hard of hearing community has, has been significant with, with cochlear implants.

JOSH SEVIER: Absolutely.

ARCH: And, and I know that the Commission for the Deaf and Hard of Hearing wrestle with some of those, with some of those issues. How, how have you, how have you seen that in your own practice with deaf and hard of hearing and family members and, and how have you navigated that with the, the technology impact?

JOSH SEVIER: That's a great question. That is something that comes up pretty regularly for me actually. A lot of my friends that are deaf, when I told them what I specialized in, it was a pretty taboo thing. They see-- a lot of them that have been raised in the-- what we call the "big D" deaf community saw it as an attack on their culture and I completely understand that. The way I view cochlear implants moving forward is not as trying to remove culture, but to give people options if they choose to pursue that. I-- when we do consultations for cochlear implants for families, we don't force one thing over the other. I want to present each option equally for you so you have the best informed decision that you can make. I have noticed, more culturally, deaf people be more accepting of later on down the road. And it's still not for everybody and that's absolutely fine, but for the people that choose not to pursue cochlear implants, I want them to have the same amount of access. But I don't look at it as a cure for hearing loss or trying to remove a culture. I navigate it as I'm going to present you with the option and I want you to make the best choice that you feel like is right for you, so I hope that answered your question.

ARCH: That does, that does, thank you. Thank you. Any other questions for Dr. Sevier? Seeing none, thank you for volunteering, and again, we'll consider this in committee and then if favorable, we'll vote it out to the floor.

JOSH SEVIER: Thank you very much--

ARCH: All right.

JOSH SEVIER: --appreciate it.

ARCH: Thank you. Are there any proponents? Opponents? Neutral? This will close the hearing for Dr. Sevier and will close the gubernatorial appointment hearings for the morning.

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ARCH: Welcome to the Health and Human Services Committee. My name is John Arch. I represent the 14th Legislative District in Sarpy County and I serve as Chair of the HHS Committee. I'd like to invite the members of the committee to introduce themselves, starting on my right with Senator Day.

DAY: Senator Jen Day. I represent Legislative District 49, which is northwestern Sarpy County.

MURMAN: Hello. I'm Senator Dave Murman from District 38 and I represent seven counties to the west, south, and east of Kearney and Hastings.

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

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

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

ARCH: Also assisting the committee is one of our legal counsels, T.J. O'Neill, and our committee clerk, Geri Williams and our committee pages, Kate and Rebecca. A few notes about our policies and procedures: First, please turn off or silence your cell phones. This afternoon we'll be hearing one bill, the last bill for the HHS Committee this session. The hearing will begin with the introducer's opening statement. After the opening statement, we will hear from supporters of the bill, then from those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given the opportunity to make closing statements if they wish to do so. For those of you who are planning to testify, you will find a green testifier sheet on the table near the entrance of the hearing room. Please fill one out. Hand it to one of the pages when you come up to testify. This will help us keep an accurate record of the hearing. We use a light system for testifying. Each testifier will have five minutes to testify. When you begin, the light will be green. When the light turns yellow, that means you have one minute left. When the light turns red, it is time to end your testimony and we will ask you to wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone and then

please spell both your first and last name. If you are not testifying at the microphone but want to go on record as having a position on the bill being heard today, please see the new public hearing protocols on the HHS Committee's webpage on nebraskalegislature.gov. Additionally, there is a white sign-in sheet at the entrance where you may leave your name and position on the bills before us today. Due to social distancing requirements, seating in the hearing room is limited. We ask that you only enter the hearing room when it is necessary for you to attend the bill hearing in progress. The agenda posted outside the door will be updated after each hearing to identify which bill is currently being heard. We request that you wear a face covering while in the hearing room. Testifiers may remove their face covering during testimony to assist committee members and transcribers in clearly hearing and understanding the testimony. Pages will sanitize the front table and chair between testifiers. This committee has a strict no-props policy. And with that, we will begin today's hearing with LB392. Welcome, Senator Stinner.

STINNER: Good afternoon, Chairperson Arch and members of the Health and Human Services 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. LB392 establishes a pathway for a licensed psychologist to complete supplemental postdoctoral education and supervised training in a clinical psychopharma-- pharmalogical-- to qualify for the prescription certificate and thereby provide more comprehensive services to patients. The bill requires postdoctoral degree in clin-- clinical psychopharmacology-- I can almost stand up and cheer because I could almost pronounce that, right-- supervised practica and a two-year, physician-supervised experience with provisional prescription certificate. The bill also requires a written collaborative practice agreement between the prescribing psychologist and a licensed physician as a condition of practice under the pre-- prescription certificate. Prior to the pan-- pandemic-- prior to the pandemic, 88 of the 93 counties were considered a federally designated mental health profession shortage area, including my district, Scotts Bluff County. This includes psychiatry, where the Panhandle has lost three psychologists-- or psychiatrists since 2010. It bears reminding that we are already faced with mental and behavioral health crisis in America, which has been magnified in rural areas. In 2019, roughly 20 percent of the adults lived with at least one adverse mental or behavioral health symptom. Fast-forward to the current day and we face

with even a more urgent need for access to mental and behavioral health services. According to a C-- CDC report published in August of last year, 40 percent of the adults reported struggling with mental health or substance abuse, a marked increase from pre-COVID era. To help alleviate this crisis, I've continued my efforts from last year to introduce the Prescribing Psychologist Practice Act, heard in your committee as LB817. I have listened to feedback received from this committee, as well as opponents, during the hearing on LB817, which is why I've added additional safeguards to ensure the safety of patients and a liability protection of phy-- physicians. There will be testifiers behind me who will elaborate on the more granular detail of the bill, but first I would like to address a couple of those concerns. As was originally in LB817 from last year, this year's LB392 stipulates that the prescribing psychologist shall only prescribe in consultation and collaboration with the-- with the patient's primary healthcare prac-- practicer-- practitioner and with the concurrence of the primary health practitioner on prescriptions. To address concerns surrounding how a collaborative practice agreement is defined, I have included language from my proposed amendment from last year, AM2416. This language would define a collaborative practice agreement as a written agreement between a prescribing psychologist with a prescription certificate and a licensed physician. The language further stipulates that a collaborative practice agreement shall establish clinical protocol and practice guidelines relevant to the scope of the practice of the prescribing psychologist with a prescription certificate. Under this language, the Department of Health and Human Services, in consultation with the Board of Psychology-- Psychology and the newly established Prescribing Psychologists Advisory Committee, would adopt and promulgate rules and regulations for establishing practice guidelines under the collaborative practice agreement and protocols for prescribing medication. Furthermore, it would be a condition of practice under the prescription certificate that the prescribing psychologist participate in a collaborative practice agreement. Second, to address concerns with oversight in the development of rules and regulations, I have revised the advisory committee to include a family practice physician. Other members of the advisory committee include a psychiatrist, a pediatrician, pharmacist with a doctorate and expertise in clinical psychopharmacology, and a psychologist. Third, LB392 protects primary healthcare providers from liability for acts of the prescribing psychologist. And finally, I've contact-- I've been contacted by the

Department of Health and Human Services with some suggestion-- suggested revisions to harmonize provisions under the current Psychology Practice and Uniform Credentialing Act. Those changes are encapsuled under AM319, which I have distributed to you for your consideration as committee amendment. I've also included some additional information on these changes, all of which are technical in nature. With that, I hope the bill properly addresses many of the concerns that were expressed last year and will be a responsible-- responsible way to move forward with much-needed expanded access to mental and behavioral health services, particularly in the rural parts of the state. All of us are concerned with patient serve-- safety. I believe LB392 protects the public, which also is increasing access to a critical tool needed for the treat-- for the treatment of mental illness. There is a critical need in our state to expand mental and behavioral health services access, which has worsened under the pandemic. I've brought to you a bill that will not solve all the access problems but certainly will take a big step in the right direction. I appreciate your consideration of LB392 and would be happy to take any questions.

ARCH: Thank you. Are there questions? Seeing none, thank you. Will you be staying to close?

STINNER: Yes.

ARCH: OK, thank you. First proponent for LB392. Good afternoon.

ANNE TALBOT: Good afternoon. Good afternoon, Chairperson Arch and members of the Health and Human Services Committee. My name is Dr. Anne Talbot; that's A-n-n-e, Talbot, T-a-l-b-o-t. I represent the Nebraska Psychological Association. I'm also here to speak on behalf of underserved consumers in western Nebraska as the co-owner of Options in Psychology in Scottsbluff. Over the past ten years, we've developed a proposal that works effectively in other states, the military, and the Public Health Service. We listened carefully to concerns from the technical review committee and our opponents. We modified, revised, and adapted and clarified the proposal that has become LB392 in order to address those concerns. We hope to obtain the support and collaboration from our medical colleagues which has been successfully obtained and applied in other states where they have practiced prescriptive authority for now close to two decades. LB392 demonstrates a different scientist-practitioner model than traditional

practice. It is a systematic team approach that considers the whole person and demands collaboration and concurrence with the medical provider. As a psychologist who began as a critical care registered nurse, and with an M.S. in psychiatric mental health nursing, I can tell you our effort can be compared to that of advanced-practice nurses who faced down similar opposition and have gone on to demonstrate the value of in-- independent advancements in practice. Psychologists and doctoral-level clinicians are already independently licensed to diagnose and treat major mental illness across the lifespan. We follow a code of ethics that keeps us within our scope of practice and our clinical experience. We're mandated to demonstrate competency. We have training and-- and continuing education. We have a larger toolkit that allows for one appointment for prescribing in psychotherapy, which allows fewer co-pays and more frequent follow-up at lower cost. No, we're not trying to diagnose and treat major complicated medical problems. When we treat patients with complex, comorbid medical issues, we do exactly the same thing our colleagues in psychiatry do. We exchange crucial clinical information. We refer to the appropriate medical provider or we send people in imminent risk immediately to their physician's clinic or to the ER. We work to ensure people across the lifespan are accurately diagnosed and treated appropriately. We are trained to assess for medical problems masquerading as a mental health issue or vice versa. We collaborate and advocate in reducing the risk of inappropriate or overmedication. We see patients more frequently in a model that allows prescribing psychologists to diagnose, prescribe and treat with psychotherapy. More frequent follow-up, combined with psychotherapy, allows for systematic tracking and monitoring progress over time. And we're more likely to treat low-income consumers with fewer resources for insurance coverage, especially in rural areas but not limited to nonurban regions. Consumer survey data was already overwhelmingly in favor of the proposal submitted in 2017. Since we began this effort, the critical unmet need has become even more desperate. Western Nebraska is now down to one full-time psychiatrist. Several psychiatric nurse practitioners have already come and gone. The wait time to see a psychiatrist has increased from two to three months to seven to eight months. We have multiple examples of systemic stress at all levels, including destabilized individuals and families, children with disrupted learning, unmedicated or inappropriately medicated individuals with serious mental illness needing higher levels of care or presenting in the criminal justice system. Nebraska's psychologists

are prepared to meet this need. In contrast to psychiatry, our numbers are growing with existing recruitment and retention efforts in place. We have an increasing number of young psychologists seeking doctoral psychology internships to practice in rural and underserved areas. In the southern Panhandle alone, we have 35 applicants just this year for our APA-accredited doctoral internship sites, many with a strong interest in the postdoctoral master's in clinical psychopharmacology. The Prescribing Psychologist Act goes a long way in helping meet the need. We will work with our colleagues in medicine to assist them to meet the needs of underserved Nebraskans and to share our skills, training and ex-- expertise to make things work better. Thank you for your consideration, and I'll take any questions you might have for me.

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

WILLIAMS: Thank you. Chairman Arch, and thank you, Dr. Talbot, for being here. In your testimony, you talked about other states that are doing this now with prescribing psychologists. Do you have a list of how many states there might be, or could you provide that to us?

ANNE TALBOT: Yes, we can provide that. The states that have done it for close to 20 years are New Mexico and Louisiana. Other states that have pra-- have recently-- have more recently established prescriptive authority include Illinois, Idaho. Iowa is one that-- that obtained prescriptive authority more recently, I think there might be other bills pending, and some of my colleagues behind me can give you even more specifics about that data.

WILLIAMS: Am I also remembering something with the military providing this kind of service?

ANNE TALBOT: Ye-- yes, you are. Thank you. The military has pro-- has had proscribing psychologists for close to 30 years now. I think they began with prescriptive authority and they have-- we have a lot of data of the safety and efficacy of that practice.

WILLIAMS: Thank you.

ARCH: Senator Hansen.

B. HANSEN: Thank you. Maybe just your opinion on this; If this bill does pass, would you see the-- the use of antidepressants and

antipsychotics would go up in the state of Nebraska to deal with issues as opposed to stay the same?

ANNE TALBOT: I don't know about staying the same. I doubt that they would go up. I think that it's more likely we will-- as you can see, and I've got colleagues who can testify to how psycho-- psychol-- prescribing psychologists are likely to be less likely to prescribe unnecessary medication, to pre-- the capacity to prescribe is also the capacity to unprescribe. Because we have a larger toolkit, that gives us more options. We have-- spend more time with-- with patients so we can track and monitor their progress over time, and we want to reduce the number of unnecessary medications, beg-- beginning with getting the appropriate diagnosis and treatment. We have more tools to work with, and when we combine the two, that tends to re-- greatly reduce the-- the risk of overmedication. I can tell you, as a psychologist who does assessment and diagnosis, that that's been a very main focus of making sure the right diagnosis is there to begin with. Then people who need medications can be referred and we're less likely to overprescribe stimulants or antidepressants or benzodiazepines because of a more effective diagnostic-- diagnostic process, as well as having a broader range of tools to work with people over time.

B. HANSEN: OK, thank you.

ANNE TALBOT: You're welcome.

ARCH: Thank you. Senator Walz.

WALZ: Thank you. Thank you, Senator Arch. Just to follow up on Senator Hansen's question, when you talk about you have more tools, that would also include counseling?

ANNE TALBOT: Yes. By that, I mean psychotherapy. There are lots of different types of psych-- of counseling involved in psychotherapy. Psychologists provide the range-- range of psychotherapeutic strategies for a range of diagnostic or mental health concerns.

WALZ: All right, thank you.

ARCH: Other questions? I-- I have one. You-- you draw a comparison between psychologists and advanced-practice nurses. That's obviously a different training track, right, for a-- for an advanced practice nurse versus a psychologist. I guess, how would you-- how would you

respond to the concern, well, sure, an advanced-practice nurse comes through that medical-- that medical side of nursing and then APRN and so forth, whereas a psychologist doesn't come through that medical side, so, therefore-- right? How-- how would you respond to those two different tracks of training where both would then be qualified to prescribe?

ANNE TALBOT: Well, I can speak to that because I am a master's-level psychiatric nurse myself. I'm not an advanced-practice nurse. I pursued psychology for different reasons, so I can speak to both. Advanced-practice nurses may be trained under more of a medical model, but they are inclined to-- I know this from my nurse friends who I spend a lot of time with-- tend to treat more of a whole person. The psychology model begins with our training in-- we are trained to diagnose and treat major mental illnesses across the lifespan. So we already deal with serious and persistent mental illness, which does have some medical overlap. The training in the postdoctoral master's degree in clinical psychopharmacology is-- is heavy laden with adding on additional assessment for medical-- medical assessments and consideration that is specific to prescribing psychotropic medications. And I think some of my colleagues behind me are actually taking the training, can tell you even in more detail what that means.

ARCH: OK, thank you.

ANNE TALBOT: Thank you.

ARCH: Seeing no other questions, thank you for your testimony.

ANNE TALBOT: Thank you.

ARCH: Next proponent for LB392. Welcome.

LORI RODRIQUEZ-FLETCHER: Hi.

ARCH: You may proceed.

LORI RODRIQUEZ-FLETCHER: Good afternoon, Chairperson Arch and members of-- of the Health and Human Services Committee. My name is Lori Rodriquez-Fletcher, L-o-r-i R-o-d-r-i-q-u-e-z, hyphen, F-l-e-t-c-h-e-r. I am a licensed independent clinical social worker. I am an independent contract therapist with a group private practice and have offices in both Alliance and Scottsbluff. I am here today to

support LB392. While I am not a psychologist, I do work closely with them and value the work that they do. I also work closely with psychiatrists and other medical professionals. As a previous nurse myself, I also value the work of our medical community. I am here today as an advocate on behalf of my clients who are struggling to get their psychiatric medication needs met. I am here as a representative of western Nebraska, where we have limited services and options for psychiatric medication prescribers. We have only one full-time psychiatrist in the Panhandle. While primary care physicians, PAs, and nurse practitioners have tried to fill the gaps, it is not enough. They are too overburdened and many of them simply will not prescribe psychotropic medications to our clients for various reasons. Because of this, our clients are waiting anywhere from three to now up to seven months to get an appointment with a psychiatrist. It is draining on me as a clinician to be working so hard to try to help the clients and families that I work with, yet I'm often limited because my clients also need medication management that they simply are not getting access to. It is clinicians like me who are sitting with clients, parents and families, crying, feeling helpless and desperate. As one of the few clinical social workers in western Nebraska, I see some of the most vulnerable clients, with the majority of them being Medicaid or Medicare. I would like to share a few short-version stories of examples demonstrating how our current system is failing. The first is a seven-year-old foster child who was prescribed rather high dose of Abilify. At our therapy session, I noticed she was having tardive dyskinesia and I immediately referred her to her psychiatry provider, only to be told that she could not be seen before her next scheduled appointment, which was still over a month away. That is unacceptable. The next involves an adult client who has chronic and per-- persistent mental illness. She is an already established psychiatry client who generally has appointments every three months. She began to decline and grow increasingly suicidal. She was calling daily to see if there were any cancellations so that she could get an earlier appointment. I was also calling and sending my notes and was told that she, too, could not get a sooner appointment and would have to go to the ER if she were unsafe. Her primary care provider would not adjust or change her medication or address her psychiatric needs because of her mental health diagnoses and because psychiatry handled her medications, I increased the frequency of therapy and collaborated with her family to make a safety plan. Despite our best efforts to maintain safety, she attempted suicide and would have completed the

suicide had I not called her to check in with her, I was able to get her to the ER, where she was EPCed and hospitalized. I believe had she been able to get a sooner psychiatry appointment, her suicide attempt and the inpatient hospitalization may not have had to happen. My last story involves a four-year-old boy having extreme mood and behavioral dys-- dysregulation and night terrors. He has been exhibiting violent behaviors toward himself and others. He recently attempted to strangle a younger sibling and also tried to jump out of a moving vehicle. I referred him to his primary care provider for not only a medical workup, but for medication management until I could get him an appointment with a psychiatrist, which was not scheduled until June. I also referred him to a psychologist for a psychological evaluation, which occurred the following week. The primary care phys-- provider has stated that she is not equipped to handle his mental health needs, as did another primary care provider that we checked in with, so here we are, still waiting for him to see a psychiatrist. Again, this is unacceptable. In my experience of working with psychologists, I believe they are well trained and equipped to prescribe psychotropic medications with the additional psychopharmacology training. Many psychiatrists, medical preven--providers, and other clinicians such as myself already rely on the testing, diagnosing and treatment for individuals with behavioral health needs. I believe psychologists can help fill the gaps by prescribing psychotropic medications safely and efficiently, and I encourage you to support LB392. Thank you for your con-- time and consideration.

ARCH: Thank you. Are there any questions? Seeing none, thank you very much for your test--

WALZ: No.

ARCH: Oh, I'm sorry. Oh.

WILLIAMS: Excuse me. Thank you, Chairman Arch. Thank you for being here. In your testimony, you talked about having some potential people that could prescribe these medications choosing not to. Can you help us understand why they would make that choice?

LORI RODRIQUEZ-FLETCHER: Yes, at times I think because some of the clients are already established with psychiatry and so they don't want to, you know, overstep of what the psychiatrist may do. I think other times, such as in the testimony with my four-year-old, she was very

concerned because of his age, number one, and didn't feel equipped to manage psychotropic medications for a four-year-old and felt that he needed to see psychiatry.

WILLIAMS: Did you get a sense that there were some of those that have legal ability to prescribe, that they were just uncomfortable because they didn't understand the--- the medications totally?

LORI RODRIQUEZ-FLETCHER: Yes.

WILLIAMS: So their training was not quite what they thought?

LORI RODRIQUEZ-FLETCHER: Well, I-- you know, I-- I respect the medical community that I work with very, very much, you know, so I-- I-- I want to be careful that I'm not trying to say that they are not trained or equipped to handle these types of things. I think they're very cautious and sometimes maybe overly cautious. But on the other side, when my clients are not getting the psychotropic medications that they need, I'm forced to send them to ER visits. I'm forced, you know, to-- to have them hospitalized. And so that-- that simply is not working when there's ways that we could manage them more effectively in an outpatient setting.

WILLIAMS: Thank you.

ARCH: Other questions? Senator Day.

DAY: Thank you, Chairman Arch, and thank you for being here today. You mentioned it just now, and also in your testimony, about people having to go to the ER or being hospitalized simply out of-- not-- I wouldn't-- I don't want to say desperation, but a lack of access to someone who can manage their medications in a timely manner. I don't know if-- can you just tell us what happens? So if-- if-- if someone is in a home and they have attempted suicide or are believed to be a harm to themselves, what then happens? Is there-- is there law enforcement involved, or how-- what's the sequence of events that happens there?

LORI RODRIQUEZ-FLETCHER: Yes. So I can tell you from our area, our counties each handle those a little bit differently to some extent. However, with me, I do what I need to do in order to get them to the hospital the best I can. If there is a family member who is present and they feel that they can safely get them to the emergency room, at

times, family members will transport them. Other times, I need to call law enforcement to do a well check who would then determine if they would need an EPC and they would-- you know, and then from there, at times, an ambulance would take them to the hospital if need be, or law enforcement, the-- the four-year-old, trying to avoid all of that at all costs, if possible, with reducing his risk to law enforcement exposure at such an early age. However, when you have a child that age who is attempting to jump out of a vehicle, sometimes you're forced to make decisions that, you know, can affect them throughout the rest of-- the remainder of their life.

DAY: Sure. OK. Yeah, that's-- I've-- I've seen it before in person happen, and so I just wanted-- I don't know if anybody has personal experience with-- it's almost a sort of traumatizing situation when someone has mental illness and, you know, law enforcement comes into the home and they're forced, you know, to be hospitalized for a certain number of days--

LORI RODRIQUEZ-FLETCHER: Yes.

DAY: --against their will, essentially--

LORI RODRIQUEZ-FLETCHER: Yes.

DAY: --because they're at risk to themselves or others. And those traumatizing situations that may exacerbate mental illness could, I think what you're saying is, be mitigated with better access to medi-- like management of medications, essentially.

LORI RODRIQUEZ-FLETCHER: Yes. And I also think there would be better follow-through because it could perhaps be done all under one agency.

DAY: OK, wonderful. Thank you so much.

LORI RODRIQUEZ-FLETCHER: Thank you.

ARCH: Senator Hansen.

B. HANSEN: Just trying to put your testimony in context a little bit. How long have you been practicing then?

LORI RODRIQUEZ-FLETCHER: I have been practicing since 2010.

B. HANSEN: OK. And then since 2010, some of the stories you gave, is that kind of a common occurrence or is it--

LORI RODRIQUEZ-FLETCHER: It's--

B. HANSEN: --just like these are three stories I've heard in ten years or just like every few months or--

LORI RODRIQUEZ-FLETCHER: No, Senator, this is a common occurrence.

B. HANSEN: OK. This helps me kind of get an understanding of kind of where you're coming from here.

LORI RODRIQUEZ-FLETCHER: Yes.

B. HANSEN: And is it pretty common with-- so I think it's just kind of interesting that when you find someone who's growing increasingly suicidal and you see that there might be kind of a-- you know, an emergency issue coming to hand from your experience, and you refer them to a psychiatrist and they say they don't have time for them, do you see that very often?

LORI RODRIQUEZ-FLETCHER: Yes. And-- and, you know, again, I don't think it's because they don't care. I think it's because they are simply overburdened and they don't have time. And, you know, our one psychiatrist who is full time is doing the very best that he can, but he has limits too.

B. HANSEN: OK. Sure. OK.

LORI RODRIQUEZ-FLETCHER: Yeah.

B. HANSEN: I understand that. Do you-- and from your professional experience, do you see any use of prescription medications for behavioral issues? Have they gone up in the state of Nebraska over the course of the years or they-- or do you think they've gone down?

LORI RODRIQUEZ-FLETCHER: You know, I think that more people are becoming more aware of behavioral health needs and mental health diagnoses. So I think you have more people seeking services because we're really trying to reduce the stigma attached to mental health services. And so I think you have some people who are, you know, seeking-- seeking out those services more so than maybe they have. I

also think with the recent pandemic, we've, you know, seen an increase of behavioral health needs. As far as specific, whether the actual number of medications has gone up or not, I think some others are testifying to what some of those numbers may be. So I think it can be misleading that just we're-- you know, that people are overprescribing, necessarily, but you have-- also have more people trying to seek services as well.

B. HANSEN: OK. And you mentioned we're becoming more aware of mental health issues. Is it possible that there are al-- there are also just more mental health issues because of our lifestyle, because of society, because of other kinds of things?

LORI RODRIQUEZ-FLETCHER: Yeah, I think it's a combination of a lot of different things, but, yes, I believe that's true.

B. HANSEN: OK. I-- I ask these questions in the context that I am a little concerned about the overuse of prescribing medications to deal with issues, which is why I always like that delineation between psychology and psychiatry with the idea we have-- we have talk therapy or psychotherapy to help deal with issues and if we can't quite meet those needs, then we move them onto somebody else. But I also understand your dilemma of not having somebody to-- to refer to and kind of where you're coming from or where Senator Stinner is coming from with trying to introduce this bill. So that's kind of-- that's kind of the-- the line I have to kind of walk and figure things out. So that's why I asked those questions. It's nothing against anything, so.

LORI RODRIQUEZ-FLETCHER: Yeah. No, Senator, I appreciate that. And I think as somebody who obviously is not a prescriber, when people come to me, I-- you know, I try to avoid medication and use that as a last resort, if at all possible, especially because I treat a large number of-- of children, including young children. So especially for children, I feel that's a very last resort, but there are some children who need medication, and if they don't get those medications, then we end up looking at long-term residential care, you know, that, again, is a very last resort only when we cannot maintain safety.

B. HANSEN: OK, thank you.

ARCH: Thank you. Other questions? Senator Walz.

WALZ: Thank you, Chairman Arch. Just a quick question: What is your caseload?

LORI RODRIQUEZ-FLETCHER: My caseload is very large. I can tell you I'm one of the few clinical social workers in western Nebraska, so in addition to having a full caseload, which my caseload, on average, I generally see around 32 clients a week. In addition to that, I consult and provide services to dialysis unit and a hospice where I provide supervision and consultation to them. And I also am an adjunct social work instructor at Chadron State College. So the need for not only psychologists and psychiatrists, but also clinical social workers in our area, and because of that, I do a lot of different things while maintaining a full caseload.

WALZ: All right. Thank you for your work.

ARCH: Any other questions? Seeing none, thank you very much for your testimony.

LORI RODRIQUEZ-FLETCHER: Thank you.

ARCH: Next proponent for LB392. Welcome.

JANELLE REMINGTON: Hi. Good afternoon, Senator Arch and members of the Health and Human Services Committee. My name is Janelle Remmington, Janelle, J-a-n-e-l-l-e, last name is Remington, R-e-m-i-n-g-t-o-n. I am Dr. Janelle Remington, clinical psychologist and neuropsychologist at Madonna Rehab Hospitals, which has facilities in Lincoln and Omaha. Madonna is a freestanding physical medical rehabilitation hospital, serving persons with a variety of neurological and medical conditions, including brain injury, stroke, spinal cord injury, and pediatrics. Madonna has over 2,000 employees between the two campuses and is one of the top ten employees [SIC] in Lincoln. Last year, Madonna served over 2,400 patients, many of whom were highly medically complex. I am representing Madonna Rehab Hospitals. 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-- adjusting to their conditions. These disorders include depression, suicidal thoughts or behaviors, intense anxiety, agitation, confusion, psychosis, and physical aggression. Madonna opts-- adopts a holistic approach to treatment, including psychotherapy, environmental management, nonviolent crisis

intervention techniques, and treatment with psychotropic medications that are often administered by psychiatrists or other physicians. We have consistently struggled to enlist the services of psychiatrists, who are the physicians most comfortable in administering psychotropic medications. Numerous local psychiatrists-- 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 when no psychiatry is available. Our Omaha facility has been unable to find consistent psychiatry support in the four 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 team integration. Although the psychiatrists who have served Madonna have been excellent practitioners who have worked hard to meet our needs, it's our impression that their many other commitments make it impractical to provide the level of support we require. On a personal level, I've enjoyed warm and respectful relationships with many psychiatrists across my career and respect their contributions, including our current part-time provider on the Lincoln campus of Madonna. 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 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 closely and frequently. We believe this will 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 fashion. For that reason, Madonna supports this bill to give limited prescription privileges to psychologists who undergo the intensive additional training outlined in the bill. In closing, I would like to mention that this bill appears to have the support of service providers for a variety of underserved populations, both because those populations may be difficult to serve and may struggle with geographical barriers, such as the western part of Nebraska. The prescription privileges in this bill will supplement the services provided by psychiatric practitioners in a number of ways. First, psychologists are simply more numerous and can provide much enhanced cover to the entire state

in a more cost-efficient manner in some cases. Second, the psychologist prescriber 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 effect-- 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. Any questions?

ARCH: Thank you. Are there any questions?

B. HANSEN: [INAUDIBLE] question. Sorry.

ARCH: Senator Hansen.

B. HANSEN: Thank you, Chairman Arch. I-- and I-- I'm not familiar with the specifics of the bill. Are-- and this is probably something I can ask Senator Stinner or somebody else following as well. Are they-- are the psychologists able to prescribe the same amount of medications as a psychiatrist if the bill passes?

JANELLE REMINGTON: So the training is different. Base-- a psychiatrist is a-- is an M.D. that goes through and gets an M.D. so they can prescribe everything as a general practitioner, but then they go on and then people will go on either to be a pediatrician, a podiatrist, or a psychiatrist, so they get the extra training in the medications and the-- and the-- the things related to what their specialty area is after their M.D.

B. HANSEN: OK. And with this bill, would-- would a psychologist be able to prescribe the same kind of medications that a psychiatrist would?

JANELLE REMINGTON: They wouldn't in that it's aimed at psychological meds only--

B. HANSEN: OK.

JANELLE REMINGTON: --whereas because a psychiatrist has an M.D. as well, they can prescribe--

B. HANSEN: Prescribe all kinds of stuff, different kinds of things.

JANELLE REMINGTON: --you know, an antibiotic or whatever for any-- anything.

B. HANSEN: OK. And that's generally probably why we see more psychologists versus psychiatrists is because of the-- the level of education typically?

JANELLE REMINGTON: Um--

B. HANSEN: I'm just trying to get at why we have so many psychologists and not very many psychiatrists. Is it because then they have-- there's more schooling or--

JANELLE REMINGTON: It's a different model. It's-- psychologists go through a just a different model of training. They go through the behavioral change process of-- of learning about human behavior and those dynamics and-- and through change a lot of-- and-- we do-- doctoral programs, you do take psychopharmacology; you do take a lot of-- you know, and I-- my program was-- as a neuropsychologist, I had to go through significant amounts of anatomy and, you know, all those kinds of things as part of my program. But it doesn't and it's a di-- it's a different degree. It's-- it's aiming towards behavioral interventions, learning how to do effective counseling, how family dynamics work, and a lot of assessment, learning how to understand how a person with stroke has a cognitive deficit and what that means and how to-- how to rehab that and how to, you know, create an environment that they can be successful. And so it's a different-- different type of a program. But I wouldn't say that the education is more years or anything like that for a psychiatrist versus a psychologist.

B. HANSEN: OK. All right. Thanks.

JANELLE REMINGTON: Um-hum.

ARCH: Senator Walz.

WALZ: Thank you, Chairman Arch. I just have a quick question.

JANELLE REMINGTON: Sure.

WALZ: And I'm sorry I don't know this. Maybe I should, but can a-- does a psychiatrist have to see the patient or can a psychologist see

the patient, communicate with the psychiatrist, and then over the phone he prescribes something? Does that make sense?

JANELLE REMINGTON: Generally doesn't work that way.

WALZ: OK.

JANELLE REMINGTON: I don't know if they can or not because I don't know what their realm of practice is. I know that, you know, I do extensive neuropsychological assessments, five, six hours with one patient where I intensively know their mental health, their cognitive functioning, their IQ, everything about a patient. And I send recommendations to the psychiatrist and to the physician saying, I think this person needs a stimulant because the ADHD is clearly here on testing, those-- things like that where I'm recommending certain things. And then that's up to that prescribing physician or psychiatrist to manage that medication.

WALZ: But they have to see the patient first?

JANELLE REMINGTON: Yes.

WALZ: OK. All right. Thank you.

JANELLE REMINGTON: Um-hum.

ARCH: Any other questions? Seeing none, thank you very much for your testimony.

JANELLE REMINGTON: Thank you.

ARCH: Next proponent for LB392. Welcome.

RYAN ERNST: Good afternoon. Thank you, Senator Arch and members of the Health and Human Services Committee today, for taking the time to hear us out. My name is Dr. Ryan Ernst. First name's R-y-a-n; last name is E-r-n-s-t. So I'm Dr. Ernst. I'm a Nebraska- and Iowa-licensed psychologist. I'm testifying on behalf of myself today in support of LB392. I worked here in Lincoln in private practice for several years, and then from 2011 to 2019, Madonna Rehabilitation Hospital. In 2019, I began employment at Clarinda Regional Health Center in Clarinda, Iowa, where I could practice to the full extent of my training in psychopharmacology. I'm currently awaiting license issuance and very

soon will become the first prescribing psychologist in Iowa. My experience in Iowa has been outstanding. While receiving training alongside several physicians, there was not a single occasion that I felt unappreciated, unapproved of, or otherwise not fitting into the medical community. Though there is no pressure for any medical staff to utilize my services, I can say with certainty that every clinic, physician, hospitalist, and mid-level provider have referred their patients to me for medi-- medication management on a repeat basis. Recently, in reference to psychologists working in hospitals as prescribing providers, the hospital CEO said to me, I do not understand, why isn't everyone doing this, which I take as a great compliment to what a prescribing psychologist can offer to a hospital. Clarinda Regional Health Center is a rural town of 5,000 residents. Before my arrival, there were no onsite mental health providers and we now have a staff of ten full-time employees with more additions planned. There is every reason to believe the same growth will happen in the small towns of Nebraska if psychologists have the same opportunities here. Personally, I would love to be able to bring comprehensive mental health services to the tri-cities area where I am from, or Holdrege or McCook, where I have many family members. To address a different topic, it is my understanding there is curiosity about whether psychologists will abandon psychotherapy for medications, thereby adding to higher medication utilization. I would like to address this with an analogy. Consider a roofer who has used a hammer for many years in his trade. He then decides to be a carpenter and finds that he can cut a board with a hammer, but not with accuracy or efficiency. So when given a saw, he finds it to be the right tool for the job, yielding a clean and accurate cut. Now which tool do you think he will use when he goes to nail up that board, the saw or the hammer? Clearly he will use the hammer, it is-- as it has long been a reliable tool for plunging nails that he is comfortable with and has been using for many years. So why would psychologists, once given a prescription pad, abandon the tools they have used for many years? It is-- it is-- is it not more logical they will use both tools based on the individual patient's needs? Prescribing psychologists are not just another provider with a prescription pad. They're a hybrid group with extensive training in both pharmacological and nonpharmacological interventions. In comparison to other psychiatric providers, psychologists have by far the most training, experience, and comfort with utilization of psychotherapy, so it does seem quite logical that psychologists with prescribing authority will be much more likely than

other-- than their medical colleagues to routinely use nonpharmacological interventions. To support this assumption, there are some published studies on the prescribing practices of psychologists. Linda and others in 2017 stated in their paper: We found no evidence of a bias toward the use of medications versus psychosocial interventions. The number of cases where providers reported beginning treatment with medication alone versus therapy alone were almost exactly the same. Peck and others in 2020 found that 73.2 percent of the patients seen by a prescribing psychologist were receiving a combination of both psychotherapy and medication treatment. Only 16.7 percent were receiving medication only, 16.7 percent, as compared to arguably well over 90 percent. In many arenas, it's going to be 100 percent who see a psychiatrist, advanced nurse-- advanced-practice nurse, primary care physician, or a physician assistant. For my personal experiences, I can tell you I schedule half the number of patients per day than my colleague and friend who is an advanced practice nurse that I work with. The difference is most all of my appointments include psychotherapy even when medications are utilized. Every profession practicing psychiatric medication has their strengths. For psychologists, it is the ability to use a balance of psychotherapy and medications in a strategic manner. We represent a profession with unique training and knowledge and by no means are just another profession handing out medications. Thank you. Are there any questions?

ARCH: Are there any questions from the committee? Senator Hansen.

B. HANSEN: OK, I'm going to bite on your analogy.

RYAN ERNST: OK.

B. HANSEN: Why would they use a saw? Because it's easier and there's less-- and-- and there are-- and there's a-- but, however, there's more risk of injury. I mean, so why would psychologists want to prescribe medications? Because, and-- and I'm-- I don't know if that's true or not, so that-- I kind of want you to respond because my fear is then it will become easier, you know, whereas before you had to work through and it took time, it took effort, and you had to fight through blocks and, you know, mental, you know, anguish that they've had before, and-- and eventually you kind of broke through certain things and you-- and you made-- you made strides toward, you know, healing the patient, whereas before, my concern is that they may not

do that anymore, like, man, we hit a block here, but maybe if we prescribe some medication, that might kind of help our psychotherapy a little bit more. And so that's where my concern is at, is that it will be easier to prescribe medication, whereas before they might have had to take some time and effort to work through some of these challenges and some of these issues that people have had in their life. And-- and one of my concerns and why I kind of preface that is that we see a growing use of antidepressants and medications to deal with people's problems in the-- in the United States and Nebraska too.

RYAN ERNST: Yeah.

B. HANSEN: It seems like we're a country that takes some of the most-- the world's most amount of antidepressants, but yet we're still one of the most depressed countries in the world.

RYAN ERNST: Right.

B. HANSEN: And so that's where my concern kind of comes from. And so in your analogy, it makes sense to use a saw because it's easier, I mean, so that's where I'm almost concerned about a psychiatrist doing the same thing, not saying there's not a need for them. I mean, and not saying that I trained for them, because when I look at the-- the prerequisites of being able to prescribe medication, there's-- it looks like more than adequate enough education that they have to go through.

RYAN ERNST: Yeah.

B. HANSEN: But my concern is more what is it going to-- what is it going do to society? And maybe it's not my right to say that, you know, as the government, and let the people kind of decide for themselves, but that's where I maybe could hope you could respond to that.

RYAN ERNST: Yeah. So the analogy was they would use the hammer because it's worked and they're very comfortable with it. They're not using the saw. They're using the hammer because they have comfort with that. So similarly, psychologists use-- we utilize psychotherapy because they've been doing that for years and years. They know that it works and they're comfortable with it. I think that-- and a related question asked before was, do you think that, you know, that medications are

going to be used to a greater extent? And I think that the raw number could increase because we're talking about a bottleneck to services. When you remove the bottleneck and people can get to providers sooner that prescribe medications, you see-- you may see a raw number actually increase. But psychologists, compared to their medical colleagues, utilize medications to a much lesser extent than overall. Over time, you're going to see a reduction of psychotropic medications being used.

B. HANSEN: And I totally agree with you because just like the gal said before, you have a lot more tools in your tool belt--

RYAN ERNST: Yeah.

B. HANSEN: --I mean, to deal with issues.

RYAN ERNST: Yeah.

B. HANSEN: And when-- when-- when you only have a hammer, everything looks like a nail, right?

RYAN ERNST: Right, right.

B. HANSEN: And so psychologists might have a kind of a different approach where they do have different tools, where they can work through other issues--

RYAN ERNST: Yeah.

B. HANSEN: --along with me-- along with prescribed medications.

RYAN ERNST: That's certainly the idea, and the-- the study I'd cited there, you know, indicated that only 16 percent of the patients seeing a prescribing psychologist were being treated with a medication only, so that's a very, you know, small number, I think, comparatively, yeah.

B. HANSEN: All right. Thank you.

RYAN ERNST: Yeah. You bet.

ARCH: Other questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch. And thank you, Mr. Ernst, for being here. I'd like to explore a little more your experience in Iowa. I'm assuming from your testimony that Iowa has legislation that is similar or very similar to what we're looking at here--

RYAN ERNST: Yes.

WILLIAMS: --and you moved there. Tell me about what you had to go through, when you first went there, with the extra training.

RYAN ERNST: OK, can I ask for clarification? When you-- when you're asking what did I go through, what do you mean by that, what did I go through?

WILLIAMS: Your-- your upgrading your education to be able to prescribe in Iowa.

RYAN ERNST: OK, sure. And I want to say, first of all, I still live here in Lincoln. I-- I drive 93 miles--

WILLIAMS: We won't hold that against you.

RYAN ERNST: --93 miles to get to work and back each day, but it's worth it for me. So what I went through before, you know, looking for additional training was I went-- it was two-and-a-half years of coursework that I went through in psychopharmacology. And so that goes through all the, you know, basic medical sciences, dives very deeply into all aspects of psychopharmacology, you know, neuroanatomy, neuropathology, all those sorts of things. So it's a very core set of-- of academic coursework on what somebody who prescribes medications would need to know. So that took two-and-a-half years, and then I was out scouting around trying to find somebody to do my clinical supervision. And so the Iowa regulations and their bill is very similar to what's being proposed here; of course, our regulations would come down the road. What they are requiring is that I would see 600 patients to do physical assessment with them, and that began with basically just observing the physicians that I worked with there. As their comfort level increased, then I would perform those physical evaluations, physical assessments myself, with their supervision, and then eventually doing that without the physician in the room at all, so 600 patients that way, all types, I mean, checking for hernias, all sorts of things, not just, you know, mental health conditions. And

then I needed to see a minimum of-- of-- of 100 patients and 400 hours of-- of supervised service prescribing psychotropic medications, so basically the practice aspect, so 400 hours of that where the physician was present, at least at some point in each of those encounters.

WILLIAMS: So a substantial amount of additional education, training and experience.

RYAN ERNST: It took me one year, four days a week, full time, to complete all that, yes.

WILLIAMS: Thank you.

ARCH: Thank you. Other questions? Seeing none, thank you very much for your testimony.

RYAN ERNST: Thank you.

ARCH: Next proponent for LB392. Good afternoon.

CONNIE PETERSEN: Good afternoon, Senator Arch and members of the HHS Committee. My name is Dr. Connie Petersen, C-o-n-n-i-e P-e-t-e-r-s-e-n. I'm a Nebraska-licensed psychologist and clinical director at Behavioral Health Specialists in Norfolk. I lead providers across three outpatient clinics, two short-term residential addiction treatment programs, and a crisis response team in the Region 4 area. For the past 13 years, I've personally watched the stress and turmoil that a lack of psychiatric providers puts on our clients, our communities, and our behavioral health system. It is heartbreaking to witness despair and fear on the faces of our clients, whose first psychiatric appointment is scheduled months out. As an employer myself, I've attempted to impact this reality through recruitment and retention-- retention efforts, but efforts have been fruitless. It has been difficult to obtain and retain psychiatric providers who will work long term with significant caseloads of severely and persistently mentally ill patients, and then on top of that, we're asking them to do such in rural Nebraska. Currently in the Norfolk and surrounding area, we have one psychiatrist in our area and their full-time job is to manage a behavioral health unit at our local hospital. We have a handful of APRNs who specialize in behavioral health, but two have overflowing caseloads. We've attempted to utilize telepsychiatry, but

in addition to overbooked schedules, many of our clients struggle with telehealth services due to poor Internet connectivity and many of our clients just want and need face-to-face interaction. As a result of inadequate outpatient psychiatric services, agencies like mine have often collaborated with local medical providers to decrease wait times. And we know the struggle; all of us know the struggle of treating chronic disease in our nation currently, and many of our clients have very complicated medical and psychiatric profiles. It's simply unrealistic for us to expect family practice doctors to treat those complicated medical issues and be leaned on so much to also practice focused behavioral health and addiction medicine. We have collaborated with primary care physicians and nurse practitioners, but some of our rural providers are not comfortable with prescribing certain medications for major mental illnesses. Providers know the importance of timely intervention, so they often feel that pull between either doing nothing or collaborating with other service providers to wrap services around the client as they wait for their first psychiatric appointment. I believe that psychologists with specialized training to prescribe needed medication can bridge this behavioral health-- health gap in Nebraska. I believe so much in-- in clients-- I believe so much in helping those clients in that rural Nebraska-- in a rural Nebraska area that I personally began the journey to obtain advanced training in clinical psychopharmacology from New Mexico State University. New Mexico has proven that they have training and oversight processes figured out. After all, as you heard, New Mexico psychologists have had prescriptive authority for almost two decades. I have moved into the next stage of my training by collaborating with a family practice doctor in my area, and through this collaboration we have demonstrated our professions can complement each other, not compete against one another, to collectively meet our clients' needs. Our clients need us to come together and see what is in their best interest, not just what's in our profession's best interest. Access to psychiatric services may not be as scarce in those highly populated cities of Nebraska. But in Scottsbluff, in Norfolk and other-- other rural locations in Nebraska, psychiatric providers are in short supply. In some locations, family practice doctors willing to prescribe psychotropic medications are also limited. Passing LB392 would allow prescriptive authority for those psychologists who have proven their abilities through clinical training, applied experiences, and their ongoing collaborative work with licensed physicians. As very conservative professionals by

nature, we have always been trained to consider all of our tools in our tool bag and choose the one that fits with the client's unique situation. When passed, I intend to be a very conservative-- be very conservative with prescriptive privileges and work diligently with my professional colleagues to do what's in the best interest of the client. I intend to use my clinical skills first and only supplement prescriptive options if less-restrictive options are unsuccessful. Clients in rural Nebraska, like the area I work, need this bill to pass. We can't keep watching individuals cope with their despair, anxiety, and psychotic symptoms by self-medicating with drugs and alcohol, by self-harm behaviors or, even worse, through losing another life to our behavioral health crisis. Thank you for your time. Any questions?

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

WALZ: Thank you, Chairman Arch. I was just thinking, as you were talking, when I worked for an agency that served people with developmental disabilities, we had a psychotropic medication committee who would oversee the medications that were given to the people that we serve. Is there anything like that for psychologists or psychiatrists? Is there a committee that does like an annual review on medications that are given?

CONNIE PETERSEN: I'm-- I'm not aware of a current committee, but I believe that there would be a lot of rules and regulations that would need to be set up. And-- and I do-- I do sit on the licensing board for the state of Nebraska, as well. I'm not representing the licensing board, but I do sit on the board and I believe there would need to be some discussions about that in the rules and regulations committee.

WALZ: All right. I was just curious. Thank you.

ARCH: Thank you. Are there other questions? Seeing none, thank you for your testimony.

CONNIE PETERSEN: Thank you.

***DIANE MARTI:** Dear Senator Arch and members of the DHHS Committee: LB392 is a bill related to expanding the scope of practice for psychologists in the State of Nebraska to provide prescription privileges to those that meet the rigorous post-doctorate training

required under this legislation. This letter is written with strong support for LB392. I have actively participated in leadership activities as a member of the Nebraska Psychological Association in Washington, D.C., for the past 7 years. This has provided me with an opportunity to learn how the growing numbers of states that have voted in favor of providing prescription privileges to their psychologists have greatly benefited their consumers. As a clinician that specializes in the area of autism spectrum disorders, developmental disorders and behavioral disorders, it has been my observation over the past decade that psychotropic treatment is initiated many times before there is a strong understanding of what the accurate diagnoses are, what environmental factors may be supporting unwanted behaviors (e.g., parent, discipline, classroom environments, reactions of peers such as bullying behaviors, etc.). A thorough understanding of how all of these factors play a role into the often "annoying" to sometimes "scary and/or violent" behaviors displayed, is highly beneficial. Clearly, understanding why certain behaviors occur and learning how to mitigate these behaviors in the most natural and environmentally supportive manner is "best". In addition, the time a clinician who specializes in these areas can spend analyzing these conditions, can only serve to benefit the "cost-benefit" analysis of deciding when to not only initiate the use of psychotropic medications, but also to identify the most effective medications to address the root causes of these behaviors (e.g., neurobiological roots connected with outlying behaviors) for the alleviation of symptoms. The practice of psychology strongly supports treatment modalities that provide evidence-based treatments and treat the "whole-patient" - which is deemed of fundamental importance when treating individuals with mental health disorders. Senators would be wise to consider the array of benefits associated with the an additional "force" to address the paucity of mental health psychiatric care services in our state. As we all may also know, the addition of the pandemic and ever-increasing numbers of individuals affected by the stressors of COVID-19, only serves to exasperate a troubling mental health crisis in our state. From my viewpoint, there is no "downside" to LB392 as it not only increases access to mental health psychiatric care in our state, has the ability to improve outcomes for the mental health care of Nebraskans most at need and vulnerable, adds professionals that would bring high levels of expertise in the areas of emotional, psychological, behavioral and psychiatric interventions, but also brings unique expertise into areas of specialties that are not always fully understood unless there is

specialization within these areas (e.g., autism spectrum disorders). In addition, providing psychologists in the state of Nebraska to gain prescription privileges would add an additional "draw" to professionals being trained in our graduate and post graduate psychology programs. This incentive would keep these talented individuals within our state rather than to lose these psychologists seeking this ability to prescribe to other states who have "wisely" moved forward with similar legislation, such as Iowa. One final note - I would like to provide a special "thank-you" to Senator Stinner, who has the vision and scope to see how a bill, such as LB392, would help not only his constituents but help all in the state of Nebraska have greater access to mental psychiatric treatment. It was my great privilege to watch him accept the honor of the "APA State Legislator of the Year" in 2018 - which he won due to his innovative and insightful work related to mental health in the state of Nebraska. Senator Stinner accepted that award with pride for the state of Nebraska (as he should have because it is quite an honor to be chosen for this national award). Senator Stinner gave the most outstanding speech regarding the importance of tackling mental health issues at its core, not waiting until it becomes a problem but "attacking" the issues early with broad band strokes of intervention. Senator Stinner was brave enough to admit to the audience of hundreds of leaders of psychology across the United States - how he initially didn't understand how mental health and psychiatric conditions could be treated and improved upon. He spoke of his journey of understanding the fruits of such interventions and had become a believer in the long-lasting impacts that early intervention in mental health treatment could pay off in the future. Senator Stinner received a long and well-deserved standing ovation from his audience, with many psychologists and state leaders enthralled by his words and empowered by his vision. I am honored and excited that Senator Stinner's vision has continued and expanded and he has brought LB392 to the members of the DHHS committee for approval and movement towards the legislative floor. It is this vision and leadership that I could honestly say - will save the lives of many Nebraskans- because we have added more "tools to our armor" and added more "soldiers to the battlefield". It is with my sincerest hopes that the members of the DHHS committee see all the benefits of LB392 that they will be presented within this hearing and vote to move this legislation to the floor for further review and passage by the Nebraska Legislature.

*Indicates written testimony submitted prior to the public hearing per our COVID-19 response protocol

***MIKE MISEGADIS:** I am writing in support of LB392. In December my wife Megan Misegadis offered her testimony in support of this bill. Megan is the president of the Autism Society of Nebraska. We are the parents of a 22-year-old on the autism spectrum. We have been advocates in the disability community for more than 18 years. In that time, we have spent countless hours talking with parents, educators, healthcare providers, and individuals with disabilities all over Nebraska. In addition, we have extensive personal experience in this area as my son has received psychological services and mental health medications for over 17 years. During the December hearing, many provided testimony of the obvious lack of access to psychiatric services in more rural parts of Nebraska, including the provision of meds. Additionally, many expressed the barrier of multiple visits created by having to visit both psychiatrists for med management and psychologists for therapy and the inherent inability for both providers to work together. But the issues with our current system go well beyond the barriers of access, multiple visits, and lack of provider teamwork. Most Nebraskans have a simple medication experience - schedule an appointment, explain the problem, and take the prescribed a med that works without issue. Unfortunately, mental health medication treatment is frequently a far more complicated, slow process with significant negative side effects. Mental health medications take time to work, time to adjust, and then you have to start all over again if the original med does not work. Even with the most experienced med providers, this trial and error process is often measured in months. To complicate this process further, many people with autism have comorbid mental health conditions (https://www.psychiatrictimes.com/view/recognizing-and-treating-comorbid-psychiatric-disorders-people-autism): "Findings indicate that 72% of the children had at least one additional DSM-IV psychiatric diagnosis." It can be difficult to find a med provider who understands autism, but even harder to find one able to tease out other possible comorbidities and correctly coordinate treatment of all maladies. You can ease this burden by allowing those that do the assessments to also treat the problems with both medication and therapy. In December Megan testified that our son with autism also suffers from OCD, depression, and anxiety disorders. His OCD was misunderstood by his psychiatric med provider who treated our son with medications for a disorder that he does not have. That caused significant new mental health issues like increased anxiety and worsening depression, along with a weight gain of over 50 pounds. After 2 years of trying to correct this, we

were forced to leave that med provider and find a new one. If his psychologist, who has known our son for well over a decade and has performed extensive assessments, could have prescribed the necessary meds, we would have saved him two years of needless suffering during a critical time in his development. Thank you for your time and consideration. Please support LB392.

ARCH: Next proponent for LB392. Seeing none, welcome the first opponent.

LuANNE EVEN: I'm sorry. [INAUDIBLE]

ARCH: Oh, are-- are you proponent?

LuANNE EVEN: Yeah.

ARCH: OK, thank you. Welcome.

LuANNE EVEN: Thank you. All right. Thank you, Senator Arch and members of the Health and Human Services Committee. My name is Dr. LuAnne Even; that's L-u-A-n-n-e, Even, E-v-e-n, and I am testifying in support of the Prescribing Psychologists Act, LB392, which you have in front of you. I'm a clinical psychologist with a small private practice and the chief behavioral health officer for the Ponca Tribe of Nebraska. I am also currently in my second year of training at New Mexico State University, working towards my postdoctoral master's in clinical psychopharmacology. I am fortunate enough to complete my practicum experiences at Ponca Health Services, where we have a fully functioning medical clinic and a contracted psychiatrist. Working for a federally recognized tribe, I am in a unique position regarding prescriptive authority. As you may know, the Department of Defense and Indian Health Services have been utilizing prescribing psychologists for nearly 30 years after the DOD began a six-year trial program in 1991 to train psychologists to prescribe medication. In the eyes of the DOD, this program was a success and demonstrated that psychologists could be taught to prescribe safely. Today, you've already heard ample testimony speaking to the lack of access to psychotropic medications. This is a widespread challenge across the state of Nebraska, which I can attest to, even in an urban area like Omaha, where patients are waiting several months for an appointment to meet with a psychiatrist. This disparity is even greater in Indian country, where a majority of our patients are uninsured and unable to

access psychiatry. Oftentimes due to the shortage of psychiatrists, patients are receiving their psychiatric medication management from a general practitioner who has often had minimal exposure to mental health and psychiatric conditions. Due to limited time spent with the patient, a general practition-- practitioner may not be fully aware of the underlying factors impacting the individual. This is not the case for psychologists. Psychologists spend ample time with their patients and intimately understand their current and past functioning, making them acutely prepared to manage their mental healthcare from all avenues, including their medications, if necessary. Additional testimony will be shared on the safe prescribing practice-- practices by prescribing psychologists. While limited, research on the practices of these professionals demonstrate that they continue to put their therapeutic routes first, before prescribing. In addition to the aforementioned points, I am testifying to the rigorous academic training and supervision requirements for this degree, which speaks to the skill set that each prescribing psychologist possesses. Before speaking to the training program specifically, it is important to note that each doctoral-level psychologist who enters a postdoctoral master's for psychopharmacology already possesses advanced interview, diagnostic, and treatment skills related to complex mental health disorders. Additionally, we already have base-level abilities to read medical records and look at medical diagnoses for potential co-occurring or mitigating psychological disorders. These professionals then enter a postdoctoral program to gain advanced knowledge in the area of psychotropic medication. Throughout the course of the postdoctoral program, we complete coursework on anatomy and physiology, pathophysiology of internal systems, and physical assessment. In addition to our coursework, we complete a 600-contact physical assessment practical experience. During this practicum, we work with a physician to complete-- com-- conduct complete head-to-toe physicals and read and interpret lab results. We complete coursework on psychopharmacology for each of the major mental health disorders, as well as coursework specific to special populations such as children and elderly. After completion of our physical assessment, we start our 100-patient, 400-hour medication management practicum, working with a psychiatrist and a physician; and then post-degree, we're required to complete the two years of physician-supervised experience with our provisional certificate and continue to collaborate with our primary care providers for each of our patients. And I think it's important to note that this collaboration is the most important piece of this

puzzle, as mental health and physical health really exist in a vacuum. I observe this daily in my clinical work as the chief behavioral health officer but also as a practicum student, as I frequently consult with our physicians and our APRNs regarding their patients' mental status, diagnosis, treatment needs, and medication recommendation based on my clinical expertise and current educational endeavors. It is clear to me that our physicians and practitioners want to help their patients in every way but often feel ill equipped to manage their patients' mental health. It is understood that opponents to prescribing psychologists-- prescribing privileges for psychologists have numerous concerns; however, lack of training and overprescribing should not be amongst them. Psychologists come from a training background of therapy interventions and research, while limited, shows that this is still the primary mode of treatment for psychologists with prescribing privileges. So thank you for your time and consideration during this trying time when so many people are impacted by mental health challenges with limited access to care.

ARCH: Thank you. Any questions? Senator Hansen.

B. HANSEN: Thank you for coming to testify, Dr. Even. I don't think I've talked to you yet before, so--

LuANNE EVEN: Uh-uh, I'm new.

B. HANSEN: OK. And again, when you're mentioning the ability for prescribing psychologists to prescribe in Indian Health Services--

LuANNE EVEN: Yeah.

B. HANSEN: --since 1991 or--

LuANNE EVEN: 1991 is when they started the pilot program, so from-- since '96 DOD--

B. HANSEN: Since '96.

LuANNE EVEN: So DOD and IHS has been utilizing proscribing psychologists.

B. HANSEN: And we've been doing in Nebraska since '96?

LuANNE EVEN: Not in Nebraska. We have-- don't have a whole lot of IHS facilities in Nebraska--

B. HANSEN: OK.

LuANNE EVEN: --so, yeah.

B. HANSEN: I'm just curious when I-- when I'm thinking of the demographics and statistics.

LuANNE EVEN: Yeah.

B. HANSEN: So if-- if-- what we're saying here, we're trying to extrapolate what's going on in Indian areas, Native American areas--

LuANNE EVEN: Yes.

B. HANSEN: --and then try and extrapolate that to the whole state of Nebraska. If we're seeing improvement in mental healthcare and access to medications and seeing the overall improvement in mental health status and Native American areas improve because we have pre-- prescribing psychologists, we would assume that would happen in the state of Nebraska. So I was kind of curious to know if you know, since we've had prescriptive authority in Native American areas, has the mental health status of Native Americans improved since then, stayed the same, or gotten worse?

LuANNE EVEN: I think that's a tricky question because I think there's so many factors going into working with Native Americans, with the generational trauma, that a pill isn't going to fix.

B. HANSEN: Yep, OK. That-- that make sense. There's a lot of kind of other different kind of--

LuANNE EVEN: There's-- um-hum.

B. HANSEN: --avenues or [INAUDIBLE] issues.

LuANNE EVEN: But I do know the access to care has gotten a lot better. That's actually one of the reasons that they started with it, is because a lot of IHS facilities tend to be a little more remote and it's hard to get practitioners, physicians, psychiatrists,

psychologists, kind of any practitioner to work for IHS, and so that's why they've kind of moved to that mode.

B. HANSEN: OK. All right. Thank you, appreciate it.

ARCH: Other questions? Senator Walz.

WALZ: Thank you, Chairman Arch. Just a quick question: Is there any communication or collaboration or contact with the behavioral health region in your area?

LuANNE EVEN: What do you mean?

WALZ: Behavioral health regions--

LuANNE EVEN: Oh, like Region 6 staff?

WALZ: Yeah.

LuANNE EVEN: Yes and no. So we-- I work-- I talk with Region 6, like we've done like some trainings for them, but we don't like receive funding for Region 6 in any way, if that's what you're asking.

WALZ: And I was asking also just, you know, looking for more resources as far as recruitment efforts.

LuANNE EVEN: Yeah, to get like practitioners to come to--

WALZ: Yeah.

LuANNE EVEN: --IHS? Yeah, I don't know how-- I know a lot of the recruitment efforts, kind of like a national, like an IHS level. I don't know locally how they are doing their recruiting.

WALZ: That's all right.

LuANNE EVEN: Yeah, we tend-- I just know, like the practitioner, like the physicians that we have hired have come naturally for the most part.

WALZ: OK, thank you.

LuANNE EVEN: Yeah.

ARCH: Senator Day.

DAY: Thank you, Chairman Arch, and thank you for being here today. So the-- where you detail the training--

LuANNE EVEN: Yeah.

DAY: --is-- would this be the same training that would be required, if we were to pass this, for a psychologist in Nebraska to have prescribing privileges?

LuANNE EVEN: So would the training be the exact same? Probably not, because there's a few different programs. However, are they--

DAY: OK.

LuANNE EVEN: --extremely similar? Yes.

DAY: OK.

LuANNE EVEN: So the programs that have psychopharmacology masters are APA-designated, and so they themselves outline what creates an appropriate program for that.

DAY: OK.

LuANNE EVEN: And that is also then based off of legislature in other states--

DAY: OK, but there is a--

LuANNE EVEN: --my understanding.

DAY: --there would-- there would be a significant difference in the training and the education to have prescribing privileges versus--

LuANNE EVEN: Not--

DAY: --to not have--

LuANNE EVEN: Yeah, there would-- there would not be a significant difference in the different programs that you would choose. Is that what you're asking?

*Indicates written testimony submitted prior to the public hearing per our COVID-19 response protocol

DAY: I think I'm asking-- I guess one of the concerns that I've heard about psychologists having the privilege to prescribe medication is that, you know, a psychiatrist has had to go through medical school and all of this training where a psychologist has not.

LuANNE EVEN: Sure.

DAY: And so I'm just trying to understand the extra training that would be involved.

LuANNE EVEN: Yeah. So the extra training, that postdoctoral master's, is where we get that-- kind of the more medically based training.

DAY: OK.

LuANNE EVEN: And there's-- think there's four APA-designated programs. Don't quote me on that. That's my understanding. And they are all based on this, you know, pathophysiology, the anatomy and physiology, and so they are outlined the same to have that more medically based training--

DAY: OK.

LuANNE EVEN: --that we do not get during our typical--

DAY: OK.

LuANNE EVEN: --doctoral training.

DAY: OK, excellent. Thank you.

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

LuANNE EVEN: Thank you.

ARCH: Other proponents?

DANIEL ULLMAN: Last one. Chairperson Arch and members of the Health and Human Services Committee, I'm Daniel Ullman, D-a-n-i-e-l U-l-l-m-a-n, a Nebraska-licensed psychologist. I'm testifying-- testifying in support of LB392. In terms of background, I worked 30 years at the Lincoln Regional Center. Today I'm sharing information regarding the safety of prescriptive authority for qualified

psychologists. Various sources of information indicate prescribing psychologists have a positive track record for safety. For example, the General Accounting Office reported in 1999 to Congress that prescribing psychologists in military provided quality care and no verse-- adverse outcomes. Following years of experience utilizing prescribing psychologists, New Mexico and Louisiana expanded these practice acts based on the safety records and benefits to the public. Louisiana and New Mexico have a combined 34 years of experience with prescribing psychologists. They call them medical psychologists, Louisiana. It's just term-- terminology. Malpractice insurance to cover the prescribing activity for qualified psychologists is generally around $200 a year, not a month, a year. Detractors of prescribing psychologists predict the amount would be in the thousands. Physicians and medical colleagues who collaborate with prescribing psychologists have confirmed the safety record for different studies. Medical colleagues overwhelmingly agree that prescribing psychologists are medical-- are safe prescribers, appropriately consult with-- about patient care, and know when to refer to medical colleagues. This next one is very important, given the questions you've had. Prescribing psychologists are circumspect about the use of medications and collaborate with a patient's primary care providers regarding the possible benefits or harm from medications. I got a quote from Dr. John Andazola, director of the Southern New Mexico Family Medicine Residency Program, and is also trained and been a colleague to many prescribing psychologists in New Mexico. And he was asked about what's this model look like. How do prescribing psychologists go about the pharmacology? And this is what he had to say. And by the way, this is recorded. You can listen to the whole interview. I've seen psychologists, instead of adding a second or third or fourth medication, actually reducing the amount of medications prescribed to the individual or bringing up ideas of, you know what, this medication could be generating anxiety issues or is associated with antihistam-- antihistaminic effect in the central nervous system that may be driving this individual's issues, and suggesting that to the primary care providers. I've been very comfortable and very impressed with their approach and I do-- I do not see people just doing it willy-nilly. I do not see "I can prescribe this because I can." I see a conscientious thought process in general, absolutely. Next, the requirements of LB392 are designed to replicate the safety record. Moreover, the following requirements for LB392 are the same or similar to requirements for prescribing psychologists in

*Indicates written testimony submitted prior to the public hearing per our COVID-19 response protocol

Iowa. Regulations in Iowa were developed jointly by psychologists and physicians. The requirements: The prescribing psychologist is first and foremost a psychologist with expertise in diagnostic assessment and psychotherapy, with appreciation for when medications have a role in treatment. The prescribing psychologist must consult with the patient's primary healthcare practitioner before starting a psychotropic medication. The psychologist cannot prescribe unless a patient has a primary healthcare practitioner. It is mandatory that the prescribing psychologist utilize a prescription drug monitoring program. Very important: Prescribing psychologists cannot prescribe opiates. An interdisciplinary team that includes a psychiatrist, family practice physician, and pediatrician and pharmacist will assist DHHS in developing rules and regulations. The interdisciplinary process will determine the scope of medications and other parameters for the prescribing psychologist. The bill requires a written collaborative practice agreement between the prescribing psychologist and a licensed physician as a condition of practice under the prescription certificate. In summary, there is documented evidence from the past 20-plus years to support the statement that educated, trained, and supervised prescribing psychologists provide effective and safe care. I think that's the first time I ever made it under five minutes.

ARCH: Well, then congratulations. [LAUGH] Questions. Senator Hansen.

B. HANSEN: Thank you for coming to testify.

DANIEL ULLMAN: Yes.

B. HANSEN: Currently psychologists are pretty-- I would assume they're prudent or they would have a prudent nature about prescribing medications based on their background. Do you think it's possible, though, when we start giving them prescriptive authority, that they would be less prudent over time or more prudent because now they have a different avenue to use?

DANIEL ULLMAN: By-- by the way, I've appreciated all your questions--

B. HANSEN: Thanks.

DANIEL ULLMAN: --because I-- it's been an internal dialogue with myself. How-- you know, I'm old enough to remember all this stuff, so

back in the 1980s, 1970s, there was an ideology against psychologists prescribing pretty much. Now that's changed quite a bit based upon the data coming out. The-- the-- another thing I've noticed, pharmaceutical companies are-- are advertising directly to the public. That's had an impact on this. One things that psychologists do, we are researchers. That is ingrained in us. So what you're seeing is various protocols, say if you're treating depression, anxiety disorder, post-traumatic stress disorder, a lot of the-- a lot of the treatments at the VA-- my wife works at the VA-- are based upon psychological interventions because the research has indicated they're first choice. That's where you start. Now you always have to sometimes deviate depending on the individual you have. I mean, you just can't-- put everybody in a certain kind of, you know, lockstep manner, so you have to assess the individual. Some individuals want the medications involved. The other thing is, is that the research indicates that people prefer psychotherapy to medication, you know, three to one. And when you're doing evidence-based practice, what is evidence-based practice? It's the skills that I bring; it's the research body; and it's also the preferences for the people. So I think we've gotten ourself in a bad spot here with you're getting more medications and, what, the rates of mental illness stay the same or go up? And I've struggled with this. I've been-- I'm not going to be a prescriber. I'm more of a scribe. I write down stuff. I've been kind of tracking this and trying to be helpful with the process. But, you know, I think what we've seen here is that psychologists are very slow at this. This has been very slow. And I'd say 15, maybe 20 percent are interested in it. Now you could be interested in it. That doesn't mean you're going to go all the work that these people had to go through to do this and set these things up, a practicum, these relationships. So it's just not going to be a flood of psychologists going into this. Psychology, as you're probably aware, apply their tools to all kinds of societal problems. And in the past few decades, it's been threat assessment. And I've got a colleague. Psychology-- psychology applied its research tools to that. And now we have a big problem with access to care, as you've already heard about. We're stepping up to the plate and we're willing to help. We won't be the solution. We want to help with this, and that-- that's-- the same way, that's our history of our-- our-- our profession-- and I'm going on too long-- World War I, World War II, Medicare, treating PTSD post-World War II. And so I think what we're trying to do here is say if a medication is needed, they could get it soon and not wait months and months. I mean, if you have a

bipolar disorder, you cannot wait that long. It's agony for these people. I'm sorry. I've got the-- anyway, I'm supposed to scan around. But anyway, so that's probably more than you wanted to know or maybe I--

B. HANSEN: No, I think-- I think you kind of got to some of the heart of my question. I think-- my concern-- and-- and I always appreciate asking you questions. You're well versed in--

DANIEL ULLMAN: Right.

B. HANSEN: --the-- the-- the practice of psychology and your professions. Do you have any concern? Because I don't really know for sure--

DANIEL ULLMAN: Right.

B. HANSEN: --do you have any concern that once we start giving prescriptive authority, that the-- the profession might be a little less prudent now because now they have something else to turn towards instead of being prudent and using--

DANIEL ULLMAN: Right.

B. HANSEN: --some of these other kinds of therapies as well?

DANIEL ULLMAN: I was on the licensing board for ten years and I think you can write regulations to really monitor for that. Now I know in New Mexico that the-- they really closely monitor use of controlled substances for these psychologists and you get information back what are-- where you are in the percentile. So I think you could apply that kind of scrutiny. You could have in the-- in the regulations that the physician that is your practice monitor audits your-- your cases, a certain number of cases, and-- and files a report. And part of that's going to be, is this person using "benzos" a lot when they could be using great psychotherapy? My wife treats insomnia at the VA. It is more effective than a lot of these controlled substances and people come back and say, really, my insomnia is gone and I'm doing great now; now I still have back pain and PTSD, but I'm sleeping pretty well, so-- and-- and by the way, when you-- we, as psychologists, you get a charge out of that. You-- you're-- you're helping people to make changes, lifestyle changes, and they learn something. Medication is, if I want to turn the furnace off, I get a hair dryer, put it over

here against the-- the thermometer or whatever, the-- yeah, you know what I'm talking about, so-- and then you take it away, then the problem's back. So you really want-- it's-- you're like an educator. You're teaching people skills and that's got to stay at the heart of it. So I'd say we would be very reluctant just to go down that route, just giving out pills.

B. HANSEN: OK.

DANIEL ULLMAN: I would-- I would say, who's on this committee that sets up the regs, pick well and get the kind of people that you want to-- to-- to have this in a right perspective, a healthy perspective for society in general.

B. HANSEN: OK. All right. Thank you. That's a good answer.

DANIEL ULLMAN: OK, I--

B. HANSEN: It's-- your answer was great.

DANIEL ULLMAN: No, thank you for your questions. I-- I really appreciate it, your thoughtfulness, I really do.

B. HANSEN: Thank you.

ARCH: Any other questions? I-- I have a couple.

DANIEL ULLMAN: Yes.

ARCH: And so I-- I would ask you to be brief in your responses--

DANIEL ULLMAN: OK.

ARCH: --if you can here.

DANIEL ULLMAN: Yes, sir.

ARCH: OK.

DANIEL ULLMAN: Yes. Chairperson.

ARCH: Do you-- do you know how many other states currently allow prescribing psychologists?

DANIEL ULLMAN: Yes.

ARCH: And if you don't-- you do know?

DANIEL ULLMAN: Yes. So Idaho has-- when you go to the website, they have a couple, but they have several people at Idaho State University in class, so they'll be coming out. I think Illinois has got like seven. But then again, there's a bolus of people coming out.

ARCH: So these are just-- these are just starting.

DANIEL ULLMAN: Yeah.

ARCH: They're coming out, as you--

DANIEL ULLMAN: Right.

ARCH: --would describe it, right?

DANIEL ULLMAN: Right.

ARCH: OK.

DANIEL ULLMAN: In Iowa-- you heard already about Iowa.

ARCH: Right, he would be the first.

DANIEL ULLMAN: Yeah, yeah.

ARCH: Right?

DANIEL ULLMAN: Yeah.

ARCH: OK. All right, so--

DANIEL ULLMAN: It's a slow process.

ARCH: --this is emerging, right.

DANIEL ULLMAN: It's a slow process.

ARCH: OK, thank you. Second question, which I'm going to make a statement that--

DANIEL ULLMAN: Yeah.

ARCH: And-- and I, again, just ask for your reaction to it. Oftentimes when you-- when we talk about psychotropic meds, sometimes it's framed within the-- this question of overutilization of psychotropic meds versus appropriate utilization--

DANIEL ULLMAN: Yes.

ARCH: --of psychotropic meds. You would agree with that?

DANIEL ULLMAN: Yes.

ARCH: Yes. And what we're looking for is appropriate utilization, not necessarily-- if we-- if we have identified a diagnosis that previously had not been identified that could benefit from--

DANIEL ULLMAN: Yes.

ARCH: --psychotropic medication, then it's appropriate to prescribe for that.

DANIEL ULLMAN: Right.

ARCH: So we set up psychiatrists and psychologists in two different camps and we say, OK, so look at all the medications a psychiatrist prescribe. But you also made a statement in your testimony that the type of patients that are referred to psychiatrists, and I'm paraphrasing here, but the type of patients that are referred to psychiatrists are often those that need medication prescribed. They would be-- they would be appropriate. They would benefit. They-- psychiatrists don't do much psychotherapy. Psychologists do a lot of psychotherapy. Would you-- would you agree that perhaps that description maybe, in looking at 17 percent of psychologists prescribe versus 100 percent sitting over with psychiatrists, some of that has to do with the-- the patients that are being referred for those-- for those two different treatment modalities?

DANIEL ULLMAN: When people have a choice, if they have a choice, that-- I don't want to misspeak here. I'm not-- you're-- I think you're talking about like something that some people would do surveys on and--

ARCH: Well, OK, I don't want to get too deep into the weeds here, but would you-- would you treat a-- a bipolar disorder with just psychotherapy?

DANIEL ULLMAN: It's-- people have found it possible. It depends on the severity of it. And oftentimes you-- medications are involved. And when you look at evidence-based practice, the-- the spectrum of people, there are some people, if it's-- they're kind of hypomanic, they don't get too far out, they can manage the depression pretty well, they can go without medication. Again, the-- the client's very much a part of this. They-- they could tell you after a few bouts of this, going, I tried it off the medication, I just don't want to. It--

ARCH: Yeah.

DANIEL ULLMAN: Things get out of control.

ARCH: Yeah.

DANIEL ULLMAN: The-- the other thing--

ARCH: So perhaps-- so perhaps both. You would-- you would-- you would see in the treatment of those severe mental disorders, you-- you--

DANIEL ULLMAN: Right.

ARCH: --perhaps you would see both--

DANIEL ULLMAN: There's going to be one--

ARCH: --benefit to both.

DANIEL ULLMAN: --with--

ARCH: And I don't want to go-- I don't want to go deep into the weeds here, so-- so--

DANIEL ULLMAN: Well, there's a difference, and I think this is the difference, is that you front load this with cognitive behavioral therapy and therapy--

ARCH: Right.

DANIEL ULLMAN: --then that person has learned something. Their biology has changed due to that and they go, I don't know if I need this medication anymore, could we try me-- myself off it and we titrate them off? In fact, when you look at practice guidelines, it says, you know, may-- six months, eight, nine months, if things are going OK, then you start titrating it down. But you need to do that. You need to-- you need to actually implement those kind of guidelines. I don't know if I answered your question. I apologize--

ARCH: You did. No, you did.

DANIEL ULLMAN: --Chairperson, if I didn't.

ARCH: You did.

DANIEL ULLMAN: OK.

ARCH: I appreciate that.

DANIEL ULLMAN: And I appreciate your all patience with me.

ARCH: Yep.

DANIEL ULLMAN: I--

ARCH: Thank you.

DANIEL ULLMAN: OK. Is there any--

ARCH: I don't see any other questions, so thank you very much.

DANIEL ULLMAN: OK. Thank you.

ARCH: Are there any other proponents? First opponent. Welcome.

KORBY GILBERTSON: Good afternoon, Chairman Arch, members of the committee. For the record, my name is Korby Gilbertson; it's spelled K-o-r-b-y G-i-l-b-e-r-t-s-o-n. I'm appearing today as a registered lobbyist on behalf of the Nebraska Psychiatric Society in opposition to LB392. I'm going to take us on a completely different-- different route here and I'm not going to talk about the medical aspects of the bill at all. I'm going to talk about the fact that the bill shouldn't be here at all. The reason why is the proponents of the legislation failed to pass a 407 process in 1997. This bill has not significantly

changed the parts of their application in front of the 407 process at HHS. And so I'm going to spend a little time going through that because I know you have new members of the committee that might not be familiar with that. But the Credentialing Review Program, or the 407 process, was created by the Legislature to fully review proposals that would change scope of practice. The process includes a three-stage review, one stage by an ad hoc technical review committee, then a-- the State Board of Health, and then the director of the Division of Public Health. There's a report created at each stage and those reports are forwarded to the Health and Human Services Committee after the process is complete. They're also available on the website, and I'd be happy to send links to all three of the reports to all of you if you would like me to. The Legislature looks to those involved in the 407 process to vet applications and, frankly, remove some of the-- the feelings from the process to look at the actual technical merits of what the program is so that it is not based on stories and anecdotal references to what's happened in other states but, rather, what happ-- what would happen in fact. The proponents failed to meet all six required criteria under the 407 process, so I'm going to run through those really quick, if I can get this done in five minutes. But the technical review Committee, as the first proponent stated, did approve the-- the application. That's where the approval ended. The technical review committee also listed numerous anecdotal reasons why they approved it and stated that there would be-- there would need to be a lot of things addressed before this legislation could be introduced. The credentialing review committee of the Board of Health considered the six criteria and felt that the proponents only met one of them, so I'm going to run through the five-- the six. Number one, the health, safety, and welfare of the public are inad-- inadequately addressed by the present scope of practice or limitations on the scope of practice. So the technical review committee said yes; the-- the Board of Health said no. Criterion two: Enactment of the proposed change in scope of practice would benefit the health, safety, or welfare of the public. The Technical Review Committee said yes; the Board of Health had a unanimous vote of no. The-- nu-- number three: The proposed change in scope of practice does not create a significant new danger to health, safety, or welfare of the public. Both groups, in this one instance, said yes. They did not think it increased the risk. Criterion four: The current education and training for the health profession adequately prepares practitioners to perform the new skill or service. Unanimous votes for both groups were no. Criterion

five: There are appropriate postprofessional programs and competence assessments measures available to assess-- assure that the practitioner is competent to perform the new skill or service in a safe manner. The technical review committee said yes. This is where they said they needed some additional things answered about what the actual aspects of the education would be. The Board of Health had a unanimous vote saying no. Criterion six: There are adequate measures to assess whether practitioners are com-- competently performing the new skill or service and to take appropriate action if they're not performing competently. The technical review committee said yes; the Board of Health, unanimously, no. The Board of Health voted overall to reject the proposal, as did the Chief Medical Officer and-- of the Division of Public Health. Both of those groups voted not to approve this. So I want to run through two little things and answer a couple of questions that Senator Hansen had. The references to the military and Department of Defense, I would encourage you to read those reports because there are specific instances where they refer to the patient population in the military as opposed to the patient population in the general public being very different, so they did not think that the two should be compared. The second one, saying that there have been no problems at all, they're in the reports again. There are-- I'll stop.

ARCH: Thank you. Are there any--

KORBY GILBERTSON: If there any questions, I can finish then.

ARCH: --there any questions? Senator Williams.

WILLIAMS: I just have one clarifying question, Ms. Gilbertson, and you may have said this and I missed it. When did-- when did the 407 process take place?

KORBY GILBERTSON: In 2017.

WILLIAMS: 2017.

KORBY GILBERTSON: Right.

WILLIAMS: OK.

ARCH: Senator Hansen.

B. HANSEN: Could you finish your thought, please?

*Indicates written testimony submitted prior to the public hearing per our COVID-19 response protocol

KORBY GILBERTSON: Yeah. [LAUGH] So there was a comment made by the proponents that there have been zero problems with anything that have gone on. There actually have been lawsuits filed in Louisiana and at least one reprimand of a prescriber. So changing this-- you know, the bottom line is changing this without a 407 review that approves it would be a complete departure from what this Legislature does. It would be setting a scary precedent.

B. HANSEN: OK.

ARCH: Any other questions? Seeing none, thank you--

KORBY GILBERTSON: Thank you.

ARCH: --for your testimony. Next opponent. Welcome.

MARTIN WETZEL: Good afternoon. My name is Martin Wetzel, M.D., M-a-r-t-i-n W-e-t-z-e-l. I'm a psychiatrist and president of the Nebraska Psychiatric Society, born and raised in rural Nebraska, and have been practicing psychiatry here since 1992. I am faculty at UNMC and Creighton Medical Schools and the former chief of psychiatry for the Nebraska Department of Corrections. Senator Arch and members of the committee, I'm here to oppose LB392, a bill allowing psychologists to perform physical assessments, order and interpret laboratory studies, and prescribe. This is the practice of medicine. Contrary to what proponents of this bill may say, psychopharmacology is a medical procedure and not a mental health procedure. Prescribing any medication must be given the same respect as any powerful yet potentially dangerous medical procedure. Because psychologists have no medical background, unlike physicians, physician's assistants, or advanced-practice nurses, the training and supervision to practice medicine must be rigorous from the time of application throughout the career of the practitioner. LB392 does not provide for these safeguards. Current medical education begins in college. Applicants for medical school, nursing, and physician's assistants programs must enroll and perform extraordinarily well in basic science classes, meet rigorous entrance requirements, and pass interviews before being even considered for admission in these highly competitive programs. There is no such selection of candidates for a clinical psychology degree, nor for the LB392 certificate outlined in this bill. The bill allows any eligible psychologist to obtain a certificate and practice medicine without rigorous prerequisites. All may enter, regardless of

basic science, aptitude, or ability. The curriculum for the prescribing certificate was not created-- it is not credentialed by any accredited medical education organization. While LB392 lists wide-ranging curriculum items such as biochemistry and neuroscience, these classes are taught in less than three months of actual classroom time. After reviewing this bill as a 407 application, the Chief Medical Officer could not accept that in such a brief period, psychologists with no background in the basic sciences could possibly learn these subjects, and we agree. Furthermore, the clinical practicums teaching physician assessments outlined in LB392 lack rigor and depth, as participants are not assessed by standardized examinations to show competency in medical assessments. Competency is verified by a signature of a supervisor on a form. It is unclear how this ensures the student is capable of safely laying hands on a patient. The final and most alarming aspect of LB392 is the period of provisional licensure. LB392 permits-- permits a provisional prescribing psychologist to independently perform physical assessments, prescribe and order laboratory tests on patients with no direct supervision during these visit-- patient encounters. Instead, LB392 states provisional licensure supervision is in person, by telephone, or by live video communication for four hours per month, in other words, no direct supervision in real time of the interactions between provisional licensees and patients. Competency in this case is determined after the fact, not by direct observation of the patient and the provider. Unsupervised examinations of patients are never allowed this early in training of medical students, nurse practitioners or physician assistants. LB392 also allows these same unobserved, provisionally licensed psychologists to treat children, the elderly and, therefore, LB392 would permit the most vulnerable of Nebraskans to be treated by inadequately trained providers. LB392 seeks to arbitrarily segregate and detour patients with mental illness from the medical community and subject them to substandard care. This places Nebraskans at risk. Any current programs in other states using this same model are unstudied and unproven and should still be considered experimental. Unfortunately, it's difficult for many patients to understand the training backgrounds of medical providers; therefore, patients trust us to require rigorous standards of competency and safety for medical treatment. LB392 lacks these standards. Across Nebraska, we value the current service of psychologists as we work together every day. Our opposition is based on promoting the safety and ethical treatment of Nebraskans with

mental illness and upholding standards of medical education in Nebraska. Those supporting this bill contend that a need for access to mental care justifies allowing psychologists to practice medicine without adequate training. Offering any substandard medical care to any patients in the name of improving access is simply unacceptable.

ARCH: Thank you. Are there any questions? Sen-- Senator Hansen, then-- then Senator Williams. Senator Hansen, please.

B. HANSEN: Thanks, Chairman Arch. Just a couple questions, and I probably should have asked this of someone earlier. But do you know like what's-- because you-- you were talking about the training aspect of it. Do you know what's involved with a postdoctoral degree in clinical psy-- psychopharmacology?

MARTIN WETZEL: Yeah, as it's outlined in the bill-- well, it's actually-- the actual curriculums are going to vary from program to program. But as I mentioned in the bill, there's about 40 hours of classroom work, which is very, very small considering the amount of-- and type of rigorous biologic subjects that are listed in the bill as being something that are-- are somehow being taught and the 407 reviewers also had that same impression.

B. HANSEN: OK. Then you were talking about they don't-- do they pa-- they have to pass an exam or anything like that?

MARTIN WETZEL: There's one standard exam--

B. HANSEN: A national-- a national exam?

MARTIN WETZEL: --and that is and that is written by the American Psychological Association. It's not written by a medical--

B. HANSEN: Gotcha, OK.

MARTIN WETZEL: --organization.

B. HANSEN: And one other thing is, I was hoping maybe you could share your perspective on what Ms. Lori Rodriquez-Fletcher, one of our first testifiers, talked about, about her inability to refer a patient who was in, looked like, dire need of care. And there's nobody around or she referred them to a psychiatrist and they were not able to take

her. What should she do in that-- in-- in-- in those examples that she gave when there is no one available?

MARTIN WETZEL: I think that's one challenge and an issue of this is trying to get down into individual cases, and I think every individual case is going to have lots of variables. I, as a psychiatrist, have had times where I've tried to refer people to all sorts of different specialists and had difficulty. So I don't think-- at least in my case, in my testimony, I'm here really to talk about the real substandard training that's outlined in this bill and the inadequacy of it and the-- the real risk that I think we're putting forward in opening this up so widely to so many people to practice medicine.

B. HANSEN: OK, I appreciate it. You know, I'm trying to get the count-- count-- pointer-- pointer-- point-- counterpoint, I mean, to-- to this, and you seemed like the most-- one of the best people to ask. That's why I was asking some of these questions. OK, thank you.

MARTIN WETZEL: Thank you.

B. HANSEN: Senator Williams.

WILLIAMS: Thank you, Chairman Arch. And thank you, Doctor, for being here. I want to follow up on Senator Hansen's. I-- I clearly understand your concerns and your profession's concerns here, and everyone on this committee fully understands the 407 process. We-- we deal with that a lot. We also have a real problem, in particular, in rural areas where we have people being underserved. It-- it cannot be disputed. And so we have Nebraskans that can't get the care that they need, especially in a critical area of mental health. So coming and opposing is one thing. Coming with an offer of some solution would be helpful. How do we address this problem?

MARTIN WETZEL: Thank you, Senator. I'll-- I'll address that question in a couple components. First, I'm from rural Nebraska. I'm actually from Curtis. Yes, and--

WILLIAMS: Just down the road.

MARTIN WETZEL: Yeah, you bet. And when I was growing up, we had a lot of medical shortages in Curtis, Nebraska, including mental health. What really pains me as a physician is that I doubt that there's very many other areas of medicine that would say that the way to solve any

access to-- to problems is to provide a substandard access to care, and I think that's true, whether it's cardiovascular surgery or whether that's psychiatry. But I'm used to our patients and our profession dealing with a certain stigma and I-- I honestly believe that there are solutions. There are solutions taking place now, and actually Dr. Brooks will be coming up and talking about some of the things that are happening in the state. As you may be aware, Nebraska Medicine has now a psychiatry residency program, in addition to the Creighton psychiatry residency program. And many of the graduates that we have seen coming out of the residency programs are staying in the state, which is very exciting. Telehealth has exploded. It exploded almost overnight due to the Coronavirus and the COVID situation and we have seen vast improvements. Now that doesn't mean that there aren't still access problems. Not everybody has a cell phone and maybe not everybody has broadband access. But there are many steps taking place in order to address this problem. I can also speak to the efforts at UNMC in terms of teaching primary care providers, teaching every medical student that comes through the program how to use tools to diagnose and manage common psychiatric problems. The vast majority of psychiatric medication is prescribed in the primary care office. A very small percentage is prescribed outside of the primary care setting, so integrating more behavioral health and education into the primary care setting has always been one of my top priorities as a faculty member at UNMC, and I know that our program does an outstanding job in teaching future physicians how to manage those common depression, anxiety problems. So there are many ways that we can address this, and I think we are and I think Nebraska has actually kind of been a leader in some of these things. So to me, whether it's psychiatry or surgery or any other medical problem, the way to do it is to get the top quality, the best quality to the people who need it the most and not sacrifice quality or substandard training as a way-- as a substitute for providing people the best care that they-- they should get.

WILLIAMS: Thank you.

ARCH: Other questions? Seeing none, thank you very much.

MARTIN WETZEL: Thank you.

ARCH: Thank you for your testimony. Next opponent for LB392. Good afternoon.

MICHELLE WALSH: Good afternoon. Chairman Arch and members of the committee, my name is Dr. Michelle Walsh, M-i-c-h-e-l-l-e W-a-l-s-h. I have been a pediatrician here in Lincoln now for more than 22 years. I am the current president of the Nebraska Medical Association, testifying in opposit-- opposition to LB392. As you may be aware, the NMA is closely involved in scope-of-practice changes for healthcare professionals in Nebraska. Whether it be in the legislative hearings or during the 407 process, physicians are uniquely positioned to provide expert input as a leader and healthcare team. Advocating for the health of all Nebraskans is part of the NMA's motto and is the reason why we take patient safety and ensuring providers are practicing within their knowledge level so seriously. As you just heard from Dr. Wetzel, there's a significant concern over patient safety should this bill advance. Many psychotropic drugs have a very narrow therapeutic range and a high level of side effects to consider, which creates a challenging risk-benefit analysis. LB392 requires both a supervising physician and the patient's primary care provider to be involved in the prescribing process with the psychologist, meaning that there could be three differing opinions for that risk-benefit analysis. While the bill includes oversight by a supervising physician and the patient's primary care provider to give the appearance of added safety nets, it does not consider the practicality of this process and the practice of the clinical level. First, this creates an added burden for the patient's primary care provider, as they would rather refer their patients to an expert they can trust to treat their patient effectively without having to oversee and ensure it is the right treatment for the patient. Depending on the level of involvement in the decision making, the primary care provider could have increased liability exposure from the psychologist's actions, which is unlike any other referral relationship. Second, the bill attempts to create a supervisory and collaborative relationship between a psychologist and a physician that mirrors a current collaborative relationship physicians possess with physic-- physician assistants. Given their education, experience and training, physician assistants are uniquely qualified to enter these types of relationships with physicians, and the physician ultimately has final say over the medical services a physician assistant may provide based on their education and training. However, because of the high level of education and training, there is a trust with the medical services physician assistants provide and this relationship should not be seen as micromanaging. This type of relationship does not translate well to psychologists in what LB392

attempts to do because a supervisory relationship only relates to one specific type of medical service, of which knowledge of the patient and their medical history would be necessary information to understand in order to provide adequate supervision. This leans more towards a micromanage relationship to ensure patient safety and is likely something physicians will not want to engage in. As you can see from the charts I handed out, Western and rural Nebraska are not exactly crowded with psychologists looking to fill the void due to perceived lack of physicians. The fact that primary care physicians in these areas, of which are there are considerably more in practice than psychologists, would rather refer to psychiatrists than attempt to treat their patients' mental health needs, should tell you just how complicated and intricate mental health and psychotropic drugs can be and why allowing psychologists to provide-- prescribe these medications is the wrong approach to take. This past year has accelerated the use of telehealth, which the NMA believes is a much more appropriate route to expand access to mental healthcare and healthcare in general across the state. Supporting Legislature [SIC] such as LB487, which matches insurance reimbursement rates for telemedicine behavioral health visits to in-person reimbursement rates will be significantly more impactful to increasing mental healthcare access in Nebraska than the clunky process provided for in LB392. For these reasons, in conjunction with the other testimonies heard today, the NMA respectfully requests the committee to not advance LB392. And then on another comment, as far as your psychotropic drugs from previous testimonies, I just want to reiterate that these medicines are not like antibiotics you would use to prescribe for pneumonia. These medicines can have very serious side effects and you have to be aware of these side effects and have to be very careful about prescribing them. And so that is one of the reasons I think that some providers are hesitant to prescribe them. Thank you.

ARCH: Thank you. Are there any questions? Senator Hansen.

B. HANSEN: Thank you.

MICHELLE WALSH: Yes.

B. HANSEN: You were mentioning in some of your testimony that there might be some reluctance for medical doctors to refer a patient to like a-- a prescribing psychologist, like [INAUDIBLE] you know, I

think it was one of the points that you kind of brought up maybe in your testimony.

MICHELLE WALSH: Yes.

B. HANSEN: What do you think like the overarching thought is of medical doctors towards prescribing psychologists? The reason I ask that is one of the testimon-- testifiers before-- make sure I get it right. That was Dr. Ernst mentioned the study done in 2017 by Linda, et al, and-- and-- and granted, it's from the-- I think the-- the-- and make sure I get this right-- Professional Psychology: Research and Practice magazine, so it might be a little bit biased.

MICHELLE WALSH: Um-hum.

B. HANSEN: But they did some studies. Granted, I think they just-- it was more of a survey that said, OK, what's diff-- what's-- what's the perception of prescribing psychologists from their count-- medical counterparts? And according to the study, was overwhelmingly positive. Again, based on some of those things I mentioned before, it seems like it might seem positive for-- for the medical community to refer patients to prescribing psychologists, but I was kind of more curious to get your take about what you think might happen in Nebraska if we did that.

MICHELLE WALSH: I guess my concern would be I do do a lot of prescribing to psychologists. They do a great job as far as like the psychotherapy, because we don't want to do medicines if we don't have to. But then I work as a pediatrician, so if you look at pediatric side effects, there's a lot of side effects and these medicines are not predictable. So it's one of those things where you think that you know the dosing, you think you know the medicine, but that person may not react the same way you would think. So rather than having the-- a positive effect, they might have a psychiatric breakdown; they might become suicidal; they might all of a sudden-- you know, I'll have parents call my office and say, this is not my kid, I don't know what-- what-- what's in this medicine, but it's not my kid. So it's one of those things where that's why when we look at psychotropic medicines, we usually look at prescribing to an expert and that's what they do. It's a specialist that that's all they do all day long is to prescribe those medicines. They're just more-- they've had a lot more training what the side effects will be, how to treat those side

effects, what medicines to use, what medicines not to use. And psychologists, yes, they do a wonderful job for helping people with psychotherapy, but there's a big difference between psychotherapy and medicines.

B. HANSEN: OK, and I'm going to pose the same question I did to someone earlier. And Ms. Rodriquez--Fletcher's test-- testimony-- sorry, I missed it again. What would you recommend someone like her do when she is caught with a patient in a crisis situation and she has no one to refer to?

MICHELLE WALSH: I would talk to the primary care provider. So in general, when I'm in that type of situation, if I call the psychiatrist and I say I'm very concerned about this patient, she's suicidal, or this child is having a breakdown, in general, they get the patient in right away.

B. HANSEN: OK. OK, thank you.

MICHELLE WALSH: Um-hum.

ARCH: Other questions? Seeing none, thank you very much for your testimony.

MICHELLE WALSH: Thank you.

ARCH: Next opponent for LB392. Welcome.

BETH ANN BROOKS: Good afternoon. I am Beth, B-e-t-h, Ann, A-n-n, Brooks, B-r-o-o-k-s, a Nebraska-licensed physician and board-certified psychiatrist and child/adolescent psychiatrist from Lincoln who is representing the Nebraska Psychiatric Society, Nebraska Medical Association, and the Regional Organization of Child and Adolescent Psychiatry in opposing LB392. I also hold a voluntary faculty appointment as a professor of psychiatry at UNMC. I'm a former residency program director who served on the ACGME residency review committee for psychiatry and a past chair of the American Board of Psychiatry and Neurology. Thus, I'm very familiar with what is required in postgraduate training programs. I testified before the technical review committee and Board of Health in 2017 during the 407 process for psychologist prescribing and at the public hearing in January 2020 for a similar bill, LB-- LB817. I've worked as a member of mental health teams for more than 40 years and hold psychologists

in high esteem for their assessment and psychotherapy skills. However, Nebraska already has medical professionals who can prescribe for patients with psychiatric disorders. What our state sorely needs are psychologists skilled in providing evidence-based therapies, cognitive/behavioral, dialectical behavioral, multisystem and parent management training, to name a few. The proponents of LB392 describe access problems, but they ignore that primary care physicians, certified physician assistants, and nurse practitioners specialized in primary care and/or mental health are dispersed all across Nebraska. These medical professionals possess the requisite medical background in 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 all imperative before deciding whether to prescribe psychotropic medication. They already are addressing access issues without the risk to patients and the administrative costs that prescribing psychologists would pose. The contemporary emphasis on telepsychiatry, collaborative care, as well as collocated behavioral and physical healthcare and regular consultation with other prescribers, is addressing the need for access to qualified medical professionals who can treat mental disorders across Nebraska. UNMC opened a psychiatry residency program in 2020, requiring a four-week rural psychiatry rotation in North Platte, which will add to the number of psychiatrists considering practice outside of urban areas. I've distributed a list of 93 widely dispersed locations throughout the state that are served by telepsychiatry providers who practice in Nebraska. It's not a complete list, but includes the larger health systems of the Avera in northeast Nebraska, Boys Town, Bryan Behavioral Health, CHI, Children's Hospital, and UNMC. The UNMC Psychiatry Department has a universal access platform for statewide telepsychiatry available by smartphone, tablet or laptop, using an app integrated with the UNMC electronic medical record. This program includes medication management. Using telehealth removes geographical barriers. It is significant that since 2017, Nebraska's insurers are required to reimburse telehealth at the same rate as face-to-face services, and there are four telehealth bills under consideration during the current legislative session. I also provided the committee with a compilation of some of the behavioral health resources available in western Nebraska, illustrating the multiple locations in which psychiatric APRNs provide clinical services. Also detailed are the collaborative care and collocated clinic models utilized by

Western Nebraska Behavioral Health in eight communities in the Panhandle and Sandhills region, where therapists practice alongside primary care providers who capably treat both mental and physical disorders. And in closing, it should be noted that Clarkson College in Omaha started a psychiatric nurse practitioner program in 2020, which will further increase the number of psychiatric APRNs in Nebraska. Thank you for the opportunity to comment why LB392, should not advance. It does not protect some of our most vulnerable citizens and there are alternatives already in place from well-trained medical professionals to address access. I welcome any questions you may have.

ARCH: Thank you. Are there any questions? Senator Hansen.

B. HANSEN: Thank you, Chairman Arch. And thank you for coming to testify, by the way.

BETH ANN BROOKS: You're welcome.

B. HANSEN: I'm a little unfamiliar with telepsychiatry. So when somebody gets involved with doing telehealth with-- with a psychiatrist, do they previously have to get a physical exam beforehand? I think one-- one of the testifiers before you, one of the psychiatrists before you said one of the concerns that they had with prescribing psychologists is that they were unable to do physical exams and kind of do some of those other kind of more invasive procedures, I guess, you know, and so that was one of his concerns. But with telepsychiatry, I think that it seems like that would take away from that, or would they have to do that before or--

BETH ANN BROOKS: I think it depends on the individual practitioner who's providing telepsychiatric services. Some are psychiatrists, some are APRNs, some are physical-- physician assistants, and others who provide telebehavioral health are licensed mental health counselors, psychologists, and social workers, so there's a wide array providing services that may be referred to as telepsychiatry. Those who are also prescribers likely have their own agency or hospital or clinic policies as to what they need to have in place before they consider prescribing. Generally, there needs to have been a health assessment that is-- they have record of and knowing if there are any allergies, what other current medications they're on, and other current physical health disorders. So it would be variable and different facilities and agencies, I think, will have different guidelines about that.

B. HANSEN: OK.

BETH ANN BROOKS: You should also be aware that we have better ability to control Nebraska practitioners of any background because they're licensed in our state and physically operate here. We have individuals who are licensed in the state of Nebraska but have never set foot here in terms of practice because they're using teleplatforms and they probably will have less access to primary care physicians' records, physical health assessments, etcetera.

B. HANSEN: OK. So someone who is going to engage in telehealth with a psychiatrist and a patient and a psychiatrist is unable to do some of that assessment themselves, they can have somebody else do it on their part?

BETH ANN BROOKS: Oh, yes--

B. HANSEN: OK. So it could-- so--

BETH ANN BROOKS: --no different, frankly, than a social worker or a psychologist providing telebehavioral could do the same, to be fair.

B. HANSEN: Well, that-- and I think that's part of-- yeah, that's part of my question, I think, I was-- that you kind of brought up there was, so if there's some concern about a psychiatrist unable to do some of those-- those evaluations themselves, they could have somebody else do it and then they can kind of work with the patient and prescribe?

BETH ANN BROOKS: Yes, but that's where clinical judgment and acumen comes in--

B. HANSEN: OK.

BETH ANN BROOKS: --in terms of the ability to integrate physical health with behavioral health and understand what physical illness-- physical health illnesses could mimic psychiatric and vice versa. And the drug-drug, or I prefer to call them medication-to-medication, side effects that can occur from a cancer medication, a heart medication, etcetera.

B. HANSEN: OK. That's one of the discrepancies I think they were talking about before, yeah, between medical doctors or psychiatrists

and psychologists. Some of those degrees and education are variations on [INAUDIBLE]

BETH ANN BROOKS: It-- it's the depth. and in my opinion, the difference is more medication training versus medical training that physicians and APRNs and physician assistants would have, rather than a 450-didactic hour master's in psychopharmacology, most of which can be done online. Dr. Wetzel referred to, for example, I think it's the New Mexico State University program that has 40 hours required in the 450 on site--

B. HANSEN: OK.

BETH ANN BROOKS: --and then the different practica. I-- I have real reservations about the previous testimony of physical assessment education and how that could be construed by a listener as physical examination procedures.

B. HANSEN: OK. Thank you.

ARCH: Other questions? Seeing none, thank you very much for your testimony.

BETH ANN BROOKS: Thank you.

ARCH: Next opponent for LB392. Seeing none, is there anybody that would like to testify in a neutral capacity? Seeing none, I would mention that we've received several letters. We received letters from 6 proponents and 48 opponents and 1 neutral. We also received two written testimonies this morning, a proponent, Dr. Diane Marti, on behalf of herself and a proponent, Mike Misegadis from the Autism Society of Nebraska. And Senator Stinner has waived closing, and so this will conclude our hearing for LB392 and the hearings for the day for the committee.