[LB721 LB722 LB849]

The Committee on Health and Human Services met at 1:30 p.m. on Friday, January 22, 2016, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB721, LB722, and LB849. Senators present: Kathy Campbell, Chairperson; Sara Howard, Vice Chairperson; Roy Baker; Sue Crawford; Nicole Fox; Mark Kolterman; and Merv Riepe. Senators absent: None.

SENATOR CAMPBELL: Good afternoon and welcome to the hearings of the Health and Human Services Committee. I'm Kathy Campbell. I serve as the senator from District 25, east Lincoln, and Chair of the Health and Human Services Committee. We're very glad you're here on a Friday afternoon. And we're all very glad it's Friday, let me tell you. I want to go through a few reminders to you. If you have a cell phone, please put it on silent or turn it off, so that it doesn't disturb those people testifying. We don't require handouts here, but if you are providing a handout, we would like 15 copies. If you don't have that, you can talk to one of the pages over there, and they'll help you. If you're testifying today, you need to complete one of the orange sheets that are on either side, and please write as legibly as you can the information that is required. When you come forward to testify, you can give your orange sheet to Elice, who is the clerk for the committee. And the pages will provide...if you have handouts, they'll distribute them for you. We do use the light system in the Health and Human Services Committee to ensure first hearing and last hearing get equal time. So you have five minutes. It will be green...the lights are up here...and it will seem like a very long time. And then it will go to yellow, and you only have one minute. And then it'll go to red, and I'll be trying to get your attention. So we appreciate your testimony today, certainly. So with that, we'll do introductions of the senators. Senator Fox.

SENATOR FOX: Senator Nicole Fox; District 7, Omaha.

SENATOR KOLTERMAN: Senator Mark Kolterman, District 24; Seward, York, and Polk Counties.

SENATOR BAKER: Senator Roy Baker, southern rim of Lincoln, down through Lancaster County and all of Gage County.

SENATOR HOWARD: Senator Sara Howard. I represent mid-town Omaha.

JOSELYN LUEDTKE: Joselyn Luedtke, Committee Counsel.

SENATOR CRAWFORD: Good afternoon. Senator Sue Crawford, and I represent District 45, which is eastern Sarpy County, Bellevue and Offutt.

SENATOR RIEPE: Merv Riepe. I represent Omaha, Millard, and Ralston, District 12.

SENATOR CAMPBELL: Elice?

ELICE HUBBERT: Elice Hubbert, Committee Clerk.

SENATOR CAMPBELL: And the two pages? Ashlee?

ASHLEE FISH: My name is Ashlee Fish. I'm a business administration major at the University of Nebraska-Lincoln, and I'm from Seward, Nebraska.

SENATOR CAMPBELL: Jay.

JAY LINTON: I'm Jay Linton. I'm an ag econ major from Dalton, Nebraska.

SENATOR CAMPBELL: All right. I think we're ready. We're going to start this afternoon with our first hearing, LB721, Senator Baker, to adopt the Surgical First Assistant Practice Act. Good afternoon once again.

SENATOR BAKER: (Exhibits 1-2) Chairman Campbell and fellow members of the Health and Human Services Committee, my name is Roy Baker, R-o-y B-a-k-e-r. I represent District 30. Currently, surgical first assistants receive three to four years of school and training. They have worked along surgeons for years. They provide a safe surgical environment and do tasks delegated by the surgeon, under his supervision. About two years ago, issues were raised regarding the need for licensure of a surgical first assistant. It was determined that seeking licensure for surgical first assistants was necessary and appropriate. The Nebraska Hospital Association worked with the surgical first assistants and began the 407 review process with the Department of Health and Human Services. This credentialing review process for surgical first assistants was approved, and now I am here with LB721. LB721 enacts a licensure process for surgical first assistants. The bill establishes a scope of practice, education, and practice guidelines approved by the Board of Medicine and Surgery within the Department of Health and Human Services. I have an amendment which has been passed around. I would like the committee to consider, view the changes made at the request of the Department of Health and Human Services: (1) inserting the operative date of January 1, 2017, to allow the department to develop rules and regulations. (2) changes Section 17 of the bill to conform to existing

provisions, procedures of the Uniform Credentialing Act. And (3) changes some language to make the sentence clear. With that, I will stop the opening. [LB721]

SENATOR CAMPBELL: Okay. Any questions from the senators? Thank you, Senator Baker. I think we'll just get this...oh, sorry, Senator Riepe. I didn't see your hand. I apologize. [LB721]

SENATOR RIEPE: Thank you, Senator. No, no, my fault. Thank you, Senator Campbell. Senator Baker, this is for direct first assistant. Sometimes in these situations, they..a medical student or resident might end up closing, which is...I don't know whether this would require of the medical student to be certified as well? And also, sometimes reps of medical devices become more engaged in surgery than one might expect. I (inaudible)... [LB721]

SENATOR BAKER: Senator Riepe, I've never been in a surgery room, so I don't know who does what in there. But I do know that the purpose of this is to have the person who typically does those types of things designated as the surgeon's first assistant. And it was determined a couple of years ago that the law requires it, and it has since 1898. But it's never been looked at until 2013 or 2014. And there was a review in the Sidney Regional Medical Center, and they found that someone was there helping the surgeon doing some hands-on things which they said that is a improper delegation under the court case of 1898. So that's why this is moving forward. [LB721]

SENATOR RIEPE: Um-hum. Okay, thank you. Thank you. [LB721]

SENATOR CAMPBELL: Senator Howard. [LB721]

SENATOR HOWARD: Thank you, Senator Campbell. You mentioned that surgical first assists have three to four years of school and training. What is required under the new licensure? [LB721]

SENATOR BAKER: I think that that...what we're saying is that that's what they have now. [LB721]

SENATOR HOWARD: Okay. [LB721]

SENATOR BAKER: And so that wouldn't necessarily amp up the requirements. [LB721]

SENATOR HOWARD: And then, can you tell me how the 407 turned out? [LB721]

SENATOR BAKER: The...my understanding of the 407 is complete for the surgical first assistant position. [LB721]

SENATOR HOWARD: Okay, perfect. Thank you. [LB721]

SENATOR BAKER: Thank you. [LB721]

SENATOR CAMPBELL: Any other questions? Thank you, Senator Baker. We'll start out with the proponents to the bill. So our first proponent. [LB721]

LINDA SHOEMAKER: Good afternoon, Senator Campbell and committee members. First of all, I'd like to say thank you for allowing us the opportunity. [LB721]

SENATOR CAMPBELL: Oh, we're going to stop you right there. I should have given that instruction. I forgot. We need to have you state your name for the record and spell it, please. [LB721]

LINDA SHOEMAKER: Linda Shoemaker, L-i-n-d-a S-h-o-e-m-a-k-e-r. Okay. I currently am employed at Sidney Regional Medical Center as the corporate compliance officer. I am an RN by experience and profession. And this all stemmed from August of 2013, when the Department of Health and Human Services was on site to do our critical access hospital survey. And when reviewing records from the O.R. department, they noticed the initials of, or credentials of, CSFA. And they told us that we had to cease and desist using this individual, because it's not legal in Nebraska, and these credentials are not recognized. So this is when we started our long process. Also, what even compounded it was what Senator Baker was talking about, the case law on the books of 1898, Paul v. Howard (sic: State of Nebraska v. Paul Howard), where a physician in the state of Nebraska cannot delegate to an unlicensed individual. So this is why we went forward with asking for licensure for the surgical first assist. And I might add that all three entities have approved the 407. The credentialing review is now complete, and licensure of surgical first assistants was approved at all levels. LB721 enacts the licensure recommendations of the Technical Review Committee, the Nebraska Board of Health, and the Department of Health and Human Services CEO, Courtney Phillips. [LB721]

SENATOR CAMPBELL: Okay. Are there any questions? Senator Howard. [LB721]

SENATOR HOWARD: Just to clarify, you mentioned that it was DHHS when they were doing your critical access review. Did you have any problems with Joint Commission? [LB721]

LINDA SHOEMAKER: We do not have Joint Commission. We have...the Department of Health and Human Services surveys us both for the state and the federal, the CMS. [LB721]

SENATOR HOWARD: Thank you. [LB721]

LINDA SHOEMAKER: Um-hum. [LB721]

SENATOR CAMPBELL: Other questions? Okay. Seeing none, thank you very much. [LB721]

LINDA SHOEMAKER: Thank you. [LB721]

SENATOR CAMPBELL: Our next proponent? [LB721]

CHRIS WILSON: Good afternoon, Senators. [LB721]

SENATOR CAMPBELL: Good afternoon. [LB721]

CHRIS WILSON: My name is Chris Wilson, C-h-r-i-s W-i-l-s-o-n. I've been a surgical first assistant for just under 20 years. I'm employed by a orthopedic group called GIKK Ortho Specialists, who are in Omaha, Nebraska. I've been employed with them just as long. My background...I have formal and informal training, both as a surgical technologist and as a first assistant, and have been practicing as a first assistant for, like I said, almost under 20 years. I work very closely with the surgeon I am employed by, and he'll be testifying today. Everything is under his direct supervision, and he is aware of what's happening. When this cease and desist came through in western Nebraska, we weren't affected in Omaha until a year post that happening. And that actually happened through Joint Commission. So the question is, was Joint Commission aware? The institutions where we worked at, they were working with Joint Commission, and Joint Commission said that all of that had to cease and desist. So since that time, I have not been working in the fashion I had been working in. All I am able to do is hold retractors and be part of the surgical procedure. When we started the 407 process, we went through different aspects of things. One of the things that we had to come up with was a scope of practice for the 407. A scope of practice is very important for any practitioner in medicine, as most people are aware. The scope of practice was actually brought together by a subcommittee of the 407 process. And we gathered different information from states that have already gone through this process, and past legislation, accordingly, for first assists. Those particular states would include Texas, Colorado, Virginia, D.C., and Florida, just recently. We also pulled from the College of Surgeons, the National College of Surgeons (sic: American College of Surgeons) and what they refer to as first assistants, as well. So it wasn't just a scope of practice that was

pulled out of the air; this has been tried and true for several years now, that we've come up with. As been written, our scope of practice would include: (1) assisting the surgical team in the intraoperative care of surgical patient, (2) positioning the patient, (3) preparing and draping the patient for the operative procedure, (4) providing visualization of the operative site, (5) assist with the hemostasis, (6) assist with the closure of body planes (that would include (a) utilizing running or interrupted subcutaneous suture with absorbable or nonabsorbable material, (b) utilizing subcuticular closure technique with or without adhesive skin closure and strips, (c) closing skin with any method indicated by the surgeon, including suture, staples, etcetera), (7) applying appropriate wound dressings to the operative site, (8) providing assistance in securing drain systems to the tissue, (9) preparing specimens such as grafts, and (10) performing tasks during a surgical procedure delegable under the provision of a licensed physician appropriate to the level of the competence of the surgical first assistant. [LB721]

SENATOR CAMPBELL: Okay. Questions from senators? Senator Riepe. [LB721]

SENATOR RIEPE: Senator Campbell, thank you. I guess my question would be, knowing Mike Gross, who's part of your group (inaudible)... [LB721]

CHRIS WILSON: Mike Gross hired me 20 years ago, sir. [LB721]

SENATOR RIEPE: Well, he's a smart man, obviously. [LB721]

CHRIS WILSON: I hope so. [LB721]

SENATOR RIEPE: My question is, does Dr. Gross have the occasion to have medical students...I'm going back to my earlier question...to close for him when he gets to a certain point? [LB721]

CHRIS WILSON: Actually, Senator, that is correct to a point. Students are allowed to suture. We typically don't have the students suture. Typically, it's either done by the physician or the direct assistant, in some types a physician assistant or licensed PA. Sometimes there is a resident, accordingly. Most times you're going to find...during private practice, you're not going to find a teaching institution. So residents and medical students aren't necessarily present during the cases in which you'll find the physician and an assistant, along with the operative team. So that would leave one of two people to close. And hence, that's part of the importance for us, is that for patient safety, that a patient is not on the table as long as they have to be. Our efficiency is in being able to close together, is really for direct patient safety, to be able to get them off the table in a safe and secure manner and as quickly as possible. [LB721]

SENATOR RIEPE: Is this certification then limited to ambulatory surgery centers as opposed to hospital surgeries? [LB721]

CHRIS WILSON: No, sir. To all surgicals... [LB721]

SENATOR RIEPE: Okay. [LB721]

CHRIS WILSON: ...ambulatory and inpatient, yes. In fact, a majority of our work in the past, before cease and desist...actually, my surgeon is a total joint surgeon. So a lot of them are inpatient surgery. [LB721]

SENATOR RIEPE: And have you, sir, seen sales reps that get engaged in the process? [LB721]

CHRIS WILSON: That I'm not familiar with, no. And in fact, sales reps since, I believe, the early 2,000's, have been very limited in what their aspect is in the surgical O.R. They have to be Reptraxed, and they aren't allowed to have any patient contact whatsoever. So, as far as representatives go in the O.R., no, that would be a whole, entirely separate, different idea. No. [LB721]

SENATOR RIEPE: Probably one of my own faults of having been around that long. I remember the day when they were, and so that was the concern. [LB721]

CHRIS WILSON: That's...they are in the O.R. only as consultants, and that's it. They are allowed no... [LB721]

SENATOR RIEPE: No touch. [LB721]

CHRIS WILSON: No touch. [LB721]

SENATOR RIEPE: Okay, thank you. [LB721]

CHRIS WILSON: You're welcome. [LB721]

SENATOR RIEPE: Thank you, Chairman. [LB721]

SENATOR CAMPBELL: Mr. Wilson. [LB721]

CHRIS WILSON: Yes. [LB721]

SENATOR CAMPBELL: So that because of the Joint Commission, this affects all states, correct? All states should have a license? [LB721]

CHRIS WILSON: That's a tricky question, Senator Campbell. [LB721]

SENATOR CAMPBELL: Oh, sorry. [LB721]

CHRIS WILSON: Let me explain to you. No, I'm glad you brought that up. The answer is no. Not all states have this particular law on the books, where a surgeon can delegate to a licensed or non-licensed participant in the O.R. Actually, Iowa is a state that is not affected by that. So if you're a non-licensed assistant in the state of Iowa, you're still able to be delegated to by a surgeon. And the fact as our training goes, it's not a lack of training; it's a lack of licensure. They don't accept a non-licensed person to be delegated to by the physician. So that's really where the issue stands point. So the answer to your question is no, not all states are affected by it, our state in particular, because of the law of 1898. [LB721]

SENATOR CAMPBELL: Got it, okay. That's helpful. Any other questions? Thank you, Mr. Wilson. [LB721]

CHRIS WILSON: Yeah, thank you. [LB721]

SENATOR CAMPBELL: Our next proponent? Good afternoon. [LB721]

NANCY GONDRINGER: Good afternoon, Senator Campbell. Good afternoon, Senator Campbell and members of the committee. My name is Nancy Gondringer, N-a-n-c-y G-o-n-d-r-i-n-g-e-r, and I am here to testify as a licensed healthcare provider, as a CRNA, with over 40 years of experience and as a consumer of healthcare services. I am here to speak in favor of LB721. The issue of the certified surgical technologist first assist, the CSTFA, and the certified surgical technologist, CST, was brought forward when the state was surveying Sidney Regional Medical Center in Sidney, Nebraska. The surveyors noted certified surgical technologist FAs and surgical technologists...certified, and surgical technologists which are non-certified STs were non-licensed providers in the state of Nebraska. Therefore, the surgeon could not delegate medical acts to these individuals, as it was in the violation of the 1898 Nebraska law. That law was cited...was Nebraska v. Paul and specifically prohibited physicians to delegate medical acts to unlicensed individuals. The ruling by the state brought great attention to this group of providers. Questions, such as who are these individuals, what is their education, could they continue to

perform these acts that most hospitals were allowing, and finally, did they have a scope of practice? In my many years as a healthcare provider working in the operating suites, these individuals are vital members of the surgical team. They're there to help support quality surgical care for all Nebraskans who need surgery. Since the concern affected hospitals, physicians, and nurses, all were in agreement that this issue needed to be resolved immediately. Therefore, the 407 process was initiated, and we thank the Nebraska Hospital Association for getting us together. The 407 process has now resulted with the introduction of LB721, which specifically addresses a portion of these providers who were historically called certified surgical technologist first assists, now identified as licensed surgical first assists, the LSFA. The licensing of the licensed surgical first assistant, LSFA, is consistent with other Nebraska regulatory models that allow physicians to delegate medical acts to others who possess the knowledge and expertise to perform such act. The licensed surgical first assistant would be required to attend and successfully pass the certifying examination approved by the Nebraska Department of Human Health Services (sic). The license would provide the legal ability to the LSFA to accept and perform delegated tasks under the direct supervision of a surgeon, while helping to "remote" and provide safe surgical care. The licensing of the LSFA will also ensure the public that these individuals with the title of licensed surgical technologist assistant, LSFA, are safe and competent practitioners and have met specific guidelines for licensure and relicensure. I urge you to adopt this legislation. And thank you for allowing me to provide input on this legislation which will help protect the safety and welfare of Nebraskans who may need surgical care. [LB721]

SENATOR CAMPBELL: Thank you for your testimony. Questions from senators? One of the questions...and I think we probably should talk about this on the record, although I asked someone that previously. And that question is, how many first assists are there in the state right now? [LB721]

NANCY GONDRINGER: I will refer to (inaudible)... [LB721]

SENATOR CAMPBELL: Well, if someone is going to testify on that... [LB721]

__________: I will testify. [LB721]

NANCY GONDRINGER: Someone will testify on that. And I want to clarify about representatives or people who come in as a O.R. director. If someone touches the patient that's not supposed to be touching the patient, we're notified immediately, and they are reprimanded. They are not to put sterile items on the table; the nurse is responsible for that. They're not to...they stand with their little pointy thing and say, this, this, and this, or they acknowledge that

this specific implant is what the surgeon is asking for. But they are not to touch the patient. [LB721]

SENATOR RIEPE: Okay. [LB721]

SENATOR CAMPBELL: I didn't know that. [LB721]

NANCY GONDRINGER: Well, we get a little picky about it. [LB721]

SENATOR CAMPBELL: Yes. Thank you. Our next proponent? Good afternoon. [LB721]

ERIK OTTERBERG: Good afternoon. Senators, thank you allowing me the opportunity to speak. And Senator Baker, thank you for introducing our bill. My name is Erik, E-r-i-k Otterberg, O-t-t-e-r-b-e-r-g, MD. I am with GIKK Orthopedic Surgery. I'm the past chief of staff at Lakeside Hospital. And I'm a member of the Mid-America Orthopaedic Association; I'm the education chairman of that regional orthopedic group. As Chris Wilson testified, this has directed me personally, but more importantly, it's directed hospitals throughout our state, particularly in the more critical access areas. Surgical technologists have been functioning in this first assistant capacity for quite some time, since I've been in practice. This was done, obviously, unknowingly that it was in violation of any type of law. But I guess no one had gone back and looked that far in the past, to 1898. I think this is an important...and the reason I look at this...in healthcare right now, patient safety is always paramount. But also, what we're looking at is value, which is quality care at a cost-effective price. And that's the only way our healthcare system is going to continue to function in a reasonable manner. And I think surgical first assistants or licensed first assistants will provide that for us. We have a quality measure that we can have people on the operating table for a shorter period of time, which decreases risk of infections. It increases efficiency and also decreases mortality...the shorter time you're in the O.R. In terms of cost, it is cost effective to have people in this role. And some of the questions I'm often asked is well, you could have another partner or a physician's assistant maybe do the same type of service. Yes, you can, but by no means is that a cost-effective way to practice medicine. Any questions of medical students and the reps, I can take care of that. I'm still...I'm the clinical instructor at the University of Nebraska. Medical students, under the direct "guise" of a...or direction of a physician, are usually allowed to close. But that falls in the category that they are a student, and they fall into an educational category. [LB721]

SENATOR RIEPE: Okay. [LB721]

ERIK OTTERBERG: Reps can't come near my table. So reps are not...in fact, in our hospital systems, reps are not allowed to come into the room until they're needed. So they aren't there for the prepping or the (inaudible) the position of the patients. They are not allowed in until they come in. I also wanted to state, as well, that the Nebraska Medical Association also asked me to come, and I'm here for them, as well. And we have this supported with the Nebraska Medical Association. [LB721]

SENATOR CAMPBELL: Okay. Questions from the senators? Doctor, I saw you turn around and talk to someone, and you said you thought you had the answer. [LB721]

ERIK OTTERBERG: Oh. [LB721]

SENATOR CAMPBELL: How many of them are in the state? [LB721]

ERIK OTTERBERG: That's a great question. So we are estimating 20 to 25. But to really know how many people have been functioning in this role, I don't think there's an answer to that, because we look at some of these, particularly in our critical access hospitals, their surgical technologists have been helping physicians at all different types of levels. So I don't think I can really put a number on it. It could be anywhere to 100 if we're really starting to look at it. [LB721]

SENATOR CAMPBELL: And my understanding is that there is not a grandfather clause in this bill. [LB721]

ERIK OTTERBERG: I do not believe there's a grandfather clause in the bill; that's correct to the best of my knowledge. [LB721]

SENATOR CAMPBELL: So whoever has been providing this service in the surgical room will have to go through the... [LB721]

ERIK OTTERBERG: It's been obtained on... [LB721]

SENATOR CAMPBELL: ...what has been laid out. [LB721]

ERIK OTTERBERG: Yep. That was proposed by the board, and we'll be going through and obtaining appropriate licensure. [LB721]

SENATOR CAMPBELL: Okay. Any other questions? Thank you, Doctor, for coming today. [LB721]

ERIK OTTERBERG: Thank you, guys; thank you very much. [LB721]

SENATOR CAMPBELL: Our next proponent? Good afternoon. [LB721]

MELISSA FLORELL: Good afternoon. My name is Melissa Florell, M-e-l-i-s-s-a F-l-o-r-e-l-l, and I'm speaking on behalf of the Nebraska Nurses Association. The Nebraska Nurses Association is the voice of registered nurses in Nebraska. And NNA seeks to support the delivery of safe, cost-effective healthcare for Nebraskans. For this reasons, we're asking you to support LB721, the certified Surgical First Assistant Practice Act. NNA supports the licensure of certified surgical first assistants under the personal supervision of a physician. We had the opportunity to work with the large group of stakeholders during the 407 process, and we appreciated that opportunity. And in meeting with those stakeholders, we came to understand the importance of providing licensure requirements for surgical first assistants and feel that the bill successfully addresses any concerns raised about public safety. LB721 includes language related to physicians' supervision, and the Nebraska Nurses Association sees that as an important language to ensure public safety. NNA recognizes the important role that certified surgical first assistants play in providing operating care to Nebraskans. And passage of the Practice Act will help ensure that those practicing in the role have the education and training to do so. Licensure will also allow CSFAs to supplement the work force necessary for delivery of surgical care, especially in underserved areas. The certified Surgical First Assistant Practice Act will help ensure quality patient care in the perioperative area without inhibiting the practice of those professions who currently practice in this setting. And the licensure of surgical first assistants is consistent with NNA's belief that all healthcare professionals should be allowed to practice at the top of their education, training, and credentials. And for those reasons, we ask that you support this bill. [LB721]

SENATOR CAMPBELL: Thank you, Ms. Florell. Questions from the senators? Senator Riepe. [LB721]

SENATOR RIEPE: Thank you, Senator Campbell. I have a question that we've talked about. There's no grandfather? [LB721]

MELISSA FLORELL: That's true. [LB721]

SENATOR RIEPE: And so my next follow-up question then is, what is the length of the training? [LB721]

MELISSA FLORELL: I believe that my colleagues refer to three to four years for the initial training, and then there is a considerable amount of in-operating-room clinical hours for them to receive the credential which is consistent with national credentialing bodies... [LB721]

SENATOR RIEPE: Okay. [LB721]

MELISSA FLORELL: ...the American College of Surgeons and also their own certifying board. [LB721]

SENATOR RIEPE: What's the access to this training. I mean, in some of our more rural communities, you know, the... [LB721]

MELISSA FLORELL: As far as a transition practice, all of the... [LB721]

SENATOR RIEPE: ...distance (inaudible) it's...or it's not online, I'm assuming. [LB721]

MELISSA FLORELL: You know, there are some programs that have a large component of online training. But I will refer that to others to answer that question directly. I can confer with them and get back to you. [LB721]

SENATOR RIEPE: I'm curious. If we don't have grandfathering, then for the next three or four years, they can't perform in that. So do we have a... [LB721]

MELISSA FLORELL: No. They... [LB721]

SENATOR RIEPE: Okay. [LB721]

MELISSA FLORELL: The folks that are practicing currently hold the national certification. So they have previously received the education and training in order to qualify for the license as it's described in the legislation. They have completed the education and also the clinical practice hours. But they would have to apply for the license once it's established. [LB721]

SENATOR RIEPE: So they have their training. Here it's just the formality of license? [LB721]

MELISSA FLORELL: Yes, yes. [LB721]

SENATOR RIEPE: Okay. [LB721]

MELISSA FLORELL: For the group that were... [LB721]

SENATOR RIEPE: I was just concerned, you know... [LB721]

MELISSA FLORELL: ...for the group that was referenced. [LB721]

SENATOR RIEPE: ...if for three years you can't have those assistants, that's a huge, huge, huge problem. Okay, thank you. Thank you. [LB721]

MELISSA FLORELL: Yep. [LB721]

SENATOR CAMPBELL: Other questions? Thank you very much. [LB721]

MELISSA FLORELL: Thanks. [LB721]

SENATOR CAMPBELL: Our next proponent? Good afternoon. [LB721]

JEANNE WARDLAW: (Exhibits 3-5) Good afternoon, Senator Campbell and committee members. My name is Jeanne Wardlaw, J-e-a-n-n-e W-a-r-d-l-a-w. I am a certified surgical first assistant here in Lincoln, Nebraska. Previously I was a CST, certified surgical technologist, before acquiring my first assisting. And in my writing, it's reiterating, or a lot of these things have been stated. I am unable, at the present time, to use my skills and credentials in the state of Nebraska, as you have all heard. And you know that our current credentials were suspended a couple years ago. It is a very important issue to me personally, as well as 10 to 14 other practicing certified surgical first assistants in Nebraska. The main issue I have today is to make sure the wording is correct in the bill that would require or guarantee that we would be eligible for licensure. Now I have been certified as a surgical first assistant for close to 20 years. And currently, there are 6...or 16 certified surgical assistants in the state. People were asking how many there were. Two of these are currently not practicing. Of the current surgical assistants that are working, only two attended an accredited program. The other surgical assistants, including myself, have been deemed competent through passage of the National Board of Surgical Technology and Surgical Assisting Exam. For more than 20 years, this method has been recognized for every state. The eligibility route to sit for the exam...Nebraska will be one of only

a select few that will require licensure in addition to certification. If the wording in the bill is intended to require graduation from an accredited surgical assisting program, potentially only two of those current surgical assistants in the state will be able to obtain a license to practice in the role of the surgical assistant. So having successfully completed an approved experimental..."expirational" training or training program, which the National Board...their education program approved, should be added. Having this clarification in the wording or language of this bill is necessary as to include these individuals who already hold the credentials to be able to obtain a license and utilize the skills they have been deemed competent to perform. I also presented two letters from two...one letter signed by two surgeons that have been directly affected by this hardship. With the experience gained over the past several years, surgical assistants are able to anticipate and perform tasks necessary to perform surgeries in a safe and efficient manner. We are able to save precious time for the surgeons as well as anesthesia time for the patient. Surgeons across the country, not just here in Nebraska, rely on certified surgical assistants on a daily basis for the skills and competency we provide for them. Every person in the operating room has a role to fill. And every citizen who enters an operating room deserves qualified professionals. Thank you for your time. Any questions? [LB721]

SENATOR CAMPBELL: Question. Senator Howard. [LB721]

SENATOR HOWARD: Thank you, Senator Campbell. Thank you for your testimony today. [LB721]

JEANNE WARDLAW: Yes. [LB721]

SENATOR HOWARD: I have to ask. So you're asking for some changes that would include experiential training. [LB721]

JEANNE WARDLAW: Yes. [LB721]

SENATOR HOWARD: And were those recommended by the technical review committee in the 407 process? [LB721]

JEANNE WARDLAW: That I'm not aware of. [LB721]

SENATOR HOWARD: Okay. There might be somebody behind you who can answer that. [LB721]

JEANNE WARDLAW: Yeah, maybe could answer that. But we just want to ensure that those of us that have been practicing...you know, we are certified through a national board. You know, we would be recognized in any state to...if there is no licensure required, we could perform our skills being just certified. [LB721]

SENATOR HOWARD: Thank you. [LB721]

SENATOR CAMPBELL: Any other? Senator Crawford, did you have a question? [LB721]

SENATOR CRAWFORD: Well, I'm just going to clarify. [LB721]

JEANNE WARDLAW: Sure. [LB721]

SENATOR CRAWFORD: So what you're saying is the concern is the word "accredited," but there is this national board that approves some programs. So... [LB721]

JEANNE WARDLAW: Yes. [LB721]

SENATOR CRAWFORD: Looks like the language of the bill I have in front of me emphasizes it's an approved board in the language already...it looks like to me. But we'll look at that. [LB721]

JEANNE WARDLAW: Okay. Okay. Well, we just want to make sure that, you know, like Senator Riepe said, you know, we're talking about two or three years. And, you know, that's not realistic. [LB721]

SENATOR CAMPBELL: In the national certification, what do they require in terms of...it was not an accredited... [LB721]

JEANNE WARDLAW: Training. Well, (inaudible)... [LB721]

SENATOR CAMPBELL: I'm just trying to clarify. Do they...they must require some, not hands-on training, but academic training? [LB721]

JEANNE WARDLAW: Actually, we did have some workshops several years ago, through Southeast Community College. That criteria was approved by our Association of Surgical Technology (sic). And it was...we did take...I had to renew my anatomy and physiology. I took

extra training in anesthesia drugs, you know, how people are sedated, positioning, which is very important. And then, at the end of that...well, we also had surgeons come in and help with wound closure, teaching us how to suture. And that's how we learned that. Then, at the end of that workshop, we were instructed to get our 200 to 300 surgical cases and document those. And then we were able to sit for the exam. And while we were...those 200 to 300 surgeries were documented by the surgeon that was precepting us. [LB721]

SENATOR CAMPBELL: So the exam is a national exam, obviously,... [LB721]

JEANNE WARDLAW: Yes, it is. Yes. [LB721]

SENATOR CAMPBELL: ...and covers what you would've had in those hours of training. [LB721]

JEANNE WARDLAW: Yes. Yes, because they covered. And I can tell you, too, experience is huge, you know. And you just...you learn, and the surgeons are very good at helping and teaching you the proper way. So, yes. [LB721]

SENATOR CAMPBELL: Any other questions? [LB721]

SENATOR FOX: Yeah, I guess... [LB721]

SENATOR CAMPBELL: Senator Fox. [LB721]

SENATOR FOX: Yes. Thank you, Senator Campbell. I guess I'm a little confused now. [LB721]

JEANNE WARDLAW: Okay. [LB721]

SENATOR FOX: So, without this particular language that you're requesting, are you saying that you would have to even go and get...pick up more? Okay, I see a head moving back there. I mean how, I mean (inaudible)... [LB721]

__________: (Inaudible). [LB721]

SENATOR CAMPBELL: Oh, I'm sorry. We can't have testimony from the audience. [LB721]

SENATOR FOX: Okay, yeah. But I mean...so you're... [LB721]

SENATOR CAMPBELL: Go right ahead. [LB721]

SENATOR FOX: So how would that...if we did not add this language specifically, how would that impact you, since you said you've taken this training, completed it...the hands-on practice? [LB721]

JEANNE WARDLAW: Well, I..yeah. [LB721]

SENATOR FOX: Would you have to obtain additional hours? [LB721]

JEANNE WARDLAW: I should not have to, because I just recently passed. You know, we have to renew our license...or certification...every four years. [LB721]

SENATOR FOX: But that's (inaudible). I guess that's what I'm trying to get at, though, is without the wording, though, you would have to. [LB721]

JEANNE WARDLAW: I think so. [LB721]

SENATOR FOX: Okay. So we're... [LB721]

JEANNE WARDLAW: But grandfathering, I think, would cover that, if I'm not mistaken. [LB721]

SENATOR CAMPBELL: And we'll follow up on those questions. [LB721]

JEANNE WARDLAW: Okay, okay. But, you know, the "expirational" training, or training program, is approved by the National Board. So, by rights, we should not have to go through another accredited program. [LB721]

SENATOR FOX: So you're saying, I mean...yeah, I'll just kind of wait and (inaudible)... [LB721]

JEANNE WARDLAW: I know it's... [LB721]

SENATOR CAMPBELL: No...that's okay, Senator Fox. I think you're asking a question that we're all thinking. So... [LB721]

JEANNE WARDLAW: Yeah. [LB721]

SENATOR CAMPBELL: I appreciate that. And one of the other things that we'll look at, in light of your question...we'll find out. And also, if there is any other licensed professionals who...in which the National Board is an accepted criteria. And I don't know the answer to that. So, I mean...and it may be that. [LB721]

JEANNE WARDLAW: Okay. [LB721]

SENATOR CAMPBELL: Any follow-up questions, Senators? Okay. Thank you very much. [LB721]

JEANNE WARDLAW: Thank you. [LB721]

SENATOR CAMPBELL: Our next proponent? [LB721]

DON WESELY: (Exhibits 6-7) Madame Chairman, members of the Health and Human Services Committee, I am Don Wesley, here representing Nebraska Association of Independent Ambulatory Centers. First, thank you, Senator Baker, for introducing the bill. There's broad agreement on the desire and need to get this passed and do it quickly. But as we were talking in the back, there's some legitimate questions, Senator Riepe, you've raised, about how this is going to work. And so all of us are willing to work with you to try and make sure we pass a bill that actually deals with the problem. And we think it does, but it's possible that we might have missed something. So independent ambulatory surgery centers are like the Lincoln Surgical Hospital and Urology Surgery Center. And there's 16 of us in this association. So actually, on the surgical first assistant issue, it's really just the one, the Lincoln Surgical Hospital, affected by this. And it's very important to them, as with the hospitals across the state, that we resolve it. So we're here in support, and thank you for your questions, which have been very good. So... [LB721]

SENATOR CAMPBELL: Questions, Senators? Mr. Wesely, why would you be the only center affected? I mean, aren't there other ambulatory surgical centers in the state? [LB721]

DON WESELY: There are, but they use surgical technologists, which is another issue. [LB721]

SENATOR CAMPBELL: Okay. [LB721]

DON WESELY: Surgical first assistants...We found that we've got just the one that really uses them and needs them very much. So we do use surgical technologists. So... [LB721]

SENATOR CAMPBELL: Okay. How many ambulatory centers are there, did you say, in the state? Do you know that? [LB721]

DON WESELY: We represent 16. There are more than that... [LB721]

SENATOR CAMPBELL: Okay. [LB721]

DON WESELY: ...probably twice that number, but... [LB721]

SENATOR CAMPBELL: Senator Riepe. [LB721]

SENATOR RIEPE: Thank you, Senator Campbell. Senator...or Mayor Wesely, thank you very much. I guess my question goes to how many, because I'm a little bit confused here, there are first assistants and there are tech. You know, how many categories and...are the...does it make sense, for public awareness, to collapse all these together? I'm big on consolidation when you can. [LB721]

DON WESELY: Um, this has gotten complicated enough, and I probably screwed up by even bringing up the surgical technologists. That's Senator Kolterman's bill; that will follow. [LB721]

SENATOR RIEPE: At least you're not filibustering, so... [LB721]

DON WESELY: I am not. The surgical first assistant...there are, we understand, 20 to 25. It's still a little unclear. The other, the surgical technologist, we're talking hundreds, like 800, 900 of those. And so we don't really want to go in that direction. We want to focus on this, get this done, and it's very important it happen quickly, so... [LB721]

SENATOR RIEPE: Okay, thank you. [LB721]

SENATOR CAMPBELL: Okay, questions? Do we have questions? [LB721]

DON WESELY: Thank you. [LB721]

SENATOR CAMPBELL: Thank you. Our next proponent? Anyone else in the hearing room? Okay. Opposition to the bill? Those who oppose it? Okay. Anyone in a neutral position? Good afternoon. [LB721]

CASEY GLASSBURNER: (Exhibits 8-9) Good afternoon. Chair Campbell and members of the Health and Human Services Committee, I am Casey Glassburner, C-a-s-e-y G-l-a-s-s-b-u-r-n-e-r, currently serving as the president of the Nebraska State Assembly of the Association of Surgical Technologists. This is the local organization of our national association, the Association of Surgical Technologists, which represents the interests of surgical technologists and surgical assistants in the state of Nebraska. Our organization firmly believes that LB721 addresses an important issue by creating a license for surgical assistants in the state, allowing these individuals the ability to fully utilize the skills they have been trained and deemed competent to perform through passage of the national surgical assistant certifying exam. We fully support the establishment of this license but want to ensure that all surgical assistants who have previously been deemed competent through passage of the exam are eligible to obtain licensure, no matter what method was utilized to obtain exam eligibility. And at the end, I would like to expand on what was said before about the different pathways to sit for the exam, because I think there's some confusion on that. And I'd like to expand on that wording. But I'd like to get through the rest of the testimony first. The professions of surgical technology and surgical assisting are very, very closely related. Most surgical assistants begin their career as a surgical technologist and then obtain additional training by attending an accredited surgical assisting program or working with a surgeon to gain experience in the surgical assisting role, which then grants them eligibility to sit for that national surgical assistant certifying exam. These surgical assistants are allowed to perform tissue alteration tasks that a surgical technologist is not trained to perform and should not be allowed to do, which includes suturing. However, surgical assistants that are employed by a facility, such as a hospital or an ambulatory surgery center, may spend most of their day performing the duties of a surgical technologist, and only a small portion of their day performing the duties of a surgical assistant, as the two roles are very intertwined during a surgical procedure. My testimony today is to have our organization go on the record as neutral, due to our concerns related to why the creation of a registry for surgical technologists was left out of LB721 when it was recommended as a portion of the surgical assistant 407 process, and which was approved by the Technical Review Committee, as well as the Board of Health, which you can reference in Part B of the November 16th report that has been provided to you. Our organization worked with the Nebraska Hospital Association, as well as Sidney Regional Medical Center during the creation of the application that was submitted during the 407 and throughout the entire 407 process. While we had concerns about some of the technicalities about the surgical technologist registry, we really felt that the final product was something that we could work with, that could be enhanced, in order to ensure proper regulation of the profession of surgical

technology and increase surgical patient care in the state. Because the registry language was omitted from LB721, along with other issues that arose through the 407 process, our organization found it necessary to ask Senator Kolterman to introduce a separate bill, LB1061, that will specifically address the creation of the surgical technologist registry, as well as additional language that will amend the delegation by surgeons to unlicensed personnel. We would like to officially thank Senator Kolterman tor his willingness to step up and address this important safety issue that exists, related to the lack of minimum education or competency standards that exist in this state related to surgical technologists. Our organization is currently working with all interested parties in an attempt to come to an agreement with an end goal of one bill that addresses the issues related to surgical technologists, as well as surgical assistants, in this state. Both professions play a vital role in the care of the surgical patient, and their duties are very often intertwined, as I described earlier in this testimony. It's necessary for the state of Nebraska to regulate both professions to ensure that it's doing everything to ensure that the patients of this state that endure surgery are being protected from the harm that can result from uneducated team members being present during a surgical procedure. So I'd like to talk a little bit about the pathway, if that's all right; or I am available for any questions that you may have. [LB721]

SENATOR CAMPBELL: Why don't you go ahead and... [LB721]

CASEY GLASSBURNER: Okay. [LB721]

SENATOR CAMPBELL: ...because you're going to answer a question that's... [LB721]

CASEY GLASSBURNER: Yeah. Okay, so the pathway to sit for the national exam...so there really are multiple exams that people can sit for in order to get their credential as a certified surgical first assistant. Okay? There's three different exams nationally. The numbers that were stated earlier is there are 16 people who hold that credential, either at CSFA, CSA of an SA-C. So there are only 16 people in this state who actually have a credential from a national certifying body. Okay? Of those 16 people, only 2 of them attended an accredited program in order to gain eligibility to sit for those exams. So the exams have different pathways that you can achieve eligibility. The one that Jeanne was referring to, that she utilized, is the National Board of Surgical Technology and Surgical Assisting, which issues the CSFA credential, allows an individual who is a CST...they have to be a certified surgical technologist first. So you get an agreement from a hospital administrator to say yes, I will allow somebody to start logging cases in my...at my hospital. And then they have to log 200 cases under direct supervision with a surgeon in certain areas. And then, once those are submitted to the National Board, then they say yes; then you can sit for the exam. So that is a pathway that is still recognized by that certifying agency. And that's what Jeanne was describing...to make sure that those people, which there are

10 of them in the state that utilize that pathway, that they're not left out, because these people do have that credential. And they were using it prior to the cease and desist that came down. And so, because it is still a recognized credential nationally, we want to make sure that they're not left out and not deemed unable to get a license in the state. [LB721]

SENATOR CAMPBELL: Did that answer the question, Senator Riepe? [LB721]

SENATOR RIEPE: I have a follow-up question, I guess. It's that...and thank you for being here, but you said that there were three examinations, and I assume that these are successive, like you take basic exam and then you take basic second exam? [LB721]

CASEY GLASSBURNER: No, they're just three different certifying bodies, so... [LB721]

SENATOR RIEPE: So if you're a candidate, you're going to take the easiest one. [LB721]

CASEY GLASSBURNER: I don't know that. Um...they differ...they...each of them has different criteria. And what has been proposed in the bill is that the people have to be a graduate of an accredited program, accredited by CAAHEP, which is the Commission on Accreditation of Allied Health Programs (sic) or ABHES, which is the Accrediting Bureau of Health Education Schools. Now only two of those exams...two of those exams require someone to be a graduate of one of those programs, in order to sit for them. So it just depends on what...each exam has its own eligibility criteria. So that's all I can really say about that. [LB721]

SENATOR RIEPE: Like the rest of healthcare, it's very complex. [LB721]

CASEY GLASSBURNER: Yes. Yeah, pretty much. [LB721]

SENATOR RIEPE: My question would be, too, if I may, Senator, is to...how many times did you...there seems to be that you've held some meetings that have been unproductive or unsatisfying. How many of those did you have? Did you have one, or did you have... [LB721]

CASEY GLASSBURNER: Several. [LB721]

SENATOR RIEPE: Several. [LB721]

CASEY GLASSBURNER: That's about what I'll leave it at. [LB721]

SENATOR RIEPE: Okay, and then you went from there to Senator...the good Senator Kolterman for... [LB721]

CASEY GLASSBURNER: Yeah, the good Senator Kolterman. He knows my mom (laughter). I'm just teasing. [LB721]

SENATOR RIEPE: Okay. The plot thickens here. [LB721]

CASEY GLASSBURNER: No. I wouldn't...if I may, I'll ask the opportunity to answer your question earlier. You asked about the length of the training program and if they were available and how many are available. If I could answer that question... [LB721]

SENATOR CAMPBELL: Sure. [LB721]

CASEY GLASSBURNER: ...if that's all right. [LB721]

SENATOR RIEPE: Yes, it is. [LB721]

CASEY GLASSBURNER: There are only seven accredited surgical assisting programs in the entire country, two of which are online, none of which are located in Nebraska. [LB721]

SENATOR RIEPE: Wow. [LB721]

CASEY GLASSBURNER: There are over 500 surgical technologist programs that are accredited nationally, 9 of which are online, 2 of which are located in Nebraska, and, hopefully a third one, which will be coming soon...at the end of this year...out in Scottsbluff. [LB721]

SENATOR RIEPE: What's the financial barrier? If there is none, and I'm not saying Nebraska needs to create one, but it sounds like it could be a very... costly, and therefore, a barrier for entry for a number of people. [LB721]

CASEY GLASSBURNER: Yeah. [LB721]

SENATOR RIEPE: ...costly, and therefore, a barrier for entry for a number of people [LB721]

CASEY GLASSBURNER: I suppose that is a potential. I wouldn't say that the surgical technology programs are against starting a surgical assistant program by any means. Maybe in the future, if there is a need, there does have to be a need established in order to set forth a program. So I mean, if the license did exist, there may be a need to educate those individuals here in the state of Nebraska, for sure. But there are people who do attend the online program. It does require an intense one-week experience that they usually travel for. And then they can usually do their clinical experience in a local hospital. Here I know a couple of people that have utilized that program. [LB721]

SENATOR RIEPE: And that's done under the tutelage of one physician; is that correct? [LB721]

CASEY GLASSBURNER: It may be multiple physicians... [LB721]

SENATOR RIEPE: Okay. [LB721]

CASEY GLASSBURNER: ...because they have to have a well-rounded clinical experience just like the students in a surgical technology program would. So there's specific case requirements that they have to meet so that it's not all in one specialty. [LB721]

SENATOR RIEPE: I was only concerned if the orthopedic surgeon, if you will, moved to the Bahamas, and, you know, you had half your coursework done, you know. [LB721]

CASEY GLASSBURNER: Yeah, that would be a problem. [LB721]

SENATOR RIEPE: Won't let that happen. [LB721]

CASEY GLASSBURNER: No, it's multiple specialties usually. As long as you have the hospital that signs off to say that, you know, it has the affiliation agreement with that school to allow them to do their clinical practicum within that facility...similar to the med students that you were talking about earlier. [LB721]

SENATOR RIEPE: Okay, thank you very much. [LB721]

CASEY GLASSBURNER: Yes. [LB721]

SENATOR RIEPE: Thank you, Senator. [LB721]

SENATOR CAMPBELL: So who are the three entities that sponsor those programs in the state? You said there were three. [LB721]

CASEY GLASSBURNER: The certification exam? [LB721]

SENATOR CAMPBELL: Yes. [LB721]

CASEY GLASSBURNER: So there's the National Board of Surgical Technology and Surgical Assisting, referred to as NBSTSA, okay? So that credential is a CSFA. There's the CSA, which is the National Surgical Assistant Organization. And then there's the other one that no other states recognize, which is the SA-C. Okay. [LB721]

SENATOR CAMPBELL: No, I meant that you mentioned the programs... [LB721]

CASEY GLASSBURNER: Oh, the three programs [LB721]

SENATOR CAMPBELL: ...in the state of Nebraska. [LB721]

CASEY GLASSBURNER: I'm sorry...that educate surgical technologists. I am sorry; I thought you were talking about the other one. [LB721]

SENATOR CAMPBELL: Right. That's okay. [LB721]

CASEY GLASSBURNER: Southeast Community College, Nebraska Methodist in Omaha, and then the third one which hopes to gain accreditation will be at Western Community College in Scottsbluff. [LB721]

SENATOR CAMPBELL: Okay, that's helpful. Thank you. [LB721]

CASEY GLASSBURNER: Yes, absolutely. [LB721]

SENATOR CAMPBELL: Any other questions? Senator Kolterman. [LB721]

SENATOR KOLTERMAN: Go ahead, Senator. [LB721]

SENATOR CAMPBELL: Oh. [LB721]

SENATOR HOWARD: Oh... [LB721]

SENATOR CAMPBELL: Senator Howard. [LB721]

SENATOR HOWARD: Thank you, Senator Campbell. Thank you for your testimony today. You mentioned Part B in the November 16 findings...or the recommendations and findings from the 407. [LB721]

CASEY GLASSBURNER: Yes. [LB721]

SENATOR HOWARD: And this may be getting into a little bit of Senator Kolterman's bill, but in reading the registry requirements, do you agree with all of the registry requirements? [LB721]

CASEY GLASSBURNER: No. The registry, from our standpoint, is missing an educational component. Right now surgical technologists are not required to be educated in this state to be serving in the capacity that they serve in, which means that anyone with a high school degree can be taken with no prior training, put in an operating room, and could be, potentially, assisting or handing instruments during a surgical procedure, which is very scary considering the environment that they function in and the high technical ability that's required to be safe and efficient in that role. We really feel that it is necessary for people to be attending accredited surgical technology programs for them to be functioning. We don't believe that on-the-job training is sufficient to be protecting the public. [LB721]

SENATOR HOWARD: So my understanding of Part B is that it does require completion of an accredited program for certification. But I guess my follow-up question is, do you know of any registries that are housed in our Department (sic: Division) of Public Health for practice groups that also require certification and licensure? Do we know of any registries that do that? [LB721]

CASEY GLASSBURNER: Well, CNAs and medication aides require an educational component, as well as a competency assessment. The bill, LB1061, doesn't seek to establish a licensure of surgical technologists. And LB721 is licensure of surgical assistants. And I know this gets very messy. [LB721]

SENATOR HOWARD: Um-hum. [LB721]

CASEY GLASSBURNER: Like Don Wesely referred to earlier...so it is...the professions are very close, but they are different. There is some differences that exist between the two. So we really feel that with the amendment to the language from Howard Paul (sic: State of Nebraska v.

Howard Paul), that a registry with an educational component would be sufficient to protect the public from the lack of regulation that does exist. [LB721]

SENATOR HOWARD: Right. Thank you. [LB721]

CASEY GLASSBURNER: Yes. [LB721]

SENATOR CAMPBELL: And the surgical technologists also put in their own 407. [LB721]

CASEY GLASSBURNER: Yes, we did. [LB721]

SENATOR CAMPBELL: But that's not complete yet, is it? [LB721]

CASEY GLASSBURNER: It is not complete yet. Nope. The Board of Health meets on Monday to make their final recommendation on that. [LB721]

SENATOR CAMPBELL: Okay. Any other questions? Oh, sorry, Senator Kolterman. You were so kind to let Senator Howard to go forward here. [LB721]

SENATOR KOLTERMAN: No, that's all right. I just want to make a point of interest. This is one of those good-sort high school graduates. And she's also a teacher at Southeast Community College in the programs we're talking about. Thank you, Casey. [LB721]

CASEY GLASSBURNER: Yes. Thank you, Senator Kolterman. [LB721]

SENATOR CAMPBELL: Any other notations for the record? Thank you very much. [LB721]

CASEY GLASSBURNER: Thank you. [LB721]

SENATOR CAMPBELL: Anyone else in a neutral position? Okay. Senator Baker, we are back to you. [LB721]

SENATOR BAKER: Well, thank you. My fond hope is that you have all the technical questions out of your system by now. You know, as a school superintendent, I was known as Dr. Baker. And, particularly, the young students oftentimes had a misperception that I was somehow able to heal as well as educate. That's not the case. You may or may not have a copy of LB721 in front

of you, but the application for the position, it spells out four things here: (1) be certified as a surgical first assistant by an approved certifying body, (2) have successfully completed an approved surgical first assistant education program approved by the board or other experiential or training program as approved by the board, and (3) having passed a nationally recognized surgical first assistant examination approved by the board. So, you know, I think, in large part, although there's some detail in LB721, I think, you know, the purpose of a statute is to say the "what." And the "how to" will come through the rules and regulations that the DHHS has asked for time till January 1, 2017, to develop those. So with that... [LB721]

SENATOR CAMPBELL: Senator Howard. [LB721]

SENATOR HOWARD: Thank you, Senator Campbell. We don't have a letter from the department in regards to their stance on this bill, correct? [LB721]

SENATOR BAKER: I do not. [LB721]

SENATOR HOWARD: And they've worked with you on the amendment... [LB721]

SENATOR BAKER: Yes. [LB721]

SENATOR HOWARD: ...for the extended time period. Okay, thank you. [LB721]

SENATOR CAMPBELL: Other questions, follow up? Okay. Thank you, Senator Baker. Letters for the record? [LB721]

ELICE HUBBERT: (Exhibit 10) We have a letter from Daniel Claussen of Omaha, neutral position on behalf of himself. [LB721]

SENATOR CAMPBELL: Okay. With that, we will close the public hearing on LB721, and Senator Baker gets to go next again. We'll give a minute while Senator Baker goes to the chair. If you are leaving, try to leave as quietly as you can, because we'll start almost immediately. All right. Senator Baker, I think we've just about got everybody out who needs to leave. This is LB722, Senator Baker's bill to adopt the Stroke System of Care Act. So, go right ahead. [LB721]

SENATOR BAKER: (Exhibit 1) Senator Campbell, members of the Health and Human Services Committee, again, my name is Roy Baker, Senator Roy Baker, R-o-y B-a-k-e-r, representing District 30. I am here today to open on LB722, which develops a system of care for stroke

patients in Nebraska to improve outcomes. Stroke is the fifth leading cause of death and the leading cause of disability. Rapid identification, diagnosis, and treatment of stroke can save lives of stroke patients and, in some cases, reverse neurological damage such as paralysis and speech and language impairments. With our aging population, I believe this legislation is an important public policy. The bill describes hospitals as comprehensive stroke centers, primary stroke centers, or acute stroke-ready hospitals. I have distributed a chart that gives you an idea of what each of these levels mean. The Department of Health and Human Services would be responsible to compile and maintain a list of hospitals which meet the criteria. Emergency hospital service protocols would also be developed, as well as a stroke registry and task force that would focus on triage, treatment, and transport of stroke patients. Testifiers coming up behind me will be going into more detail on each of these components. [LB722]

SENATOR CAMPBELL: Okay. Questions that you have? Senator Baker, do you happen to know how many other states have this kind of classification? [LB722]

SENATOR BAKER: No, I do not. I do not, Senator Campbell. [LB722]

SENATOR CAMPBELL: I'm assuming that the national organization might be able to tell us that, but I was just curious. Did you want to make any comments about the fiscal note for it? [LB722]

SENATOR BAKER: Well, there is a fiscal note on this. And I don't know if you have it in front of you or not, but it shows General Fund expenditures of $248,594 in 2017/18 (sic: 2016/17), and $300,064 in 2017/18. The bill requires the Department...DHHS to develop rules and regs for designation of hospitals, etcetera. And they feel they need a .3 FTE...or three FTEs to implement the provisions of the bill. The tracking system would cost about $65,000. There's no provision for fees in the bill for the stroke designation. And we're not sure if any licensing fees would...could be used to offset a portion of these costs. So at this point, all costs are shown as General Funds. [LB722]

SENATOR CAMPBELL: And at this point, Senator Baker, probably we'll want to review whether there are any fees that could cover the cost... [LB722]

SENATOR BAKER: Yes. [LB722]

SENATOR CAMPBELL: ...just because you're going to get asked the question about the fiscal note. And it would seem to me that one of the other questions that we might...I don't...is the Department of Health and Human Services here to testify or provide anything? Okay. One of the

questions that we may want to ask them is, do they already have people on staff who look at designations of hospitals, on special? Three FTEs, I have to say, when I read that, I kind of went, "Hmm." [LB722]

SENATOR BAKER: Agreed, agreed. [LB722]

SENATOR CRAWFORD: Um-hum. [LB722]

SENATOR CAMPBELL: I mean, I realize that the hospitals are...there will be a lot of designations, but I would like to see that questioned, perhaps, and looked at. [LB722]

SENATOR BAKER: (Inaudible). [LB722]

SENATOR CAMPBELL: Senator Riepe. [LB722]

SENATOR RIEPE: Senator Campbell, thank you. Senator Baker, I have a question. Who was it that...who was it that asked you to carry this legislation? [LB722]

SENATOR BAKER: This was, I believe, the American Heart Association. [LB722]

SENATOR RIEPE: Heart Association, okay. Part of the reason I ask... [LB722]

SENATOR BAKER: American Stroke Association, along with that. [LB722]

SENATOR RIEPE: ...because I know...this is what I keep, my little thing (holding up card). It's kind of interesting. This little...it's called Face-Arm-Speech-Time, and it's to identify quickly stroke things for the, you know, average person on the street. You don't have time to fully go through a lot of things. But there are four basics. And my question is the need versus what's already out there without us being able to inventory everything that's out there. This is one little thing. [LB722]

SENATOR BAKER: Yeah. [LB722]

SENATOR RIEPE: All right, (inaudible). Thank you. It's worthy of discussion. [LB722]

SENATOR CAMPBELL: I am making the assumption that the bill would help consumers identify what... [LB722]

SENATOR BAKER: Clearly. [LB722]

SENATOR CAMPBELL: ...clearly what amount of preparation that they have put into place that designate, for the consumer, what that hospital has done to be ready for stroke. [LB722]

SENATOR BAKER: Right. And it's very, very important deal. My mother experienced a stroke at age 77, and, you know, it...that was some time back. And I think she probably would have fared a lot better today, had she been transported to the proper place sooner. [LB722]

SENATOR CAMPBELL: All right. Any further questions, Senators? Okay. Thank you, Senator Baker. We'll start today with our first proponent for LB722. [LB722]

DENISE GORSKI: (Exhibit 2) Madame Chair and members of the Health and Human Services Committee, my name is Denise Gorski, that's D-e-n-i-s-e G-o-r-s-k-i. I am the director of Diagnostic and Therapeutic Services at Nebraska Medicine-Bellevue. I am testifying today on behalf of Nebraska Medicine and as the chair of the Nebraska Stroke Advisory Council. I am here to speak in favor of LB722. Geography matters, and it shouldn't. The fragmented approach to stroke care exists in many regions of the United States, and Nebraska is not immune. Nebraska is...in contrast, may be particularly vulnerable to the fragmented system, given our landscape. This fragmentation is a significant obstacle to reducing the disability and death attributable to stroke across our state. To address this fragmentation in care, the American Heart/ American Stroke Association recommends the establishment of stroke systems of care. Outside of the major metropolitan areas, if you are lucky when you call 911, the dispatcher will recognize what is happening and understand what to do with a sense of urgency. They will respond to your call with...working from an algorithm and send a first responder unit with the highest priority. But the reality is that, in Nebraska, we have a fairly large number of public safety answering points. And, unfortunately, it appears that a majority of those do not have medical oversight with ongoing education provided on an as-needed basis. If you are lucky, you will have your stroke in a densely populated area. Your field assessment will be done by medically trained individuals. Assessment will be rapid, and communication with the receiving hospital will be swift. But fragmented care does not play favorites in Nebraska. You see, if I am a first responder in eastern Nebraska, I may have a choice as to which hospital to take the patient. What do I do? Do I go to the closest hospital? Do I ask the patient where they want to go? Or do I work from a well-orchestrated plan...a plan that gives the responder the priorities and necessary steps to provide the best possible outcomes? The Stroke System of Care defined in LB722 results in a systematic, time-sensitive, and reproducible plan. Ideally, you will arrive at a hospital

that has protocols in place and staffed by providers who know exactly what every minute means to brain tissue suffering from a lack of blood flow. However, when the stroke is severe, does the hospital have a plan in place to transfer you if necessary? How long will it take? How will they decide which hospital can meet your needs? Does the hospital know all options that are available? As the stroke program coordinator for the region's most comprehensive facility, I have a unique insight into our fragmented system. Across our state, we have significant variations in readiness and access to care. I have witnessed firsthand the outcome of patients transferred from facilities that were not prepared or did not recognize the severity of what was in front of them. As time is critical in treating stroke patients, it is not my intent to suggest that local healthcare facilities should be bypassed in all instances. Rather, a goal is to make sure all hospitals are well-trained and prepared to receive and treat stroke patients with the best knowledge and practices as possible. I have also witnessed, in startling contrast, the positive outcomes that are possible when patients are managed under the guidance of well-defined protocols. You see, a patient's chance at intervention and a positive outcome should not be largely influenced by geography, yet sometimes it is. LB722 addresses the entire system of care. It provides the groundwork for developing a hub-and-spoke structure that is imperative for time-critical diagnoses. It encourages the adoption of telemedicine to put expertise at the bedside. LB722 will improve stroke intervention, no matter what our resources or level of care in the area where the stroke occurs. We will declare our level of readiness so that we can understand our own resources and those resource limitations around us. Do understand that, with the right system in place...that this is not about transferring patients to higher levels of care; it's about doing what is right for the patient in the most appropriate setting. We have a responsibility to reduce the impact of stroke within our communities. To do this systematically, efficiently, and consistently, a statewide approach is imperative. The closing thought I will leave you with is what we know about brain tissue death resulting from strokes. In a 2006 Stroke journal research article, Jeffrey Saver highlights: For each minute that stroke is untreated, the typical patient loses 1.9 million neurons, 14 billion synapses, and 7.5 miles of myelinated fiber. The faster blood flow can be restored to the brain tissue, the greater chance of full recovery. These are delays that we cannot afford. Thank you for your time. I encourage you to advance LB722, and I would be happy to answer any questions that you may have. [LB722]

SENATOR CAMPBELL: Questions? Senator Riepe. [LB722]

SENATOR RIEPE: Thank you, Senator Campbell. It's my understanding that there is a antidote, for lack of a better term, for strokes, that if you can get that, too...but that it's rather expensive. You know, my question would be is, would we be better served to make sure that rescue squads across the state have that intervention, if you will. And that maybe, instead, and as opposed to education and training of the hospitals, that it be education training more at the rescue squad level, because my experience is that most of the hospitals have, working off of best practices and with a keen interest in making sure that patient care is delivered well, because of Joint

Commission and Medicare...Medicare accreditation, all those kinds of rules, that...I think there are these...many of these guidelines are already in place in institutions. Or, well, maybe we're talking rural/urban here; I don't know. My experience is urban, so... [LB722]

DENISE GORSKI: Yes. I think what's important, within the context of this bill, and there's several different questions that you asked. And I know one of our proponents will speak to the thrombolytic, the clot-busting medication that we can give, and why that is not a good idea to do that in field, because we don't have all the diagnostics. We don't quite know what we're dealing with. But really, the context of this bill is to make sure that everybody has a plan, with not only that rapid response and what we do, but where we go. Significant time delays are created if a medical response unit or EMS takes a patient to a hospital that is not prepared. And we do have hospitals that are not prepared in this state. The thrombolytic drug that you referenced...there is hesitancy within the medical field because of a lack of neurology support at the bedside. So that's why telemedicine becomes a big key player in that. But if you take that individual to the wrong hospital, you've...that hospital will go through its entire assessment and diagnostics and eat up two hours of brain tissue prior to transferring to another hospital who may, or may not, be able to help that patient. So this is about declaring who you are in the state, and what you're capable of doing. And there are different approaches as to how that can be done. [LB722]

SENATOR RIEPE: Minute. [LB722]

SENATOR CAMPBELL: Senator Riepe. [LB722]

SENATOR RIEPE: My concern gets to be...is that oftentimes when we should use a rifle to go after something, we use a broadcasting shotgun. That we wanted to have all the hospitals...mandate to them that they all have to respond to this program, when, in fact, it's one or two hospitals that maybe shouldn't be in the business to begin with. The other question that I would have is, is because, as a state, as you know, and I think we're about $140 million down, you know, if you're American Stroke Association or the American Heart Association, charitable organizations, 501(c)(3)s, I wonder, is...I think we should look at, you know, same to you, God bless you and raise the fiscal note money and the three FTEs, that it shouldn't be something that comes to the state to look at. And all these communities have a vested interest in having this service, whatever that is. [LB722]

DENISE GORSKI: Right. The certifications that were proposed in the bill are those certifications that hospitals have either gone after or are planning on going after in some fashion. And then there will be those hospitals that do not plan to go after any formal certified program by an external accrediting body. For those hospitals that do not wish to be certified, the idea would be that they at least be prepared to triage, and they, at least, have a plan in place. They

know who they're calling, and they know when to activate transport and where that patient should be going. [LB722]

SENATOR RIEPE: And you don't think that exists now? [LB722]

DENISE GORSKI: I do not see that happening now. I see it happening in pockets. And so, in my role as the stroke coordinator, which I have been out of for approximately two months now, in that role, I had an obligation, as do the other primary stroke centers within the state, to reach out and work with hospitals and make sure they're developed and understand how to reach us. But it's very pocketed within the state. It depends where you're at. [LB722]

SENATOR RIEPE: So it sounds like a little urban thing. [LB722]

DENISE GORSKI: It is on some levels. It depends what element of the system that you're talking about. EMS is a big piece of this...their readiness, their education, their recognition, their ability to know what to communicate, how they communicate it. [LB722]

SENATOR RIEPE: I'm somewhat familiar with the cardiology program at Bryan and Bergen, some others, and I know...I think they're awfully prepared. I mean...I'm sorry, I don't want to be (inaudible) that I, you know, I will save it for (inaudible). Go ahead. Thank you. [LB722]

SENATOR CAMPBELL: Senator Fox, do you have a question? [LB722]

SENATOR FOX: Actually, I have two questions. [LB722]

SENATOR CAMPBELL: Go right ahead. [LB722]

SENATOR FOX: My first question has to do with the thrombolytic question. [LB722]

DENISE GORSKI: Um-hum. [LB722]

SENATOR FOX: And it's my understanding that there's different kinds of strokes, too. [LB722]

DENISE GORSKI: Correct. [LB722]

SENATOR FOX: So that might be another reason to not have thrombolytics... [LB722]

DENISE GORSKI: That is the reason. [LB722]

SENATOR FOX: ...in the field, because if you have a hemorrhagic stroke, you... [LB722]

DENISE GORSKI: Correct. [LB722]

SENATOR FOX: ...don't want to be giving a blood thinner. My second question, then, kind of deals with the fiscal note, because, obviously, if we're lessening...you know, if we're lessening damage, then the recovery from that stroke is going to be less. And, therefore, we're going to be reducing healthcare costs to the... [LB722]

DENISE GORSKI: Right. [LB722]

SENATOR FOX: ...whether it's to the, you know, the stroke victim or... [LB722]

DENISE GORSKI: Right. [LB722]

SENATOR FOX: ...to the state or to the insurance company. [LB722]

DENISE GORSKI: I have seen the fiscal note. Um...it is significant. I think there are ways, based on my knowledge within the Nebraska Stroke Advisory Council, that it could be done differently. However, to your point, when you look at the cost of the fiscal note in general, in comparison to the reduction in disability, lost work hours, productivity...um, there are significant gains to be made from a well-organized system. [LB722]

SENATOR CAMPBELL: Go ahead. [LB722]

DENISE GORSKI: You had asked if other states...other states with stroke legislation currently in place...Illinois, North Carolina, Wyoming, New Mexico, Arizona, Minnesota, North Dakota, Kentucky, Washington, D.C. And, unless there has been something...oh, I know Missouri has worked on something. And all of them just a little bit different in their approach. Our approach would not be to reinvent designation at the state level when it already exists out in the community., but to have the state acknowledge and work with EMS to say yes, these places are certified in the plan. [LB722]

SENATOR CAMPBELL: So I just want to be clear here, on the steps for this. So each hospital in the state of Nebraska would determine which of these they are. Would it be a self determination,

or the Department would go into a hospital and do a survey and say, basically, you are a PSC? [LB722]

DENISE GORSKI: Right. [LB722]

SENATOR CAMPBELL: Is that right? So the hospital doesn't designate anything themselves. [LB722]

DENISE GORSKI: The hospital must seek certification by an accrediting body and then submit that to the state for the plan, for the large state plan. So a hospital may be a comprehensive facility, a primary stroke center, or an acute stroke ready, or nothing. The hospital has the choice to be nothing. However, if a first responder...if we have a well-orchestrated plan and we're working with EMS and that's published, so EMS first responders know where my stroke centers are, and I have one who's certified and I have one who's not, I would seek out the certified center because they're ready...to whatever capacity they can, based on their resources. So there's three levels (inaudible). [LB722]

SENATOR CAMPBELL: So it...I'm sorry. [LB722]

DENISE GORSKI: Yeah. [LB722]

SENATOR CAMPBELL: So it's incumbent upon the hospital to go through the accreditation that they think they're best suited for. [LB722]

DENISE GORSKI: Right. The hospital determines that, based on their resources. [LB722]

SENATOR CAMPBELL: So Hospital X, you know, goes out, gets the accreditation, and then the department steps in and surveys or looks at that, or do they just accept the accreditation? [LB722]

DENISE GORSKI: They can just accept it. There's a lot of work by the external accrediting body that will demonstrate proof that the state will not have to go those lengths. They will accept that certificate. [LB722]

SENATOR CAMPBELL: Okay. And I have to tell you that, based on your explanation, my question on the fiscal note has far more to do with why do you need three employees if the hospital is going to do the accreditation themselves and show up and say to the state, I have this

piece of paper. I can't...that's...I mean, and I totally understand there isn't any amount of money that wouldn't be worth one person's saving. I get that. But I...that's my question. It has to do with the administration of this. [LB722]

DENISE GORSKI: That's a fair question. I would agree. [LB722]

SENATOR CAMPBELL: Particularly if the hospital is going to do all the work to get to that point. [LB722]

DENISE GORSKI: Right. And the EMS, which is detached from the hospital in many cases, is a significant portion of this network, of this infrastructure. And so some of the operational expenses and the need goes to organizing those pieces, but not all. [LB722]

SENATOR CAMPBELL: ...which would be incumbent upon the hospital, though. [LB722]

DENISE GORSKI: When possible. [LB722]

SENATOR CAMPBELL: Okay. Senator Howard...or Senator Crawford, did you have a question? [LB722]

SENATOR CRAWFORD: So thank you. I was just going to give you an opportunity. You had said earlier, when we were talking about the fiscal note, that you thought it could be done in other ways. And we've already started this discussion about what would the state's key responsibility be, and you said, well, thinking about our stroke task force, we could think of other ways we could support and help. So I just wanted to give you a chance to maybe finish that conversation of, as you look at what you see the key state responsibility needs to be. What is the key state responsibility that we need to make sure is covered by the state and paid for by the state? And if you have any comments of how other people would pick up other pieces beyond what we've just said that the hospital does already. [LB722]

DENISE GORSKI: Right. In this case, the key state responsibility, in my opinion, is to establish the task force that can come together, a multiple disciplinary task force of thought leaders, so that they can develop the protocols. They can ensure the education is developed. They can ensure the education is taken out to the rural facilities or the volunteer responders or to the well-organized metropolitan areas. I think the registry, which is a significant component, is my belief, can be done. We don't need to reinvent registries. Registries do exist at a national level. People who are certified as acute stroke ready, primary stroke center, or comprehensive, already participate in some form of registry. However, our limitation is the option of which registry to

participate is just that. It's...I can choose American Heart Get with the Guidelines, I can choose another registry, I can build my own. So it's having some structured way to bring data in that we can look at statewide. What we need to see is, where are the gaps in service? Where are our needs not being met? Where are the delays? Where are people not getting the intervention? We know, historically, nationally, and in Nebraska, our intervention rates for acute ischemic stroke, the kind caused by a clot, are very low...lots of opportunity to improve the delivery of health. [LB722]

SENATOR CAMPBELL: Senator Riepe. [LB722]

SENATOR RIEPE: Senator, thank you. One of my underlying concerns is...is the certification for strokes, and there's a certification for diabetes, a certifications for Parkinson's. And, quite frankly, hospitals get inundated with all of these...you know. That's why the administrative costs grow from 25 percent of the healthcare cost up to 75 percent, if we aren't careful. And that takes...you know, I just..where does it start? Where does it stop? That's... [LB722]

DENISE GORSKI: That's a fair question, and one, I think that many hospitals are asking. I will say I have a huge belief in quality. And quality comes from having well-articulated, evidence-based guidelines. And certifications drive performance; they really do. In many cases, if you structure things right, you're going to see a difference in hospital performance and quality outcomes related to certifications. But I appreciate that comment because there are a lot that exist. In this case, the certifications provide the framework for how we would respond in the field and if a patient gets treated or not. [LB722]

SENATOR RIEPE: Okay. [LB722]

SENATOR CAMPBELL: Follow-up questions? Thank you very much for your testimony. [LB722]

DENISE GORSKI: Thank you. [LB722]

SENATOR CAMPBELL: Our next proponent? [LB722]

JAMES BOBENHOUSE: (Exhibits 3-4) Good afternoon. [LB722]

SENATOR CAMPBELL: Good afternoon. [LB722]

JAMES BOBENHOUSE: Madam Chairwoman and members of the Health and Human Services Committee, my name is James Bobenhouse, spelled J-a-m-e-s Bobenhouse, B-o-b-e-n-h-o-u-s-e. And I am a stroke neurologist in Lincoln, Nebraska. I appreciate the opportunity to speak with you today in support of LB722, for the development of the stroke system of care in Nebraska and establishment of a stroke registry. I would also like to thank Senator Baker for presenting this bill. I am a board-certified neurologist in general and vascular neurology and have been in clinical practice for 31 years in Lincoln. I am a member of the Nebraska Medical Association as well as the American Academy of Neurology and serve as the Stroke Center Medical Director for both Bryan Health and CHI Health-St. Elizabeth in Lincoln, Nebraska. Over the past three decades, great strides have been made in our understanding and treatment of stroke. When I first entered practice in 1984, a long time ago, we had a limited understanding of the mechanisms and causes of stroke, and we had very little to offer with regard to treatment of acute stroke. We knew strokes were more common in patients who had hypertension, diabetes, and atrial fibrillation, but we didn't have well-established targets for blood pressure and glucose control. And we didn't know how best to treat atrial fibrillation, whether full anticoagulation with Coumadin, blood thinners, or aspirin was as good. We debated whether limiting cholesterol was beneficial. We didn't even know whether cholesterol was an important risk factor. And we didn't know if operating on blocked arteries in the carotid...it's in the neck...was better than treating with aspirin alone. Over the next several years, we came to a deeper understanding of the causes of stroke and how to prevent stroke. However, it was not until 1995 that two studies were published in the New England Journal of Medicine which confirmed the benefit of IV tPA, which is a clot-busting medicine (in other words, it breaks up the clot when the artery is occluded), in the treatment of acute stroke. And what they found was that in patients who received IV tPA, 12 out of 100 that received it would've got better and back to normal, or near normal, that would not have if they didn't receive this medication, but carrying a risk of about 6 out of 100 of hemorrhage. Because of safety concerns, the use of IV tPA was initially limited. And including myself...my own concern was this risk of bleeding versus the benefit. And so we were weighing the benefit versus the risk. With more experience in the use of IV tPA, it became clear that this medicine was beneficial and led to better outcomes in stroke patients if given within three hours post onset of symptoms. It was at this time that the stroke centers were being developed, which resulted in better outcomes with higher recovery and lower mortality rates. It was also found that patients had a greater chance of recovery with fewer complications if the tPA was given early. This led to renewed efforts to educate the public in rapid identification of stroke, emphasizing the importance of seeking immediate medical attention. And then, based on a large European study in 2008, the use of IV tPA was extended to 4.5 hours post stroke onset. And then subsequent studies led to the elimination of several contraindications for IV tPA. In other words, there were a lot of reasons why we didn't give it. And we almost, at times, were looking for reasons not to give it because we were afraid that the person might have bleeding. And so, by doing that, then there was an increased number of patients who were made eligible for treatment. If you could please refer to your handout there, showing the time frame for treatment and

outcomes related to the tPA use. And this a meta-analysis, so in other words, several studies that were put together. And what they showed was that if you treated a stroke with tPA, and this is kind of answering...speaking to your question, Senator...was that if you treated within 90 minutes, there was a 2.5 times increased risk, or 250 percent, if you want to look at it that way, increased chance of getting back to normal or near normal. Whereas, if you get to 180, or 3 hours, then it's only 60 percent increased chance of getting back to normal. Then finally, at 4.5 hours, which is really the cutoff on treatment with IV tPA, it was only 30 percent chance of improvement. And beyond that time, it was not significant. So what that shows is that we really need to treat a stroke as early as possible. And not only that...there was other...there was another study that looked at 15-minute intervals, backing up and saying, well, if we save 15 minutes, what percentage of patients did better, and that sort of thing. And what they found was that there was a 4 percent decreased chance of hemorrhage, 4 percent decreased chance of death, 4 percent increased chance of walking at discharge, and a 3 percent increased chance of returning home. So that's for every 15 minutes. So you really have a lot of bang for your buck. If you save 15 minutes, you've got this benefit. And you can see how it would add up if you had more than 15 minutes saved, if you had 30 minutes saved, etcetera. So this confirmed the need to treat stroke quickly and efficiently in order to provide the best stroke care possible, and prompted calls nationally to develop integrated and coordinated stroke systems of care throughout the country. So, in other words, we're not creating anything here in Nebraska; we're following trends that really started...there were articles that came out in 2006 about setting up stroke and systems of care. In 2015, five separate studies were reported at the International Stroke Conference that showed nearly twice the chance of recovery in larger strokes when clots were physically removed within six hours, using a catheter inserted into the occluded artery. And that's referred to as endovascular therapy. So in light of these findings, stroke centers are now adopting a pit crew approach, and that's occurring in Lincoln, as well. So we've looked at...literally, we watched pit crews at race tracks and looked at how they were efficient, and then tried to mimic that in a medical setting. In order to streamline the evaluation process and in attempting to give IV tPA as quickly as possible, and then determining if endovascular therapy is warranted, there are currently 14 Joint Commission certified primary stroke centers in Nebraska, but there are still large areas of the state that are neurologically underserved. Establishing a stroke system of care for Nebraska, as well as a stroke registry, will help establish protocols and promote collaboration across the continuum of stroke care, beginning with stroke education for early stroke identification, coordination of emergency medical services, rapid evaluation and treatment in the emergency room, and, in selected instances, transfer to a primary or comprehensive stroke center. So I thank you for allowing me to testify in support of this bill. [LB722]

SENATOR CAMPBELL: Thank you for your testimony. Questions? Senator Riepe. [LB722]

SENATOR RIEPE: Thank you, Senator Campbell. Thank you, Dr., for being here with us today. I guess my question...I have a couple here on IV tPA. Well, what's the cost on that for a dose for, you know, initially to... [LB722]

JAMES BOBENHOUSE: I'm taking a ball park figure. I think it's about $5,000...I think. [LB722]

SENATOR RIEPE: Okay. I was thinking it was pretty expensive. [LB722]

JAMES BOBENHOUSE: It's very expensive. [LB722]

SENATOR RIEPE: What's...do you know the shelf life on that? I mean, is it...does it have to be refrigerated? [LB722]

JAMES BOBENHOUSE: It's...no. It's, I think, at least a year. And the other thing is that the...Genentech will replace it if it goes bad, for example. So a lot of hospitals...they might just have one sitting there, but they can replace it if they need to. [LB722]

SENATOR RIEPE: I know many rescue squads do a lot more than they used to do five or ten years ago. [LB722]

JAMES BOBENHOUSE: Right. Um-hum. [LB722]

SENATOR RIEPE: And I know...you know, there are personal defibrillators. I happen to have one myself that I carry in my vehicle. But the question is this: Could not a rescue squad be able to administer this under almost a "right to choose" of the family that says we'd rather do that than take our chances of a two or three or four hour transport, maybe into more of an urban center or your cardiology center that would be pretty responsive? Is that out of the question? [LB722]

JAMES BOBENHOUSE: Well, the problem is that about 85 percent of the strokes are ischemic; in other words, there's a blocked artery. But the 15 percent are ones that have hemorrhaged. And if we were to give tPA to someone that had a hemorrhage in the brain, which we don't know until we've done the scans, is that that likely would lead to their death...I mean, if they would have bleeding. And so, so the reason that we need to be very careful about how we give the tPA is because of this bleeding risk. And a person needs to have a CAT scan, or MRI scan sometimes, but mostly CAT scans, emergently to know whether or not there's been bleeding. And in fact, to your point then, in fact, it is possible to conceive of that, the tPA being given in an ambulance, as long as you had a CAT scanner in the ambulance. [LB722]

SENATOR RIEPE: Are there any? [LB722]

JAMES BOBENHOUSE: And there actually are a couple places in the United States they're doing that... [LB722]

SENATOR RIEPE: Really. [LB722]

JAMES BOBENHOUSE: ...but at a tremendous cost. [LB722]

SENATOR RIEPE: So what I hear you telling me is that we need to, in the future, need to staff our rescue squads with MDs. [LB722]

JAMES BOBENHOUSE: Well, it's not just MDs; you'd have to have a scanner, because otherwise you have no way of telling if there's been a hemorrhage. [LB722]

SENATOR RIEPE: Could you get it on a phone app? [LB722]

JAMES BOBENHOUSE: You could do it through telehealth. But again, you'd have to have a scanner in the...you'd have to have...and that's why, actually, all the hospitals, I believe, in the state now have a scanner, a CT scanner. But...and that's why hospitals can conceivably give tPA outstate in a rural or a community hospital, because they have the scanners. But it's really not so much the paramedics that would be...you would need to have some way of ruling out hemorrhage. That's the biggest issue. [LB722]

SENATOR RIEPE: I hear you. Thank you; that's very informative. Thank you. Thank you. [LB722]

SENATOR CAMPBELL: Other questions? Others? Thank you for your testimony today. [LB722]

JAMES BOBENHOUSE: Thank you. [LB722]

SENATOR CAMPBELL: Our next proponent? Good afternoon. [LB722]

JILL DUIS: (Exhibit 5) Good afternoon. Madam Chairperson and members of the committee, my name is Jill Duis, that's J-i-l-l D-u-i-s. I am a registered nurse, and I am a stroke survivor. And I am happy to say that I celebrated my 16th year, last October, of survivorship. I also

volunteer for the American Heart Association. And I also want to thank Senator Baker for sponsoring LB722. As someone who works in the medical field and has survived a stroke, I want to express my support for this bill. This is a very personal issue for me, and I can tell you firsthand, both as a medical professional and as a stroke survivor, how important rapid identification, diagnosis, and treatment is when treating stroke. In addition to being the fifth leading cause of death among Americans, stroke is also the leading cause of disability, serious long-term disability. Stroke affects the arteries leading to and within the brain, and a stroke occurs when a blood vessel that carries oxygen and nutrients to the brain is either blocked by a clot or bursts. And this is exactly what happened to me 16 years ago. When that happens, part of the brain can't get the blood and the oxygen that it needs, and it dies. When that part of the brain dies from a lack of blood flow, the part of the body that that brain controls is affected. Strokes can cause weakness, paralysis, affect language and vision, and cause other devastating problems. And that is what happened to me. Most strokes are embolic in nature, as you've heard from Dr. Bobenhouse. And my stroke was embolic in nature. I was evaluated at a local hospital. I received the diagnostics needed, including lab and a CT scan, and was determined eligible to receive tPA. There are three eligibility requirements for tPA. They're very, very easy to attain. But there's also 25-30 requirements that knock you out of it...ability to get tPA. So why are systems of care important in Nebraska? They're important because they need to reduce death and disability from stroke. And it's important to address the whole system, including the hospital designation, EMS, and continuous quality improvement. That's what this bill does. Time is brain when it comes to stroke, and the longer left undiagnosed and the longer left untreated, the more damage to the brain. More and more states are addressing stroke from a system perspective, including rural states such as North Dakota. The time is right to address some of the gaps in stroke care in Nebraska, as well. By addressing and implementing plans that address our stroke system, we can help to ensure that the best care is delivered promptly, and we can improve outcomes. And we can also implement future improvements in the systems of care. I thank you for allowing me to testify on this very important and personal matter to me. [LB722]

SENATOR CAMPBELL: Thank you for your testimony. Questions, Senator, that you would like to ask? (Inaudible). Okay. Thank you. [LB722]

JILL DUIS: Thank you. [LB722]

SENATOR CAMPBELL: Our next proponent? [LB722]

BRIAN KRANNAWITTER: (Exhibit 6) My name is Brian, B-r-i-a-n. Last name is Krannawitter; that's spelled K-r-a-n-n-a-w-i-t-t-e-r. I am the Government Relations Director for the American Heart Association. I...you heard from three experts, and they've been able to talk to issues of tPA and have the medical background. I guess what I just wanted to do, very briefly, is

talk about how we came to this point. I have been fortunate to work with all three of the previous individuals who are all part of a stroke coalition, if you will, of doctors, stroke coordinators, stroke advocates. And we've been working on this issue for the last couple of years and studying different states, studying model legislation, studying best practices, if you will, journal articles such as "Circulation" from the American Heart Association. And what we committed to was looking at, you know, trying to find what was best for Nebraska. So we studied different states and we talked to a lot of different individuals around the state...doctors, Doctor (inaudible), Hastings, Omaha, Lincoln, and trying to do our due diligence to talking to a wide variety of different individuals. And one theme kept coming up over and over and over again. We need a stroke system. Jill mentioned, and this is what I wanted to bring up, North Dakota. And, you know, we just didn't want to look at something on the East Coast or West Coast. What about a rural state? North Dakota has been kind of out ahead of the curve on this and really started addressing this in 2009. And they "piecemealed" it a little bit, where they didn't do it all at once, but they have put in hospital designation, you must transport protocols. They have a registry and they also have a task force. And they've achieved some pretty impressive results. And I will just hand this out to you and I will read it here. And Dr. Bobenhouse and the others talked about the importance of tPA. And it says here, the percents of acute ischemic stroke patients who arrived at the hospital within 2 hours of time last well known and for whom I...tPA was initiated within 3 hours for eligible patients increased from 30.9 percent in 2010 to 80.9 percent in 2013. That's a very impressive result. And a lot of that is a tribute to the task force, of being able one, to measure where we're at. And then also, to make a concerted effort to go out and provide interventions to improve the distribution of tPA. A couple other things...one on the fiscal note, needless to say, I think all of us were very surprised at the three FTEs and the amount there. We would hope, at a minimum, and it looks, from my reading from the fiscal note, that the registry incurs a lot of that cost...unless I am reading that incorrectly. You know, if that is deemed too high of amount, we would hope, at least, that the committee would consider addressing, then, the hospital designation and EMS component and, you know, and maybe even, hopefully, too, the stroke task force that is...that's very important. That would substantially reduce the fiscal note, and we could keep working towards, you know, getting a registry in place. That is still the ideal of what we would like to see. But I just would throw that out to the committee, that, you know, we would work on language changes, you know, to reduce the fiscal note of the bill and at least address some of the components in it. Finally, I will say this. This is a little bit of a personal story for me. You know, working at the Heart Association, you deal with both heart and stroke. And a lot of these systems issues overlap. My mom, and bear with me here, she had a STEMI heart attack. She lives in a different state, her and my dad. And as with stroke, having protocols in place is incredibly important. A STEMI heart attack is the most dangerous type of heart attack. You have to get to the cath lab, put the stent in to open up the artery, because you have 100 percent blockage. Where they lived, the EMS fortunately had a protocol in place. They took her to a hospital that had that capability. It's not that their local hospital is a bad hospital; it isn't. But they don't have a cath lab. And that's what we're trying to get at here, as well, with stroke.

There's different capabilities to get the best type of treatment. And fortunately, by them doing that, it saved her life. And so it's a very personal issue for me, as well. And with that, I conclude my testimony. And I will hand this out for the committee. Now, I would be happy to answer any questions. [LB722]

SENATOR CAMPBELL: Any questions? Senator Crawford. [LB722]

SENATOR CRAWFORD: Thank you, Senator Campbell. And thank you for your testimony and your work with our task force. So if you've been looking at these other states, I think part of what the fiscal note may be assuming, too, is that we have to create many of these things from scratch. And it looks like, you know, we have like this joint commission model. [LB722]

BRIAN KRANNAWITTER: Um-hum. [LB722]

SENATOR CRAWFORD: Now is there, similarly, already a model on EMS protocols that could be adopted? [LB722]

BRIAN KRANNAWITTER: There's certainly protocols, you know, from other states that can be looked at so you're not, you know, starting from scratch. When I looked at the fiscal note, that looked like the big chunk of the data goes for the persons or persons overseeing the data collection... [LB722]

SENATOR CRAWFORD: Um-hum. [LB722]

BRIAN KRANNAWITTER: ...and the registry, not so much the protocols, as I read it. [LB722]

SENATOR CRAWFORD: Um-hum. Um-hum. [LB722]

BRIAN KRANNAWITTER: But yeah, there's, you know, fortunately, by having other states go first, you know, you have something to work off of and then adapt to your own. [LB722]

SENATOR CRAWFORD: Thank you. [LB722]

BRIAN KRANNAWITTER: And I would also...one last point I should say is that it's also my understanding...talked to an H. A. colleague...that in addition to the states that have already addressed hospital designation and the EMS, which is, I think, 12 and the District of Columbia...it's my understanding there's up to 17 that were and are states addressing it this year

in various state legislatures. So you see where this is going. It's not going to be less; it's going to be more doing this. [LB722]

SENATOR CAMPBELL: Anything else, Senators? [LB722]

BRIAN KRANNAWITTER: Thank you very much. [LB722]

SENATOR CAMPBELL: Thank you. Thank you for your testimony. Any other proponent? I appreciated that they all came forward, sat down there, ready to go. Those who oppose the bill, LB722? Anyone in opposition? Anyone in a neutral position? Okay. Senator Baker, did you want to close? [LB722]

SENATOR BAKER: Just very quickly...we will pursue that fiscal note and find out how that was arrived, because, you know, it's sure the same concern bogging down a bill that has a fiscal note like that on it. So we will pursue that. [LB722]

SENATOR CAMPBELL: Okay. Thank you, Senator. [LB722]

SENATOR BAKER: With that, I close. [LB722]

SENATOR CAMPBELL: Any other questions? Senator Crawford? [LB722]

SENATOR CRAWFORD: Thank you, Senator Baker. I was just curious if...what kinds of discussions you've had with EMS folks, just because they weren't...I didn't see if any of them were here to testify on the bill, so I didn't know if you... [LB722]

SENATOR BAKER: I haven't. [LB722]

SENATOR CRAWFORD: You haven't, okay. [LB722]

SENATOR BAKER: No. [LB722]

SENATOR CRAWFORD: Okay. Okay. Thank you. [LB722]

SENATOR CAMPBELL: I think we have a letter from them. [LB722]

SENATOR CRAWFORD: Okay. [LB722]

SENATOR CAMPBELL: At least I do. Elice, you want to give us the letters for the record? [LB722]

ELICE HUBBERT: (Exhibit 7) A letter of support from the Nebraska Emergency Medical Services Association. [LB722]

SENATOR CAMPBELL: Okay. All right. That will close the public hearing this afternoon on LB722. And we will move to LB849. Senators, do you want a quick break or do you want to just keep going? Anyone want a break? No? Okay. So Senator Crawford, take your time, but when you're ready. Whenever you're ready, just go right ahead. [LB722]

SENATOR CRAWFORD: (Exhibit 1) All right. So thank you. Good afternoon, Chairwoman Campbell and fellow members of the Health and Human Services Committee. My name is Sue Crawford, S-u-e C-r-a-w-f-o-r-d, and I represent the 45th Legislative District of Bellevue, Offutt, and eastern Sarpy County. I am happy to introduce LB849, the Assisting Caregiver Transitions, or ACT act, today. Family caregivers are a key part of a patient's healthcare team. They assist their loved ones in a myriad of ways when that child or adult needs assistance due to a medical or behavioral condition, disability, or advanced age. In fact, last year, over 43 million American adults served as a family caregiver. In Nebraska, almost 200,000 adults served as family caregivers in 2013. Just under half, or 46 percent, of these caregivers were asked to complete complex health tasks, such as wound care, managing multiple medications, managing incontinence, and preparing foods for special diets. Most of these caregivers are tackling these tasks on their own. Nearly 70 percent of caregivers reported their loved ones did not have home visits by a healthcare professional. The Assisting Caregiver Transitions Act ensures these family caregivers have the tools they need to keep their loved ones safe, healthy, and in their homes as long as possible, avoiding hospital readmissions and postponing costly long-term care. Already, $2.00 out of $5.00 we spend on Medicaid goes to long-term care services. These long-term care needs will only continue to increase as Nebraska's population ages. Health experts are increasingly recognizing the importance of improving health literacy so that people can manage their own and their families' health. I want to clarify that the caregiver this bill addresses is the informal family or friend caregiver...so what we're talking about in this bill, not a professional caregiver. One study utilizing focus groups of patients, caregivers, and healthcare providers found that caregivers were less likely to be involved in discharge education and did not receive copies of paperwork summarizing medication schedules post release. The same study also found that discharge tends to be a busy and hectic time for patients, many of which are anxious to get home. As a result, there tends to be less focus by patients on discharge instructions and aftercare needs. LB849 can help empower patients and caregivers especially, giving them a more central

role in the discharge and post-release period. Just to clarify, the bill establishes a process where patients can voluntarily choose to designate a family or friend caregiver to be notified if they'll be discharged and to be present to hear discharge instructions when their loved one leaves the hospital. This will allow a spouse, son, or daughter to hear medication instructions, any drug interactions or side effects the patient should be aware of, and so forth. It does not, in any way, compete with existing home services. Home health nurses and aides will continue to provide valuable services to the patients that they serve. Currently, 18 states and Puerto Rico have enacted measures similar to the ACT act. Under the bill, patients will have an opportunity to designate a caregiver upon admission to the hospital. And the caregiver can either accept or decline this designation. The hospital will then provide a notice to the caregiver of the patient's transfer or release of the hospital. The Assisting Caregiver Transitions bill requires that the discharge plan for the patient includes a description of aftercare tasks, as well as a demonstration of the aftercare tasks. As part of this process, the patient and caregiver will have the opportunity to ask questions about the plan or the tasks themselves. The pages are now circulating an amendment to LB849. This makes several changes to the bill to address concerns raised by the Nebraska Hospital Association. They are now in support of the legislation, and I believe they are submitting a letter, for the record, to that effect. I will briefly summarize the changes in the amendment. First, it clarifies that the hospital will provide the patient an opportunity to designate a caregiver as soon as practicable, following admission. This was an important change, particularly for patients who are admitted through the emergency room, where the initial 24-hour period can be particularly intense from a care perspective. Second, the amendment deletes unnecessary duplicative language in Section 4 regarding consent. The hospitals say this is unnecessary, given the current standard information consent processes. Finally, it eliminates the requirement the hospital prepare a formal list of community resources as part of the discharge plan. At this time, this requirement represents a significant amount of resources to comply. In our discussion with the Hospital Association, there was an agreement of the broader need to continue to move to this sort of planning when patients leave the hospital on partnership with community partners, such as the aging resource centers. I expect these conversations will include local assessments of resources and education of caregivers on the resources available in our communities. Those discussions will continue between hospitals, other healthcare providers, and community partners. Some of you may ask whether this...legislation like this is necessary and question whether these conversations are already happening between the patient and provider. While many hospitals are communicating these tasks with patients and caregivers, it's not happening consistently. One national survey conducted by the National Alliance of (sic: for) Caregiving and AARP found that nearly half, 47 percent of caregivers, indicated they'd never received training from any source for their tasks. The process created in LB849 ensures that these conversations happen in a consistent and a deliberate way with both patient and the caregiver responsible for much of the care. CMS regulations already require hospitals to be attentive to patients' needs for discharge planning. LB849 goes a step further to ensure that a family caregiver gets the instructions that they need. With new changes as a result of the

Affordable Care Act, hospitals are now financially liable for readmissions of patients within 30 days of discharge. LB849 provides one tool to help hospitals and caregivers ensure patients get the proper care they need. Involving family caregivers more fully in the discharge planning process could also serve to empower caregivers as they take on their new or more complex tasks when their loved one returns home. The same National Caring Alliance study on caregivers found that family caregivers who received training were more likely to feel like they were making an important contribution and helping their family member avoid nursing home placement than those who received no training. The legislation takes on increasing importance as the number of Nebraskans over the age 65 is projected to grow from 247,000 to more than 404,000, and the number of Nebraskans 85 years and older will grow 75 percent over the next 20 years, according to a University of Nebraska-Omaha analysis. Many more Nebraskans will find themselves in the position of caring for aging family members and friends with chronic health conditions. We must ensure these family caregivers have the resources they need, both to improve health outcomes and to ensure Nebraskans are able to stay in their own homes as long as possible. With that, I am happy to answer any questions you have now or at closing. [LB849]

SENATOR CAMPBELL: Questions for Senator Crawford? Senator Riepe? [LB849]

SENATOR RIEPE: Senator Campbell, thank you. Did you say that this had the support of the Nebraska Hospital Association? [LB849]

SENATOR CRAWFORD: Yes. [LB849]

SENATOR RIEPE: Okay. I am a little surprised with that, given the requirements and regulations of Medicare and everyone else. And they have a lot at risk for readmission. So that surprises me some. Second would be is, is there a fiscal note on this or... [LB849]

SENATOR CRAWFORD: Well, it does not have a fiscal impact. [LB849]

SENATOR RIEPE: Does not. [LB849]

SENATOR CRAWFORD: Right. [LB849]

SENATOR RIEPE: Okay. Thank you. [LB849]

SENATOR CAMPBELL: Senator Crawford, I have a question. Is the hospital, or wherever the person might be...are they responsible for the training of the person? [LB849]

SENATOR CRAWFORD: So they're responsible for...yes, educating the caregiver... [LB849]

SENATOR CAMPBELL: Okay. [LB849]

SENATOR CRAWFORD: ...informing the caregiver. [LB849]

SENATOR CAMPBELL: So you...at this point, you don't see that as extensive. I mean, it's like, we're going to sit down and talk to you a little bit about what your responsibilities are? [LB849]

SENATOR CRAWFORD: Yes. It would be very similar to the discharge instructions they're already giving the patient. But now they're going to give it...make sure that another person...if the person wants another family member or someone else to be there, that they can be there to hear those instructions, as well, and ask questions about those instructions, as well. [LB849]

SENATOR CAMPBELL: Senator Riepe? [LB849]

SENATOR RIEPE: Thank you. Is there a HIPAA violation there? [LB849]

SENATOR CRAWFORD: Well, we are assured by the people we spoke with about the hospital that their consent processes would allow for this to happen, that if someone is...that they have a way of making sure that they provide consent for this discussion. And the instruction is the instruction, you know, how to care for that person. And they would...and we are told that this is allowable under their existing consent processes. [LB849]

SENATOR RIEPE: Okay. [LB849]

SENATOR CAMPBELL: Any other questions? Senator Crawford, just one quick one here. In terms of...have you had an opportunity to talk to the public guardian? Is there any language in here that might give them any heartburn? [LB849]

SENATOR CRAWFORD: That's a good question. We have not talked to...or we could do that. [LB849]

SENATOR CAMPBELL: You might want to just have Michelle take a look at it, just because there are certain things that they're requiring of guardians, and in the training of them, which might be really helpful for the bill. I didn't see anything, but I have not paid close attention to that. [LB849]

SENATOR CRAWFORD: I don't think so. It wouldn't be..it wouldn't...yeah, the patient indicates if they want someone to be a caregiver. [LB849]

SENATOR CAMPBELL: But I'm just...I'm trying to be real cognizant... [LB849]

SENATOR CRAWFORD: Yeah. Uh...sure. Absolutely. [LB849]

SENATOR CAMPBELL: ...of any bill that comes by now that we have a public guardian... [LB849]

SENATOR CRAWFORD: Right. [LB849]

SENATOR CAMPBELL: ...that we take advantage of their review. [LB849]

SENATOR CRAWFORD: Absolutely. We will get their input; thank you. [LB849]

SENATOR CAMPBELL: Thanks, yeah. Anything else? Okay. [LB849]

SENATOR CRAWFORD: Thank you. [LB849]

SENATOR CAMPBELL: We'll start out with the proponents. The first proponent for LB849. Good afternoon. [LB849]

MARK INTERMILL: (Exhibits 2-3) Good afternoon, Senator Campbell and members of the Health and Human Services Committee. My name is Mark Intermill, M-a-r-k I-n-t-e-r-m-i-l-l, and I am here today on behalf of AARP. A priority of AARP is to support family caregivers. Family caregivers provide support to enable a family member who has a disability to live in the setting of their choice. Family caregivers provide a valuable service to the state of Nebraska. Their efforts have contributed to a low growth...rate of growth in Medicaid payments for services made on behalf of Nebraskans over the age of 65. We strongly support LB849, and our support is based, in part, on the findings of a survey that we conducted last fall. The survey included 800 Nebraskans over the age of 45. Of those individuals, 408 indicated they are currently or have in the past provided unpaid care to a loved one. We asked those current and former caregivers about the caregiving tasks they performed. About two thirds said that they were, or had been, responsible for medical or nursing tasks. And about the same number had responsibility for medication management for the person they were caring for. Reimbursement policies place pressure on hospitals to discharge patients expeditiously. And we know that the number of

nursing home residents in Nebraska has declined from 17,000 in 1995 to 12,000 today. So many of the nursing tasks that may have been performed in a licensed healthcare facility in the past are now performed at home. And that can be a good thing. Being at home can facilitate recovery. But we need to make sure that those who provide care for individuals who have a disability and are coming home from a hospital have the information that they need to ensure a successful transition from hospital to home. We also asked caregivers about their experiences with hospital transitions of their loved ones. Specifically, we asked those who said that their loved one had been admitted to a hospital if they'd been provided with instruction or a live demonstration of any medical tasks that may need to be performed for their loved one after discharge. And 70 percent in Nebraska said that they had received instruction or a demonstration of a required task; 25 percent said they had not. And when we reviewed this with the people who conducted the survey, they told us the findings on this question in Nebraska were unusual. In other states, respondents were less likely to have received instruction on aftercare tasks. So I want to take this opportunity to recognize Nebraska hospitals that are incorporating caregiver instruction into the discharge process. The final finding that I want to share with the committee is that we found strong support for the three provisions in the Assisting Caregiver Transitions Act, the first one being requiring hospitals to record the name of the patient's family caregiver. We found that 81.4 percent of respondents supported that particular provision. We asked about requiring hospitals to keep a caregiver informed of major decisions like transfer, discharge; and support went up to over 91 percent. And when we asked about requiring hospitals to explain or demonstrate any medical or nursing tasks, family caregivers will need to perform after the patient returns home, support nearly reached 94 percent. And, having done surveys for AARP for several years now, we never see that type of support. Support was bipartisan. When I looked at the crosstabs, I found that 95 percent of self-identified Democrats and about 95 percent of self-identified Republicans supported requiring an explanation or demonstration of aftercare tasks. AARP supports LB849 because it will facilitate provision of information about aftercare tasks to the people who will be in a position to make sure that the transition from hospital to home is successful. Our support for the bill is bolstered by the finding that its provisions are supported by an overwhelming majority of Nebraskans over the age of 45. We request the committee report the bill, as amended, to the General File with a favorable recommendation, or, I should say, as proposed for amendment, to General File. [LB849]

SENATOR CAMPBELL: Questions from the senators for Mr. Intermill? Senator Riepe? [LB849]

SENATOR RIEPE: Thank you, Senator Campbell. I think you said that it's a valuable service. Was that in your testimony, that it's a valuable service? [LB849]

MARK INTERMILL: That the aftercare... [LB849]

SENATOR RIEPE: Yeah. [LB849]

MARK INTERMILL: ...that family care was provided? Yes. [LB849]

SENATOR RIEPE: I guess my question would be then, is to AARP members...would they be in a position and prepared to pay out $1,000 or $5,000 if it has value, that falls outside of Medicare? [LB849]

MARK INTERMILL: Maybe...I may have misunderstood the question. Which service... [LB849]

SENATOR RIEPE: I was saying there's some...does it merit enough? Is it worth enough to pay an out-of-pocket cost for? It's easier to spend someone else's money than it is to spend your own. I am just...I am just curious where your membership might be. [LB849]

MARK INTERMILL: Yeah. I would say that this is a valuable service for the caregivers, but it's also a valuable service for a range of other entities, including the state of Nebraska. It is a...successful transition from hospital to home without having to go back to the hospital saves the state money. [LB849]

SENATOR RIEPE: Okay. [LB849]

MARK INTERMILL: Or to make sure that the individual is able to recover fully, that they don't wind up in a situation where they need long-term care, which is even more likely to be covered by the state, there are a number of beneficiaries of this service. So it's not exclusively the caregiver. The caregiver is performing, I would say, a service of value to the state by being a caregiver. What we think is that we just need to make sure that they're in the best position possible to fulfill that responsibility. [LB849]

SENATOR RIEPE: So is that a yes or a no that they would be willing to pay some out of pocket? [LB849]

MARK INTERMILL: This is my personal response to the question. It would be that they're already paying, I think, in terms of the service they're providing for the individual. This is a way to provide them with the support that they need. [LB849]

SENATOR RIEPE: That they're seeming to want more services. [LB849]

MARK INTERMILL: I think caregivers want to be able to do the job. [LB849]

SENATOR RIEPE: I'm more concerned about the patient than the...you know, the recipient is the patient. And I'm just curious whether they are prepared to say, you know, there's not unlimited funds at any level. And are they...you know, if it's worth something, then write the check. (Inaudible). That's where I come from. So... [LB849]

MARK INTERMILL: Okay. [LB849]

SENATOR RIEPE: I hear you saying, fundamentally, no. [LB849]

MARK INTERMILL: I think that's correct. [LB849]

SENATOR RIEPE: No. Thank you. [LB849]

SENATOR CAMPBELL: I would have to say, Senator Riepe, I think the hospitals will benefit greatly, because they are going to be penalized for readmissions. And it would seem to me that...I'm sure that's why they have a letter of support and why they spent time to find the correct language with Senator Crawford. They don't want that readmission. And so if they can educate another person who listens...having gone through this with two of my own parents and with myself, I'm like...having someone else there who can listen and take down notes and so forth makes a lot of difference for when that person goes home. [LB849]

MARK INTERMILL: Yeah. And in conversations that I have had with hospitals when the readmission program came up, they were in the process of looking at what are the things that cause readmissions. And changes in drug regimes are one of the...probably the primary reasons for that. And that's where having that caregiver involved at the point of discharge...if there have been changes in medications so that they're informed of those decisions, those changes, and make sure that they're done appropriately, I think that provides a lot of value. [LB849]

SENATOR RIEPE: Senator Campbell? [LB849]

SENATOR CAMPBELL: Yes. [LB849]

SENATOR RIEPE: May I? [LB849]

SENATOR CAMPBELL: Sure. [LB849]

SENATOR RIEPE: I would contend that, as I stated earlier, I think under Medicaid, hospitals do have every incentive to make sure you don't get rehospitalized. So the question gets to be, if that incentive is already there, why then the purpose of this legislation to force more? They've got every reason in the world to want to do that. [LB849]

MARK INTERMILL: I would say that, in Nebraska, what we found was that 70 percent of the people that were surveyed said that they had had those discussions, but 25 percent had not. So I think we want to just to make sure that those 25 percent get brought into the process and get the same benefits that the 70 percent are...appear to currently be receiving. [LB849]

SENATOR RIEPE: Okay, thank you. Thank you, Chairman. [LB849]

SENATOR CAMPBELL: Um-hum. Questions? Anyone have questions? Thank you, Mr. Intermill. [LB849]

MARK INTERMILL: Thank you. [LB849]

SENATOR CAMPBELL: Our next proponent? Good afternoon. [LB849]

SUSAN CAMPBELL: (Exhibit 4) Good afternoon. Senator Campbell, you're my senator. [LB849]

SENATOR CAMPBELL: Well, welcome. [LB849]

SUSAN CAMPBELL: And the other senators, as well. My name is Susan Campbell, S-u-s-a-n C-a-m-p-b-e-l-l. I have been a caregiver, and I am now just advocating for caregivers. I am a member of the Lincoln Caregiver Education Group. I'm a Caregiver Chick. I serve on the advisory board of the Southeast Respite Network. I am a member...I am cochair of the Nebraska Caregiver Coalition. I worked for Aging Partners for 28 years and worked with a lot of caregivers and in respite situations, hospitalizations, and so on. And I can say that I have heard lots and lots of stories about not understanding, when somebody came home from the hospital, what was to happen. I can't share those stories; I can only share my own. And so I think that this is extremely important legislation, to assure that all caregivers and the recipient of care, of course, understand what's needed when they come home. I was thrust into caregiving when I was a young mother with four young sons. And my parents lived in the village of Memphis, Nebraska. And my mother was killed in an automobile accident. And so I took over the care of my father, who was diagnosed with hardening of the arteries. Really, it was a dementia, but in 44 years ago, they said hardening of the arteries. He was put in the hospital for some tests, and they

did a lot of things to him, and without asking anyone, because they found him unresponsive. And they called me at like five o'clock in the morning and said he was unresponsive. I only saw him once that day, and he was still unresponsive and so full of tubes and so on. And then he passed. So there was no aftercare. My husband was ill the last 16 years of his life, and he was originally diagnosed with two kinds of bladder cancer. And he was treated for that. Later he had some heart attacks and was diagnosed with a degenerative heart disease that killed his father when Fred was only three years old. He was in and out of the hospital many, many times. He had 9 surgeries during those 16 years. Two instances...it really came to mind when I was reading this bill and deciding to testify. And I shared at the press conference, too, so I am just reiterating. What I said then was he was sent home with a hole in his back, a wound. And I was told that I needed to dress that wound and to make sure that it didn't get wet. Well, they didn't send any dressings. They didn't demonstrate. And how I tried to keep it from getting wet...I put a plastic bag, taped that on; that didn't work. I actually wrapped Saran Wrap all the way around him; that didn't work. And it scared the living daylights out of me, because his immune system was so compromised that, had he gotten infection in that wound, it would've probably meant his immediate death. He just couldn't have handled it. So the other one was when he had a quadruple bypass. And they took a vein out of his calf, the full length of his calf. And, of course, that was stitched. And so and then, then they told me I had to put TED hose on there. Again, scared me because of tearing that wound open...I mean that was what, 16 inches wound and infection. So...so to me, they could have sent...he was too ill to really care. And if they had taken 10 minutes or 5 minutes and given me those instructions, it would've helped a great deal. And the recipient of care needs to have their dignity recognized and have the proper care and expeditious care, so they can transition back into life and save the state money so they don't go into...to skilled-care facility. That was stated very well before. So... [LB849]

SENATOR CAMPBELL: Thank you, Mrs. Campbell. I always appreciate people who do the testimony, but they don't really read it. They sort of tell us. And you must have thought very thoroughly about your testimony, because it's almost as if you had it memorized. You did a great job. [LB849]

SUSAN CAMPBELL: I lived it. [LB849]

SENATOR CAMPBELL: And that's very obvious from your testimony. Questions for Mrs. Campbell that you might want to ask? [LB849]

SENATOR FOX: I've got a question, Senator Campbell. [LB849]

SENATOR CAMPBELL: Yes. Senator Fox? [LB849]

SENATOR FOX: Thank you so much for your testimony. I was reading through it, even though you didn't read it. And my background is in cancer care, so I'm so sorry for your loss. And what you have written here is something I encounter almost every day when I am at the hospital. I work with surgical oncology, and so I totally understand what you're saying here. Some of the things that I see...I mean, I have healthcare knowledge, and... [LB849]

SUSAN CAMPBELL: I don't. [LB849]

SENATOR FOX: ...I would be, I would be overwhelmed being told to pack wounds and those types of things. My question is, kind of going back more to the in-patient setting, because you said he had multiple hospitalizations, did you find that the day-to-day, you know, as the hospital stays progressed, that the changes in nursing kind of affected, maybe, what was going on? And I guess what I am trying to say is, you know, a continuity of care issue that obviously impacts what happens towards the end of the hospital stay and discharge, when nurses are changing from day to day, and handling, maybe, educational issues and trying to prepare you for that discharge differently. Do you think that that, you know, maybe impacted your readiness at discharge? [LB849]

SUSAN CAMPBELL: It could have. He wanted to go home, of course. He wanted to die at home. And that last time he was in five weeks. I normally spent much of my time, after I retired, much of my time with him in the hospital so that I could ask questions and make sure that he got the care, because he was too ill, often, to respond to that. And the answer about the nurses...I found, through the years, the first hospitalizations...there were more nurses. [LB849]

SENATOR FOX: Um-hum. [LB849]

SUSAN CAMPBELL: And through the years, there were less and less nurses to...they had to take care of more and more patients. So they pay...were... [LB849]

SENATOR FOX: Spent less time. [LB849]

SUSAN CAMPBELL: I mean, it's not their fault. It's just... [LB849]

SENATOR FOX: Yeah. [LB849]

SUSAN CAMPBELL: I mean, there are only so many minutes that you have to spend with each patient. Often I did a lot of things for him that probably a nurse, in the past, would have done. But...and we had some excellent, excellent nurses. And we had some who were less likely to

answer my questions. And, not being medically trained, I didn't always ask the right questions. [LB849]

SENATOR FOX: You didn't know what questions to ask. [LB849]

SUSAN CAMPBELL: Did that answer your question? [LB849]

SENATOR FOX: Um-hum. [LB849]

SENATOR CAMPBELL: Any other questions? Thank you, Mrs. Campbell, for your testimony today. [LB849]

SUSAN CAMPBELL: Thank you; I appreciate it. [LB849]

SENATOR CAMPBELL: Our next proponent? Good afternoon. [LB849]

JAMES SUMMERFELT: (Exhibit 5) Good afternoon. Good evening, whichever it is. [LB849]

SENATOR CAMPBELL: It's still afternoon. [LB849]

JAMES SUMMERFELT: Still afternoon. [LB849]

SENATOR CAMPBELL: We're going to keep that way. [LB849]

JAMES SUMMERFELT: My name is James Summerfelt, J-a-m-e-s S-u-m-m-e-r-f-e-l-t. I am the president and CEO of the VNA, which is a provider of healthcare in the home. I have been for 120...I haven't been, but our organization has been for 120 years. And I come to testify today in support of this bill. And when I first read it, you've got my testimony. And there's also a letter that I reference from our state association, Lana Woods (sic: Wood), from the Nebraska Home Care Association. So it was interesting; we both had similar responses when we read the bill. First, and there's three of them that I'll try to touch on...so the first one is that this is best practice. Discharge planning, as you can imagine and is said, and best practice is to start discharge planning the first day of admission into the hospital. And when you find a good discharge process, that's when it happens. In identifying who the caregiver is, a lot of times those caregivers are not available, because they're working during the day. And it's just difficult to get the patient and the family together. So it was interesting just to read a bill that was...this is best practice. And Joint Commission looks for this. State surveyors...Medicare surveyors are looking

for this practice when they come in to assure licensure and accreditation. That's number one. Number two...there are individuals that have chosen a very independent lifestyle that live alone, that are very private. And so these are guidelines, and I think that is good on one point. But on the other hand, there's no teeth to it, because they are just guidelines. So we need to respect those peoples who have chosen a very independent lifestyle and don't want to have a caregiver, don't want to have anybody involved. But they do well when they're discharged to home with a home health agency like the VNA. So we want to make sure that we're sensitive to that part. Number three is, the staff of the hospital are not necessarily trained or educated in home health care. They're specialists in acute care. What they do so well is, at the moment, a very structured environment in a hospital. When you go home, it's just the opposite. It's very unstructured. There's a lot of variables that go on at home; that's why you have home care agencies like the VNA that go home to help further the care as people progress, because you don't want to rely on the care that you were instructed it in the hospital. And assuming that that's not going to change when you get home. Things will change; people will progress up and down, and you need to have continual instruction and demonstration as you get home. A lot of times we have found, and I can give you a lot of anecdotal experiences of it, it develops a conflict of family or patients saying, well, I was instructed this way in the hospital, and now you're telling me this way at home. Who am I to believe? And it's a progress. So again, I just kind of caution the committee and the sponsor of the bill to that respect, as well. And just an aside...you know, I am trying to get more schools involved in having their students learn home health care for the present and the future, just because there's going to be more need for healthcare at home. And we do...you know, I don't want to make this sound like we're not in supportive of caregivers. We do need them involved. We have a transitional care program with Nebraska Medicine that we're using the Coleman transitional care model, where there are coaches that are trained in Denver, Colorado, by Dr. Coleman. And so they see the client, the patient, in the hospital. And then they follow them home for another visit. So there's continuity of care there, and it is a lot of instruction about their disease process and how to take care of themselves, as well as get back to their primary care doctor. So it's a team effort. I will stop there, and thank you for your time and allowing me to testify. [LB849]

SENATOR CAMPBELL: In some cases, Mr. Summerfelt, are you, in essence, then the person, the caregiving person, for someone who goes home but doesn't have anyone else? [LB849]

JAMES SUMMERFELT: If they don't have a willing caregiver at home, yes. We will end up providing that care, but also trying to do the best we can to teach that patient how to take care of themselves, so they don't end up in trouble again and end up back in the hospital. [LB849]

SENATOR CAMPBELL: In those cases, do you go to the hospital and listen with the person, or do you...does your service start when they get home? [LB849]

JAMES SUMMERFELT: You know, this project that we have going with Nebraska Medicine, the transitional care, we actually have a coach that meets them in the hospital, bedside, and then follows them home for another visit. And then for 30 days, stays in touch with them on the phone, as well. [LB849]

SENATOR CAMPBELL: Very good. I just want to clarify that for the record. [LB849]

JAMES SUMMERFELT: Yeah. [LB849]

SENATOR CAMPBELL: Senator Riepe? [LB849]

SENATOR RIEPE: Senator Campbell, thank you very much. I think in your testimony...I see that you're from Omaha...that in your testimony, you said that hospitals are in the hospital business and not in the home healthcare business. We spent this morning debating pork producers who are vertically integrating. And I think hospitals have been vertically integrating. Do you know if CHI, for example, have...offers a home healthcare program? [LB849]

JAMES SUMMERFELT: Yes. [LB849]

SENATOR RIEPE: Okay. [LB849]

JAMES SUMMERFELT: They have a home healthcare program similar to ours. Yes. [LB849]

SENATOR RIEPE: And Methodist, as well? [LB849]

JAMES SUMMERFELT: Methodist has a home health and a hospice...their home care is not Medicare certified. [LB849]

SENATOR RIEPE: So the traditional or old-fashioned hospital has, all of a sudden, become a vertically-integrated delivery system that does provide some home care followup. [LB849]

JAMES SUMMERFELT: Yes. And I think the hospitals and the systems that do not have their own department of home care or hospice are partnering with freestanding agencies like ours. For example, we are on NeHII, along with the hospital, so we're able to exchange our health record with theirs and see theirs and (inaudible). That's one of the beauties of NeHII in the state. This is a great state for health exchange, information exchange system like that. So we're in, as I said, demonstrating with the transitional care program. We're working with Nebraska Medicine

because they do not have their own department. We function as that and work very closely with discharge planning and clinical pathways and such. [LB849]

SENATOR RIEPE: I think my point was this: There's continuity of care. For what used to be hospitals, there are now systems. [LB849]

JAMES SUMMERFELT: Yeah. I would say that is one model, but it's not exclusive. Patients have the ability to choose whatever agency they wish. They don't necessarily need to use...like CHI used the Alegent Home Care agency. And so the continuity of care can exist without ownership. [LB849]

SENATOR RIEPE: Um-hum, I agree. Thank you. [LB849]

SENATOR CAMPBELL: Any other questions, Senators? I think... [LB849]

SENATOR FOX: Can I? [LB849]

SENATOR CAMPBELL: Oh, sorry. Senator Fox, go right ahead. [LB849]

SENATOR FOX: I guess, just to kind of help...as far as Senator Riepe's question, like at Nebraska Medicine, we do not have a home care. Would you say some of that, too, the purpose for a stand-alone, would be because, for those patients who have ended up in the more metro areas, they've been transferred from the rural parts of the states you're contracting with, agencies, maybe, out... [LB849]

JAMES SUMMERFELT: Yes. [LB849]

SENATOR FOX: ...in rural Nebraska, and that might be a reason to have an outside home healthcare agency? [LB849]

JAMES SUMMERFELT: You know, for example, we manage Fremont Health, Home (Health) Care and Hospice. And so where we use to be just Douglas and Sarpy County, we're now Dodge, Saunders, Washington, Burt, and parts of Lancaster Counties, as well. So as the Nebraska Health Network continues, and ACOs continue to develop and evolve and form, I see organizations like ours working across the state, not just in Omaha metro. [LB849]

SENATOR CAMPBELL: Anything else? Thank you for your testimony. [LB849]

JAMES SUMMERFELT: Thank you very much. [LB849]

SENATOR CAMPBELL: Our next proponent? Anyone else? Those who are opposed to the bill? Anyone in a neutral position? Good afternoon. [LB849]

JEANNE McCLURE: (Exhibit 6) Good afternoon, Senator Campbell and the members of the Health and Human Services Committee. My name is Jeanne McClure, J-e-a-n-n-e M-c-C-l-u-r-e, and I am the Government Affairs administrator and a registered lobbyist for CHI Health. And I am here today to testify, in a neutral capacity, regarding LB849. On behalf of CHI Health, I would like to thank Senator Crawford and her staff for their continued interest and concern to improve the healthcare for patients across our state. Hospitals nationwide that participate in Medicare and Medicaid are required to follow extensive regulations administered by the Centers for Medicaid and Medicare Services, or CMS, regarding patient discharge planning. These regulations are quite robust and do explicitly address that hospital staff is to request of a patient whether family or friends are willing to provide required care and assistance upon their discharge and act on the patient's behalf. These can be found on the CMS Web site. And, because that Web site is so huge and confusing, I provide you, with my testimony, the Web address, as well as the 21 pages of the 525-page document that specifically relates to discharge planning and evaluation. The regulations include the planning for the needs of patients' post-hospital services and the evaluation of a patient's capacity for self care or need for assistance following hospital discharge. Knowing that these comprehensive regulations are already in place and being followed by hospitals, does LB849 really add value? A greater challenge and concern is for patients who lack a caregiver, either a facility and/or a person to care for them following a hospital stay. Frequently, these patients are required to stay in the hospital, without having any medical care provided, while the hospital searches for an accepting care provider. Many of these patients suffer from mental health issues, are homeless, or have a medical diagnosis for which placement is difficult. One example, in one of our facilities, provided immediate medical care for a homeless person. As this person is a vulnerable adult due to their cognitive disorder, and is violent, an acceptable caregiver was difficult to identify. The patient spent more than 200 days in the hospital, required almost 24/7 security monitoring due to violent outbursts, all while having no acute medical needs that required hospitalization. This type of patient situation, in which a caregiver cannot be identified, is of great concern, a concern that we believe needs attention. While LB849 is a good idea, we believe it already is followed by our hospitals in Nebraska and across the nation. And it's not harmful, but is it necessary? As always, on behalf of the more than 12,000 employees of CHI Health, we thank you all for your service to our state. And we welcome the important discussion of improving healthcare and would love to be part of the solution. Please use us as a resource, as you consider this and other matters. [LB849]

SENATOR CAMPBELL: Okay. Questions? So are you...you're saying, I think, Ms. McClure, that already in existence is a rather lengthy requirements for discharge planning. [LB849]

JEANNE McCLURE: And then penalties, as well. [LB849]

SENATOR CAMPBELL: In that discharge planning, does it require a discussion with a caregiver? [LB849]

JEANNE McCLURE: It requires that consideration for...is there a caregiver on the other end? And when the patient leaves the hospital...and what is that patient going home to? And so then if the consideration...if there's not, then what other services in the community exist to help that patient? It's pretty extensive within there, we believe. And it's interesting to hear of a story from the previous testifier of 40 years ago. My dad has been recently in the hospital at Nebraska Medical Center, and there were extensive instructions given on meds and care and all of those things, and to many family members present. [LB849]

SENATOR CAMPBELL: So when the patient comes into the CHI facility, then, at admissions, the name is written down as to who that caregiver is, because I think that's a part of what Senator Crawford is trying to get at here, is that at the very beginning that person is identified. Do you know whether, in all the hospitals, CHI, that they do identify that person? [LB849]

JEANNE McCLURE: I'm not saying that they identify and write that down. I'm saying that it is...it's not part of CMS to write the name of that person down, but it is to ensure that someone is there to help the patient when they go home, and that we will not...that we are...we're not going to release someone without a good care plan on the other side, because...I mean, because it's (A), it's the right thing to do, to make sure that patient is cared for well. But through all kinds of regulation, we get what we called "dinged," fined for readmissions under Medicaid and Medicare. So not only do we want to provide the best care for the patient possible, but we don't want to be fined by CMS for that. And so what...we just feel like this might be duplicative. [LB849]

SENATOR CAMPBELL: So if you have...if you know that someone has a caregiver, is that...I don't know whether I want say the word "required." But is that person there to hear the instructions, also? Do you know? [LB849]

JEANNE McCLURE: I would say most of the time they are, because they're the person going to have to get that person home. [LB849]

SENATOR CAMPBELL: Okay. All right, thanks...a lot of information. Senator Riepe? [LB849]

SENATOR RIEPE: Thank you, Senator Campbell. Thank you for being with us. The question that I have is, when patients are given instruction both verbal, is it safe to say that they're also given written instructions so that, if there's some overwhelming piece, that they can go back and refer? [LB849]

JEANNE McCLURE: Right. There are. And I would say to people who haven't been in the hospital recently, it's very similar to when you get a prescription from the pharmacy. You have the opportunity to talk to the pharmacist, but if you decline that, they're sending you home with this big piece of paper...very similar to what happens in the hospital. This big...all these care instructions come home with you, with highlighted emphasis and things like that to say, these are the things that you need to do. Here are the numbers you need to call if you have a problem with, you know...if you develop a fever within the next 24 hours, if all of these things. The other thing, I would say, that happens now, that is a more recent development in the last five years is, there are follow-up calls from the hospital to the patient's home to say, how are you, following your stay at our hospital...at the hospital? And are you complying and are you taking your medication and things like that. [LB849]

SENATOR CAMPBELL: Okay. [LB849]

SENATOR RIEPE: May I ask a follow-up question? [LB849]

SENATOR CAMPBELL: Sure. [LB849]

SENATOR RIEPE: This is a curiosity question, I guess, a little bit more. The patient who spent more than 200 days in the hospital...I don't want to see that bill. Was that a behavioral placement inability? [LB849]

JEANNE McCLURE: Um, it was a homeless person that had injured themselves. Rescue squad brought them to the hospital. And the police won't arrest him, because they say he's mentally incapacitated. And the state won't take him, because they say it's a cognitive, a dementia. And so we're caught with this patient in the middle. So we won't release him, because we can't...because we feel it's not the right thing to do. The patient's on Medicaid. And so the state is being billed for that. [LB849]

SENATOR RIEPE: So we're (inaudible)... [LB849]

JEANNE McCLURE: But it's caught in a limbo situation of, what do you do with this patient who doesn't have a caregiver? [LB849]

SENATOR RIEPE: So we have some interest in this 200-day bill, too. [LB849]

JEANNE McCLURE: 200-day bill. [LB849]

SENATOR RIEPE: Thank you. [LB849]

JEANNE McCLURE: Thank you. [LB849]

SENATOR CAMPBELL: Any other questions, Senators? Thank you. Anyone else who wants to provide neutral testimony? Okay. Senator Crawford, do you wish to close? [LB849]

SENATOR CRAWFORD: Yeah. So just to clarify...the caregiver we're talking about with this bill, is someone who will receive instructions. And it's optional, for the patient can identify it. But we're not...our bill doesn't in any way impact someone's ability to be discharged. We're not impacting those parts of the regulations; we're talking about identifying a caregiver who could receive the notification of discharge and instructions...just to clarify that. So what I thought I would...wanted to do, also, in closing...I talked in the opening about a lot of what the bill does. And I just wanted, in closing, to just clarify, for the record and for committee members, some of the things that it does not do. So we clarify, in the bill, that it does not create a private right of action. So it is not the case that this becomes something that you could sue a hospital for if they did not do this. And it is...it does...so it doesn't create that additional civil or regulatory liability. It does not affect licensure; so that is not how it would be, in any way, enforced through a licensure. And it does not establish a new requirement to reimburse or pay for these services. So it is not the case that we are setting up something that's going to be a new line for reimbursement. And the bill clarifies it does not interfere with the valid healthcare power of attorney. So we're not, in any way, wanting to interfere with those responsibilities and rights. So it is the case that there are regulations requiring discharge planning. Those already exist, and you need to consider the needs of the patient. It's my understanding that those still do not clearly do exactly what this bill does and asks, in allowing someone to have a person identified and requiring that that person receives instruction at discharge. Clearly, the AARP results show that many of our patients are receiving that. As he said, the fact that 70 percent said they were, shows that many of the hospitals are doing their fair share and trying to do a good job with this. But still, two things are true: (1) 25 percent are not getting these instructions, which is critical. Now the second thing is that, by having a consistent expectation of what patients can expect, I think will help them understand, going in, that they can ask to put a person's name on the record and know that they're supposed to be able to expect and ask to make sure that person is there on discharge. So that is an important benefit of the bill, even if many hospitals are already providing some of this education, because it allows educators and people who are working with families and advocates and the aging resource centers to talk to patients and talk to family members about

what they can expect when they enter the hospital, because the hospitals are required to do this. And so they can make sure that they are encouraging their patients, encouraging family members to ask for...ask to be recognized and ask for these instructions on dismissal. So I think that that's an important reason why you would still pass the bill and to make it so it's a shared expectation that people know about and know how to ask for it on discharge. So again, I want to reinforce that this is...this doesn't replace or interfere with home health. We're talking about the informal family member and making sure that, if there is someone that the patient expects to help them with their caregiving, that they are able to designate them and make sure they get instructions at discharge. So, I am happy to answer other questions that people might have. [LB849]

SENATOR CAMPBELL: Senator Crawford, I just have one last question. Does the bill apply to the ambulatory surgery centers or any of where you would have some kind of procedure? You're not in a hospital, per se, not what we think is a community hospital, but there are other areas where you have some procedure done. And you're getting ready to leave. And the question is whether somebody is prepared to know what's going to happen to you. [LB849]

SENATOR CRAWFORD: So the bill, as it's written now, the hospital means a general, acute hospital. [LB849]

SENATOR CAMPBELL: Okay. [LB849]

SENATOR CRAWFORD: So it is written to apply to those hospitals. [LB849]

SENATOR CAMPBELL: Okay. It just might be an interesting question to figure out if any other states... [LB849]

SENATOR CRAWFORD: Um-hum. That's a good question. I appreciate that question. [LB849]

SENATOR CAMPBELL: ...because you testified to that. Have you included any other... [LB849]

SENATOR CRAWFORD: ...to see if it applies to the other ambulatory centers. It's a good question. They may have less infrastructure for that, but it's a good question. [LB849]

SENATOR CAMPBELL: Anything else, Senators? [LB849]

SENATOR FOX: I'd just like to say, I think...yeah. Thank you for your work on this. Just being in healthcare, I...what we say in the hospital a lot is, hindsight is always 20/20. And I think...I see

this as being proactive, in terms of trying to reduce healthcare costs and readmissions, because, almost like Senator Campbell said, even something such as an ambulatory outpatient procedure can go wrong and require a hospital admission. [LB849]

SENATOR CAMPBELL: Right. [LB849]

SENATOR FOX: Or, a simple procedure can turn into something much more complicated or end up with, you know, added infections and comorbidities by the...you know, what should be a quick hospital stay can be a long one. So I think it's always good to be proactive and plan ahead. [LB849]

SENATOR CRAWFORD: Thank you. [LB849]

SENATOR CAMPBELL: You know, I think of myself as a good listener, and I can pay attention and understand what somebody is saying. But when I had my knee replacement, my son was with me to listen to the instructions. And I did not hear them correctly. I didn't. And he said, no mom, you shouldn't be taking that medication now; that's not what it says. So I can see the value to this; I truly can, from a...and maybe it was just me, but I doubt it. [LB849]

SENATOR CRAWFORD: No, I think people are sometimes under anesthetic (inaudible)... [LB849]

SENATOR CAMPBELL: Absolutely. You know, I wasn't... [LB849]

SENATOR CRAWFORD: ...or in a rush to get home (inaudible). [LB849]

SENATOR CAMPBELL: You think you're all clear-headed and ready to go home, but maybe not. That concludes our hearings for today. [LB849]

SENATOR CRAWFORD: Thank you. [LB849]

SENATOR CAMPBELL: Everybody have a good weekend. [LB849]

SENATOR CRAWFORD: Thank you. [LB849]