HANSEN: All right. Good afternoon and welcome to the Health and Human Services Committee, which you will find is the best committee in all of Lincoln, so. That's right. Feel blessed that you're here. My name is Senator Ben Hansen. I represent the 16th Legislative District in Washington, Burt, Cuming and parts of Stanton Counties and I serve as Chair of the Health and Human Services Committee. I would like to invite the members of the committee to introduce themselves, starting on my right with Senator Ballard.

BALLARD: Beau Ballard. representing District 21, northwest Lincoln and northern Lancaster County.

WALZ: Lynne Walz. I represent Legislative District 15, which is Dodge County and Valley.

HARDIN: Brian Hardin, representing District. 48: Scottsbluff, Gering, and Kimball.

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

RIEPE: Merv Riepe, District 12, which is a chunk of Omaha and Ralston.

HANSEN: Also assisting the committee is our legal-- our research analyst, Bryson Bartels, our committee clerk, Christina Campbell, and our committee pages for today are Delanie and Payton. A few notes about our policy and procedures here. Please turn off or silence your cell phones. We will be hearing three bills and we'll be taking them in the order listed on the agenda outside the room. On each of the tables near the doors to the hearing room, you will find green testifier sheets. If you are planning to testify today, please fill out one and hand it to Christina when you come up to testify. This will help us keep an accurate record of the hearing. If you are not testifying at the microphone but want to go on record as having a position on a bill being heard today, there are white sign-in sheets at each entrance where you may leave your name and other information. Also, I would note if you are not testifying, but have an online position comment to submit, the Legislature's policy is that all comments for the record must be received by the committee by noon the day prior to the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. We would ask if you do have any handouts that you please bring ten copies and give them to the page. We use a light system for testifying. Each testifier will have five minutes to testify. When you begin, the

light will turn green. When the light turns yellow, that means you have one minute left. When the light turns red, it is time to end your testimony and we will ask you to wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone and then please spell out both your first and last names. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters of the bill, then from those in opposition, followed by those speaking in a neutral capacity. An introducer of the bill will then be given the opportunity to make closing statements if they wish to do so. And we have a strict no-prop policy in our committee. So with that, we will begin today's hearing with LB202. And we welcome Senator Walz to open. Welcome, Senator.

WALZ: Thank you. Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Lynne Walz, L-y-n-n-e W-a-l-z, and I represent Legislative District 15, which is Dodge County and Valley. Today I'm introducing LB202, which really is a continuation of LB812 that was introduced last year by Senator Hilkemann. This bill would allow pharmacy technicians to distribute vaccines with the supervision-- oh, under the supervision of a pharmacist. I should start out by explaining that pharmacy technicians nationwide have been distributing COVID-19 vaccine and pharmacy, pharmacies-- under pharmacist supervision for over a year. LB202 will codify the federal provisions that have been in place, allowing pharmacy technicians with appropriate training to continue to help pharmacists meet the vaccine-- vaccination needs of their patients. Since 1994, pharmacists in Nebraska have been distributing vaccinations like the flu shot. LB202 would alleviate the workload of pharmacists that may be overloaded. Oftentimes, pharmacies are the most accessible healthcare providers in many Nebraska communities. LB202 would help pharmacists be able to fulfill all of their duties with the help of additional staff to distribute vaccines. This is especially helpful during flu season. The requirements of the pharmacist and pharmacy technicians for the delivery of vaccinations in this bill are as follows. First, prior to the administration of a vaccine by a pharmacy technician, the vaccine must be reviewed and verified by the pharmacist. The pharmacy tech would then-- would be limited to administering vaccination to patients three years of age and older. The vaccination can only be given in the deltoid muscle of the arm. The pharmacy technician is required to hold a certificate in basic life support. The pharmacy technician must be certified and trained to administer vaccinations. And finally, the supervising pharmacist would be required to be on site. A survey of pharmacists

and pharmacy technicians practicing in Nebraska and conducted by the University of Nebraska College of Pharmacy reflected no increased risk to the Nebraska-- to Nebraskans as a result of the current pandemic waivers, and indicated overall support for allowing pharmacy technicians to continue to administer vaccines. Last session, when LB812 was before the committee, Chairman Arch and our members agreed that this should have a 407 review before passing any legislation. Since then, this has gone through the 407 review and the credentialing review committee. The committee met four times and recommended approval of the application submitted by the Nebraska Pharmacists Association. The application also received approval from the Board of Health. This application is still awaiting a recommendation from the Chief Medical Officer of the Division of Public Health. Pharmacy technicians have been distributing vaccines in a safe manner since the waiver period and have been integrated by pharmacists into their workflow for administration of vaccines. This would allow pharmacies to continue running just as they are. I just want to note again that sometimes pharmacies are the only healthcare facility that Nebraskans can get to, especially in rural areas. This is an important way to ensure that everyone across our state can access-- has access to immunizations. Thank you and I'd be happy to answer any questions.

HANSEN: Thank you, Senator Walz.

WALZ: Um-hum.

HANSEN: Is there any questions from the committee? Seeing none, we'll see at close, right?

WALZ: Sure.

HANSEN: OK. All right. So with that, we will take our first testifier in support of LB202. Welcome.

MARCIA MUETING: Good afternoon. My name is Marcia Mueting, M-a-r-c-i-a M-u-e-t-i-n-g. I am a pharmacist and I am the CEO of the Nebraska Pharmacists Association. My testimony includes many, many of the things that Senator Walz just covered so I'm going to, I'm going to do my best to summarize to avoid any repetitive information. Senator Hansen and members of the Health and Human Services Committee, last year we brought to you LB812. Committee requested a 407 review, which was completed last week. The credentialing review committee met four different times and unanimously voted in favor of our application. That application did receive the Board of Health's

full support and as Senator Walz mentioned, waiting for the Chief Medical Officer to sign off on that. As you know, pharmacy technicians are allowed to administer immunizations under the federal authority that's, that's in place right now during the public health emergency. Where we're, we're, we're a bit concerned is that right now the Feds are saying that the end of the public health emergency could occur as early as mid April. If we don't pass a bill, the pharmacy technicians that are, that are helping pharmacists with immunizations right now in Nebraska will no longer be able to do that. To date, 23 states in the United States have made changes within the scope of practice to include pharmacy technician administration of vaccines. And as you all know, in Nebraska, we already require pharmacy technicians to be registered before they can work at all in a pharmacy. And with one year-- within one year, they have to become certified. And then there's additional education required. I'm very fortunate to have a group of testifiers today who are going to talk about the education requirements. We've got a technician who's actually going to talk about her experience as an immunizing technician as well as others. So if you have any questions, I'm happy to answer those. Thanks for the opportunity to offer testimony.

HANSEN: All right. Thank you.

MARCIA MUETING: Um-hum.

HANSEN: Are there any questions from the committee? Yes, Senator Ballard.

BALLARD: Thank you, Mr.-- thank you, Mr. Chairman. Thank you for being here again. Good to see you.

MARCIA MUETING: Sure.

BALLARD: So in order to. Wrap my head around this, how, how many vaccines do pharmacies administer today currently?

MARCIA MUETING: Well, it depends. The answer is always It depends, right?

BALLARD: Of course.

MARCIA MUETING: Pharmacies in general before COVID were only allowed to administer immunizations that they could do so under an agreement with a prescriber, almost always a physician. And it was called a collaborative practice agreement or in Nebraska, we call it a

pharmaceutical care agreement. So this agreement says, I, Dr. So-and-so, allow these pharmacists to administer these vaccines to these people. Ages are dictated by the prescriber, which vaccines are dictated by the prescriber. I will tell you that we do have a pharmacist who has some data about which vaccines are most popularly given and I don't want to steal his thunder.

BALLARD: Thank you.

MARCIA MUETING: Sure.

HANSEN: Any other questions? Seeing none, thank you very much.

MARCIA MUETING: Thank you.

HANSEN: All right, we'll take our next testifier in support. Welcome.

JULIE WOLLBERG: Chairman Hansen and the members of the Health and Human Services Committee, my name is Julie Wollberg, J-u-l-i-e W-o-l-l-b-e-r-g. I am a certified pharmacy technician. I have been working as a certified, certified pharmacy technician in Nebraska since 1997. Currently, I am the Southeast Community College pharmacy technician program director, and I work part time as a senior certified pharmacy technician. I strongly support a change to the Pharmacy Practice Act allowing for vaccine administration by pharmacy technicians. This bill would give the pharmacist discretion to allow technicians to vaccinate. The pharmacist would be on site and ready to help, to respond to emergencies. Not every technician would be allowed to administer vaccinations, only those that have trained and demonstrated competency in administration of vaccines. I have invested my time to become a qualified vaccinating technician. I completed multiple hours of vaccination administration competent-- competency training, which included a hands-on skill check, vaccine storage and handling training, administration requirements, emergency response protocols, OSHA-approved bloodborne pathogen training, CPR and AED certification, as well as documentation and reporting. I have vaccinated hundreds of patients for COVID-19 and influenza without incident since January of 2021. Without a change to the Pharmacy Practice Act, I will no longer be able to provide this service to the patients I serve and this will significantly impact the workload put on the pharmacists. It will also diminish my ability to practice to the full extent of my training and education. Prior to the pandemic, 17 states had already changed their practice acts to allow for pharmacy technicians to administer vaccines and many more are following their lead. Allowing properly trained technicians to

continue to immunize will greatly improve public access to vaccines and reduce vaccine-preventable disease. It will reduce the need for public clinics and likely free up doctor's offices to treat patients for other conditions. It also significantly elevates the role technicians play in healthcare. With the current pharmacist staffing challenges in retail pharmacy, technician immuno-- immunizers have allowed pharmacists to focus on patient care and safety. My technician colleagues and I have demonstrated our ability and willingness to play a vital and direct role in the administration of vaccinations. The last two years have been a research project of sorts. The PREP Act allowed pharmacy technicians the ability to administer vaccinations in all 50 states. Thousands of qualified technicians have invested in the training to perform vaccinations. We redesigned our workflow to enable this task in practice, and the research has proven that the technicians can safely and efficiently administer vaccines. If we fail to change the law and allow for certified and technician-- trained technicians to vaccinate, we will squander this historic investment in public health. And how can anyone justify saying that we were qualified to safely administer immunizations throughout the pandemic, but we are no-- now no longer qualified? So I respectfully request that the committee advance LB202 in the full-- to the full Legislature. So thank you for the opportunity to comment. I'd be happy to answer any questions.

HANSEN: Thank you.

JULIE WOLLBERG: Um-hum.

HANSEN: Are there any questions? Yes, Senator Riepe.

RIEPE: First of all, I think it's a very good program, very good legislation. Thank you for bringing it forward. I don't want to slow things down because we have other work to do. I see that you're the program director.

JULIE WOLLBERG: Um-hum.

RIEPE: My question would be is demonstrating competency and what's the length of the program?

JULIE WOLLBERG: OK. So the program itself does not provide this training because it wasn't part of our prior-- I mean, prior to the pandemic, we weren't doing this. So we actually become certified and then we have to complete another immunization training program.

RIEPE: And it merits being certified? I mean, I just think it's more work--

JULIE WOLLBERG: So the program at--

RIEPE: --little more--

JULIE WOLLBERG: --Southeast will get you certified. So we-- it's like a school. You go two semesters. So it's a diploma program. Once you complete, you sit for a national certification exam and then you can complete a--

RIEPE: It wouldn't take a diploma, a two-year program, though, to train a--

JULIE WOLLBERG: No, a diploma is a one-year program.

RIEPE: Would it even take that long? Yeah, I come as an old Navy corpsman. You know, I mean, we gave shots probably two weeks after we were-- went through--

JULIE WOLLBERG: Yeah.

RIEPE: --corps school.

JULIE WOLLBERG: Yeah.

RIEPE: Now, maybe we were working on other sailors, so it didn't matter, but do you have internship programs or-- I mean, is there--

JULIE WOLLBERG: Yes, we do. Yes, we do.

RIEPE: OK.

JULIE WOLLBERG: So my students complete 225 hours--

RIEPE: Yeah.

JULIE WOLLBERG: --at two different types of pharmacy settings.

RIEPE: My only concern with this is it comes-- like many other healthcare areas, there becomes a doctorate in it. You know, then I have a problem with it, you know, that you have to have eight years of training and become a Ph.D. in it before you can do it. And I'm kind of going, I don't think so.

JULIE WOLLBERG: Well, and that's not a requirement. So the education portion is not a requirement to become a technician in the state of Nebraska.

RIEPE: Thank you, Mr. Chairman. Thank you. Thank you for being here.

HANSEN: Any other questions? All right, seeing none, thank you. We'll take our next one. Welcome.

TODD LARIMER: Chairman Hansen, members of committee, my name is Todd Larimer. It's T-o-d-d, last name, L-a-r-i-m-e-r. I am proud to be a licensed pharmacist for the last 35 years, 32 of those years in the state of Nebraska. I am currently the pharmacy manager for Wal-Mart Stores Inc. in Nebraska City, and I'm also a member of the Nebraska Board of Pharmacy, although I'm not here in that capacity as a board member today. In my day-to-day work, I rely on the support and expertise of pharmacy technicians in providing care and services to our community members. And I appreciate this opportunity to present testimony in favor of LB202, which would allow pharmacy technicians to administer vaccines to individuals three years of age and older. Community-based pharmacists and pharmacy technicians are vital members of the communities and bring significant value to the individuals they serve. The role of pharmacist is expanding, and pharmacists are in a unique position to provide a variety of clinical services intended to improve patient health outcomes. This can include not only delivering effective and tailored pharmaceutical care, counseling and education about medications, diet, health and wellness, but establishing meaningful personal connections and building positive relationships. Pharmacists are trusted healthcare professionals and the role-- as the role of pharmacist expands, we should be and could be the first stop for patients' healthcare journeys most frequently due to availability, affordability and geography. From both a policy and patient healthcare perspective, to reach the most vulnerable patient populations, pharmacists and pharmacy technicians must be able to practice to the full extent of their education and training. Expanding the role of pharmacy technicians to other activities that do not explicitly require professional judgment of a pharmacy such as vaccine administration will allow pharmacists more time to furnish direct patient care. This past fall, I personally saw an increased demand for influenza vaccine, probably a four-fold increase over 2021, and pharmacy technicians helped me meet that demand. Medicare D now is going to cover-- Medicare D as in drug plans-- are now going to cover shingles and tetanus shots for people on Medicare D plans. So the demand for vaccine services is not going to diminish and pharmacy technicians

can lessen the burden on pharmacists should this bill pass. With our increased capacity, pharmacies will be able to spend more time with community members providing the services I described above, including counseling, medication, therapy management and such. This creates the potential for better patient outcomes and supports broader health and wellness for the citizens of Nebraska. I am strongly supportive of LB202, which amends the Nebraska Pharmacy Practice Act to allow pharmacy technicians who are trained to vax-- back to-- are trained in vaccine administration and under the supervision of a pharmacist to administer vaccines to individuals three years and older. Passage of this bill will help maximize the use and value of pharmacy technicians without sacrificing patient safety. Modernizing the Pharmacy Practice Act by recognizing the essential role that pharmacy technicians have in caring for Nebraska population will facilitate an important step toward healthcare in the state of Nebraska. Chairman Hansen, members of committee, I appreciate your time. I urge you to support LB202.

HANSEN: Thank you. Are there any questions from the committee? Yes, Senator Hardin.

HARDIN: Yeah. I completely believe in letting decisions be made and problem solved at the lowest possible level. That way you can focus on the top 5 percent of the most difficult issues, which are probably the ones I come to you with as a consumer. But as you look across your experience, has there ever been a situation where someone who was certified had a problem or have you heard or read about problems across the country? And if so, is there any theme to those problems? Is there a problem with doing this?

TODD LARIMER: No, I-- you know, in my practice, I've never had one complaint. I don't know of any complaints that have ever been filed with the state as far as a technician providing an immunization. So I, I-- as far as a national scope, I know in Idaho, when they first-- they were the pilot program in the state of Idaho and they had pharmacy technicians immunizing and they do a lot more things there with their technicians than we do in the state of Nebraska. They had no complaints at all when they first started this years and years ago and it was a statewide program. So it can be done safely. They get-- technicians going through the same training basically the pharmacist do to provide immunizations. The-- at CPI training, they have to do a hands-on assessment. And then we-- in my practice, we had to observe them give a number of shots before we allowed them to basically fly solo. You know, go in and then be able to provide immunizations without us looking over their shoulder. So they do it very

effectively. It's a huge relief of a burden on my shoulders, especially on busy days. During the peak of the pandemic, to kind of circle back around the number of vaccines that were given, I know in 2021, we gave over 8,000 just COVID shots in 2021. This last year, between COVID and flu and some of the other expanded-- what we call expanded vaccines, which is tetanus, pneumonia, you know, things like that, we gave over 4,500 shots. So the demand is still there. When you think about the number of shots that we give a day, especially during the peak of things like the flu season when we have 30 and 40 shots, it's, it's imperative that we have all hands on deck that can help them in those situations. So I'm, I'm a very adamant supporter of this legislation and I think it's something that needs to, needs to take place.

HARDIN: And just as a follow-up, you're mentioning that the workload of flu vaccines are much higher than they have been in the last couple of years. Is that something that you sense will go down after this year? Is it kind of a rebound or pendulum swing here?

TODD LARIMER: I think it's going back to what we-- where we were at.

HARDIN: I see.

TODD LARIMER: You know, during the pandemic, I think everybody was more focused in on if I'm going to get a shot, I'm going to get a COVID shot. And then it became vaccine-- people got vaccine weary. You know, just-- you know, because we were getting shots and boosters and people also weren't getting as sick with the flu because we were masking. We were social distancing. You know, the spread was not there. This year, we're not doing those things. Flu was able to run its course as it normally has in the past. So I think we're going to get back to where we're going to be giving large number of flu vaccines yearly unless we go back to the situation where we are masking again, we are social distancing, we're limiting crowd sizes, and that will cut down on the spread.

HARDIN: Every year or every two years, is there a re-up on the certification or the training that they go through?

TODD LARIMER: Well, the-- you don't have to go through the training per se. You do have to get your CPR renewed every two years. You know, so that has to be current. As long as you're giving immunizations, I wouldn't-- there's no reason to continue to-- there's nothing to update, right? An immunization is an immunization.

HARDIN: So riding a bike.

TODD LARIMER: It's it-- once you do it, yeah, you don't forget it, so.

HARDIN: Thank you. Thank you, Mr. Chairman.

HANSEN: Yep. Yes, Senator Ballard.

BALLARD: Thank you, Mr. Chair. Just a brief question. So I know it's going to vary from pharmacy, from pharmacy to pharmacy, but how many technicians do you employ in your practice?

TODD LARIMER: So I have, I have currently three full-time and two part-time--

BALLARD: OK.

TODD LARIMER: --technicians.

BALLARD: Yeah, and you-- do you sense a workforce problem in this, in this sector, pharmacy technician?

TODD LARIMER: Oh, there's a huge workforce problem in pharmacy and in healthcare in general.

BALLARD: Of course.

TODD LARIMER: I mean, it-- we were having a conversation earlier about being able to try to find pharmacists. And it would be nice to have a pharmacist tree where you just go pick one off and we could plug it into our practice and, you know, and it would work that way. But it's very difficult to find people that want to be on the front lines. You know, it was-- people's-- the public's tolerance levels became very, very small during the pandemic. People were anxious, they were rude, demanding, and it put a big strain on people in the pharmacy profession, especially retail pharmacists. And there was some that got out of it. Some of them, you know, said we aren't doing this anymore. And so to answer your question, yeah, here's a big problem.

BALLARD: OK.

TODD LARIMER: I think this-- but you talk to pharmacy technicians who provide immunizations, their job, job satisfaction is higher than those that don't. They enjoy what they do and they enjoy taking care

of people. and it just gives them another layer of responsibility that they, they really invest in.

BALLARD: Thank you.

HANSEN: All right, any other questions? Seeing none, thank you. Welcome.

JUDITH NEVILLE: Good afternoon. My name is Judith Neville, J-u-d-i-t-h N-e-v-i-l-l-e. I'm an instructor for pharmacy technicians and pharmacy students at the University of Nebraska Medical Center College of Pharmacy. My testimony today is on my own behalf. It's not representative of the university. I am a Nebraska Pharmacists Association member and I sit on the NPA legislative committee. So last year, NPA brought LB812 to you and the PREP Act provided a pathway for Nebraska to rapidly create a new vaccination workforce of pharmacy technicians. In Nebraska today, we have pharmacy technicians providing vaccination services under the PREP Act and this valuable service should continue when that PREP Act expires. So as a director arranging the training and education for vaccination administration, I would just like to take this opportunity to tell you what that training entails. So now I'll stop reading and talk a little bit more of experience and from the heart. So our vaccination training, I want to assure you, includes a skilled demonstration. So the technicians who desire to vaccinate-- first of all, it's those who have a desire. They come to us and they have a didactic educational part of the theory behind the vaccinations. So that includes, you know, the storage and different aspects of the vaccination itself and then the actual practical demonstration of giving the vaccination. Vaccinations being administered by technicians is not something new in many states. And because of that, there are educational opportunities available for continuing education. So the technician will initially become certified to give vaccination and that can be something that happens rather quickly. In the course that we offer, it is a self-directed course and it happens as quickly as that technician goes through the didactic part and demonstrates their skill. And so then after that, there's continuing opportunity-- education opportunities kind of all over the place to then enhance the skills that they've learned. Thank you.

HANSEN: Thank you for your testimony. Are there any questions? I don't see any. Thank you. We'll take our next testifier in support.

DANIEL ROSENQUIST: Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Daniel-- Dr. Daniel

Rosenquist, D-a-n-i-e-l R-o-s-e-n-q-u-i-s-t. I'm a family medicine physician in Columbus and the current president of the Nebraska Medical Association. The NMA supports LB202, which would allow properly trained and supervised pharmacy technician, technicians to administer routine vaccines to individuals ages three and older. Our support for this proposal is consistent with our mission to advocate for high-quality medical care in Nebraska. Pharmacies and pharmacy technicians have played a critical role throughout-- in making essential vaccines readily available to Nebraska patients throughout the pandemic. Additionally, our physician members appreciate that this proposal will free up pharmacists' time to perform the important work that only a pharmacist can do, increasing the efficiency and the delivery of pharmacy services to Nebraska patients. As a family physician, I value the opportunity for my patients to get their vaccines wherever they can. It's very important as we increase the number of vaccines across the community, we can decrease the actual spread of all these various contagious diseases. The NMA has supported this proposal throughout the technical review committee policy-- process, while voicing concerns that vaccines must be timely reported to the Nebraska State Immunization Information Service, called NSIIS. And additionally, the NMA will continue to advocate for Nebraska children to routinely see their personal physicians for well-child exams and checkups. These concerns do not undermine our support for the proposal. Pharmacy technicians have been safely and effectively administering vaccines under the authority of the Public Readiness and Emergency Preparedness, PREP, Act since October of 2020. It makes sense to extend this authority through the state laws so Nebraska can continue to benefit from this efficiency beyond the COVID-19 public health emergency. Again, we, we support, as the Nebraska Medical Association, LB202. Thank you. Questions?

HANSEN: All right. Thank you, Doctor. Are there any questions from the committee? Yes, Senator Hardin.

HARDIN: Dr. Rosenquist, are there well-child visits and immunizations for kids under the age of three?

DANIEL ROSENQUIST: Yes.

HARDIN: And so would the techs not be able to administer those?

DANIEL ROSENQUIST: That's correct. Those would need to be done through the, through the pediatrician or the family physician or personal provider.

HARDIN: Thank you for the clarification.

DANIEL ROSENQUIST: And you're-- a question that you've answered-- asked before, have you seen complications from vaccinations? Yes, I have. I have seen complications of vaccines that have been given in our offices, other offices, in emergency rooms, in pharmacies and various locations. I think part of this is all about training. And we always look at those types of things. We have to identify infections, nerve injuries, complications, swelling, adverse reactions. But I think that's all part of the training and that's what we went through with a lot of the-- when we went through the technical review process to try and assure that this-- that people will be properly educated to know how to early identify and manage those and, and then access the proper level of care.

HARDIN: The younger the patient, the more they squirm, so.

DANIEL ROSENQUIST: Fifth-- kindergartners-- seventh graders are actually the worst. They're bigger. They move a lot more. They're stronger.

HARDIN: I think when they're in their fifties, they squirm more. Thank you.

HANSEN: All right. Any other questions?

DANIEL ROSENQUIST: Thank you.

HANSEN: All right, thank you. We'll take our next testifier in support. Hello.

LINA BOSTWICK: Good afternoon, Chairman/Senator Hansen and committee. Thanks for hearing testimony today. My name is Dr. Lina Bostwick and I am speaking on behalf of Nebraska Nurses Association in support of LB202. The Nebraska Nurses Association is the voice of more than 30,000 registered nurses in Nebraska.

HANSEN: Can I interrupt you for one second? Can you please spell your name for us?

LINA BOSTWICK: Oh, I'm sorry.

HANSEN: You're fine.

LINA BOSTWICK: Yes, it's L-i-n-a B-o-s-t-w-i-c-k. Thanks for the reminder.

HANSEN: Yep.

LINA BOSTWICK: NNA seeks to support the delivery of safe, cost-effective care of Nebraskans and we recognize the critical services that have been provided by pharmacy techs during the challenge with COVID-19 since 2020. I want to start by thanking the Human-- Health and Human Services Committee for hearing our concerns with LB812, the pharmacy technician bill last year, and referring this proposal change to the scope to the 407 credentialing review process. The credentialing review hearings provided a mechanism for all stakeholders to examine both the need and safety of the proposed changes. So the scope of activities for pharmacy-- the-- for the pharmacy technicians in Nebraska. Last year, we pointed out that pharmacy techs can provide vaccines if they are also on the medication aide registry. Nearly third-- 300 pharmacy techs have been-- done this option. This is a path still available to all pharmacy techs. There are many paths available in nursing for people to provide a wide array of nursing services. We also recognize that there can be alternate paths for a pharmacy tech to provide additional services such as vaccine administration. We look forward to working collaboratively with many providers to increase availability of safe vaccine administration in Nebraska. And in the spirit of collaboration, the NNA supports LB202 and encourages the committee to advance LB202 to General File.

HANSEN: Thank you.

LINA BOSTWICK: Yes. Any questions?

HANSEN: Yep, are there any questions from the committee? You're off the hook. I don't see any.

LINA BOSTWICK: OK. Thank you.

HANSEN: Yep, thank you for your testimony. We'll take our next testifier in support, please. Welcome.

RICH OTTO: Welcome. Good afternoon, Chairman Hansen, members of the Health and Human Services Committee. My name is Rich Otto, R-i-c-h O-t-t-o, testifying in support of LB202 on behalf of the Nebraska Retail Federation and the Nebraska Grocery Industry Association. Big thank you to Senator Walz for introducing this legislation. Just-- again, to go through the process, I know you've heard that this was introduced last year, LB812, Senator Hilkemann, which we appreciate. Again, the committee did encourage the 407 review process. That is

what you have in front of you that I've handed out to the page. That is the findings and recommendations of that 407 review. So we do appreciate that. We really appreciate the Nebraska Pharmacists Association taking the lead and getting a timely review done. That is credit to them. And we also appreciate the Medical and Nurses Association testimony in support of this as well. Nebraska pharmacies have been working harder than normal over the last several years to deliver vaccinations. Senator Ballard, I do have some high-level numbers as far as vaccinations administered in the pharmacy setting: 2021 was our highest number, 1.2 million. Over that 1.2, 17,664 is the number I have for vaccines administered in the pharmacy setting then. We still have a high demand. We are still more than 50 percent higher than pre COVID numbers above 2019. So we may not be at our peak of 2021, but we still have 50 percent more people wanting to come to the pharmacy than prior to the pandemic. We need LB202 to adequately meet this demand. There's several reasons why we believe that demand will stay high: public awareness, convenience of the pharmacy settings, labor shortages in other areas. I know from firsthand experience when my daughter turned five, I wanted her to at that point get the COVID vaccine. Her pediatrician was short staffed and encouraged us to go to the pharmacy or public health to get it from the county at that point. So there is need for all hands on deck to continue to give vaccinations. And again, we support the medical arena and their support of this bill. Thanks to pharmacy workers throughout the years. We appreciate it. Again, we believe LB202 will help increase immunization rates, reduce overall health costs, and save lives. We encourage the committee to advance this and I'm happy to answer any questions you may have.

HANSEN: Thank you for your testimony. Are there any questions from the committee? I have one question I just thought of. So if this passes, will, will that negatively affect anybody in the pharmacy tech world? Like, if they choose not to do vaccines or--

RICH OTTO: No.

HANSEN: --for some, for some reason?

RICH OTTO: Not to my knowledge, Senator. We have a need for more techs still. I think the labor market everywhere-- any industry could say, hey, we need more workers. Healthcare is-- definitely that's true of and those are essentials to the population. We need techs. Now, as the previous testifiers stated, techs don't have to get the training for immunizations. It's their choice. Do you want to be more engaged with customers? Get this additional training and then you can

provide these. My latest-- I got my COVID and flu shots in December at the same time. Pretty tough, both in one arm, and it was a tech that did that. She said that she really enjoys it and wants to be able to continue this. So we see it as, as something that they can choose to do, but we need as many techs as possible.

HANSEN: OK. All right. Thank you.

RICH OTTO: Yep.

HANSEN: All right, we'll take our next testifier in support.

JINA RAGLAND: Good afternoon, Chair Hansen and members of the Health and Human Services Committee. My name is Jina Ragland, J-i-n-a R-a-g-l-a-n-d. I'm here today testifying on behalf of AARP Nebraska in support of LB202. Many of the things in my testimony have already been noted today and so to save you time and, and agony of hearing it all over again, I'm just going to skip to a few notes. I do want to make sure on the record AARP was here in support last year on LB812 and we continued to be supportive through the 407 and now with the new bill of LB202. As our population age continues to rise and the needs of those aging rise, pharmacy technicians play a critical role in assisting to meet the ever-changing and growing needs surrounding our aging population. Allowing pharmacy technicians to continue with administering vaccinations makes sense and is the right thing to do, allowing all Nebraskans to-- better access to care and services, especially as it allows Nebraskans 50-plus to age in place in their communities and often assisting them in remaining in their homes and at the lowest level of care. Over 90 percent of Americans live within five miles of a community pharmacy. And more than any other segment of the pharmacy industry, independent community pharmacies are often located in underserved rural and urban areas, where a lot of our aging population also is located. These pharmacies are frequently the most accessible healthcare providers in many Nebraska communities and are vital in the provision of immunizations, testing and other services, especially to our older Nebraskans. With the proper training and pharmacist supervision, pharmacy technicians can participate in activities to support vaccinations such as information gathering, screening, promotion, marketing, record, record keeping, procurement and so forth. With that, I will again end my testimony again to save you the, the agony. But thank you for the opportunity to comment. Thank you to Senator Walz, of course, for introducing the legislation. We do ask that you support and advance the bill and I'd be happy to answer any questions.

HANSEN: Thank you. Are there any questions from the committee? Seeing none, thank you. Is there anybody else wishing to testify in support? All right, is there anybody wishing to testify in opposition? Welcome.

JEANNE GREISEN: Hi. My name is Jeanne Greisen. It's J-e-a-n-n-e G-r-e-i-s-e-n and I'm a pharmacist. And a background, I have been a pharmacist and I am licensed, at one point, in five states. I've practiced in Texas, Kansas, Nebraska, Minnesota, and California, which I have let California go because I was never going to move back there. And I maintain all my other licenses. And I've worked anywhere from retail to a community pharmacy to a compounding pharmacy and just worked in a 503(b) and created a whole-- their whole portfolio for sterile medications. And so I am here in opposition because of all my experience working in pharmacy. I've never worked in one that has not been crazy busy and I've done vaccinations in clinics in California, and it is not an easy thing to work into your whole processes. And to say that a pharmacist can supervise a technician filling medications and checking orders and then also going to supervise giving vaccinations is nothing short of a dream. So I think there's only going to be bad things that can happen. And in addition to that, I don't know why we are focusing more on having technicians be getting certified to give vaccinations when they should be getting certified to actually bring true health to the people in Nebraska, a la teaching them how to do lifestyle management, healthy eating so they don't need to get vaccination. Right now, I'm doing consultation as a pharmacist to actually help people that have been vaccine injured, whether it be from COVID or other vaccinations. But these people have been injured and they've had immediate results from injury right after that. So are we going to keep going down this line and putting more people giving vaccinations when really we should be focusing on something else? And part of that, too, is I don't think we're hunting for people to get vaccinations right now. The University of Nebraska was begging kids and enticing them to come get vaccinations. Clearly, there's enough people giving vaccinations right now. I don't think we need more people giving vaccinations. We need to be focusing on other health-related issues, how people can maybe live healthier and go to the pharmacy less. And then the question that needs to be answered is having technicians giving vaccines, are we really about people's health? Are we really about money? That's really the question. And then in addition, if we're really focused on helping pharmacists, which I'm not in that capacity now because I'm doing consultation-- consulting instead, if you really wanted to give pharmacy a break, how about you give

prescriptive authority to pharmacists? They really know about medications more than anyone. That would make more sense. So that's my testimony. Any questions?

HANSEN: All right. Thank you. Are there any questions from the committee? Yep, Senator Riepe.

RIEPE: I have a quick question. You talked about the-- an overdue influence of looking at are we looking at health or are we looking at money? I would ask you, do you consider access an issue?

JEANNE GREISEN: Is access an issue? No, I don't feel like access is an issue.

RIEPE: OK. OK. Thank you. No more.

HANSEN: Yes, Senator Hardin.

HARDIN: Do you have some sense in terms of how many people have been vax injured in Nebraska?

JEANNE GREISEN: Well, that would mean that we'd have good reporting, but people don't coincide with when they have had the injury to when they have the shot. Sometimes it's immediate, sometimes it's down the road, sometimes it's months later. And then because people aren't aware, they don't correlate it to what happened a month ago or two months ago. So they don't put that two and two together. And until somebody says, well, have you had anything? Have you had any vaccines here or there? They just think they got CMV just out of the blue. You don't just get CMV just out of the blue. So they don't know. And until you can correlate it, then you say, well, can you rule it out? We can't rule it out. We don't know. So is the reporting accurate? Maybe 10 percent, 1 percent gets reported to the VAERS reporting. We don't know because people haven't been trained well enough. Healthcare providers as well haven't been trained well enough to attribute it to a vaccine injury and that's where we are.

HARDIN: With COVID, have we created a culture of wanting vaccinations?

JEANNE GREISEN: Have we created a culture? Absolutely. Have we just brainwashed people to say, yes, just give me a shot? Yes. But why are we not talking about how can you have a healthy lifestyle? What are you eating? Are you eating toxic medications? Are you poisoning yourself? So have we created that culture? 100 percent.

HARDIN: Thank you.

JEANNE GREISEN: Yeah.

HANSEN: All right, thank you. Are there any others wishing to testify in opposition? All right, is there anybody wishing to testify in the neutral capacity.

GUS PONSTINGL: I'm going to be in opposition.

HANSEN: We'll-- OK, we'll go back to opposition.

GUS PONSTINGL: I didn't have a pen so I didn't fill this out, but I will announce in a second. My name is Gus Ponstingl, G-u-s P-o-n-s-t-i-n-g-l. I'm here to state my opposition to this bill. I had an opportunity to call all your staff over the last couple of days and ask a lot of questions about knowledge about vaccines and the effects of vaccines. And frankly, very few of your staff understand what goes on in the vaccination process. I-- and I called Jennifer's staff and I asked them quite a few questions and they don't even know what the VAERS system is, which is really-- it's an amazing thing. That somebody would introduce a bill and not even understand the basis of reporting vaccine injuries, I find that to be a shocking, surprising side effect or-- I think it's really, just really surprising that they wouldn't know what would happen or what, what would be a critical process-- part of the vaccine process is that you can get injured. As the previous person was testifying, there are many different types of injuries. Are you guys aware of the various types of injuries that occur as a result of being vaccinated? It isn't just the ouch in the arm, by the way. That vaccine-- all vaccines, by the way, not just the COVID vaccine, which is not truly-- the COVID vaccine is, is a little bit special because they develop something called mRNA technology, which is different than the previous vaccines. And it essentially isn't truly a vaccine. But the vaccines in general, the ones they are talking about, whether it's measles, mumps, rubella, chickenpox, all these things, they all have side effects-- or not side effects. They all can have damage to your, to your body indirectly, long term, short term. And those, those, those injuries should be reported to the VAERS vaccine system. Once they're reported and then they go in the database. As she said, very few people are aware-- even doctors aren't aware of all the-- often what to do in the event of a vaccine injury. So just to be, just to be clear, that has got to be one of the most important things that go on in this process is making sure that vaccine injuries are reported correctly and that they're, they're kept track of. Second, the, the

other thing that I was going to say-- sorry, my mind's going blank. I feel like there's a, there's a big risk with letting people that don't have medical training to prepare people correctly or screen people correctly before they get vaccinated and going in and giving them a vaccine without fully screening them for all the potential risks they have with having an injury. I'm going to tell you a little bit of my-- a little story. I was calling a pharmacist here in Lincoln and asking their techs-- I got two of them on the line-- and I went through the process of just figuring out whether or not they understood what would happen in the process of getting a vaccine and I was injured. So I first asked them, are there any risks associated with getting vaccinated? And all of them were like, well, I don't know, maybe. There could be. They had no idea what potential risks were there. And so then subsequently I asked them, well, here's some known risk. And I, I was really talking about the COVID vaccine, which are risks such as myocarditis or strokes or other things. And they were, like, well, you know, you know, it's possible, but I really haven't heard. So they weren't aware of any of the, the known-- or these, these risks that are coming out. And then third, I was like, well, do you know that there's no liability? Like, I can't get compensated if I'm damaged during the vaccine process? And they're like, yeah, I don't know. It's on you, buddy. You know? So my problem is that there's no liability for pharmacist-- for these, for these vaccinations either from the pharmacist, from the tech or from the doctor. And the liability, the medical liability is on the individual. They've been screened or shielded from having any liability and that's a big deal, too. So I feel like it's a huge risk that people aren't talking about. There's a lot of vaccine injuries that are possible and that ultimately they should not-- this, this should be restricted and not allowed to be administered by a lot more people. I think the, the industry is preparing for a lot more vaccinations coming, a lot more mRNA-type vaccinations coming. Even yesterday, a Pfizer executive was admitted to doing a, an evolution process to the COVID virus in their, in their labs right now. So this is, this is something that I think is coming out that people aren't aware of. But the, the industry itself is ramping up for more and more vaccines. They want to make it easier and easier for people to get access to these vaccines and the opposite should be happening. We should, we should make vaccines more thoroughly studied. The, the, the damages should be more sterilized-- thoroughly studied. People should have longer-term studies. I think we should put together a committee to study the results of the COVID vaccine, which I think we're going to find that the people that are dying suddenly is probably a result of the COVID vaccine, especially the myocarditis.

When that mRNA lipid protein gets injected in the bloodstream, it hits the heart, it hits the other-- anyway, there's my time. But I think there's a lot of problems that are intrinsic to vaccinations and they're not being fully explored.

HANSEN: Thank you for your testimony. Are there any questions from the committee? All right, seeing none, thank you.

GUS PONSTINGL: Thank you.

HANSEN: Is there anybody else wishing to testify in opposition? All right, is there anybody wishing to testify in the neutral capacity? Seeing none, Senator Walz, you're welcome to close.

WALZ: All right. I'll make it short and sweet. Well, thank you for-- to everybody who came to testify today and thank you, committee members, for taking the time to listen today. I just want to close out this hearing with a couple more notes. Just to remind you that, one, I'd like to note one more time that this did go through the 407 review process and was approved, and was approved by the Nebraska Board of Health. Secondly, this bill will seriously help a lot of communities in our state and ensure that we're distributing vaccinations in a safe, supervised manner. And finally, pharmacy technicians would still be under the supervision of a pharmacist and will have training in basic life support skills. So thank you again for taking the time to listen. I hope that we can all work together to get this bill across the finish line and with that, I'd be happy to answer any last questions.

HANSEN: Thank you. Are there any questions from the committee? All right, seeing none.

WALZ: Thank you.

HANSEN: Thank you very much. All right. And that will close our hearing for LB202. With that, we'll welcome Senator Fredrickson and open on LB123. Welcome, Senator Fredrickson.

FREDRICKSON: Thank you so much.

HANSEN: You're welcome to open.

FREDRICKSON: Good afternoon. Thank you, Chair Hansen and members of the Health and Human Services Committee. For the record, I'm John Fredrickson, J-o-h-n F-r-e-d-r-i-c-k-s-o-n. I represent District 20, which is in central-west Omaha. I'm happy to be here today to

introduce LB123, which fulfills the recommendations of the Chief Medical Officer and the Nebraska State Board of Health to create an application process for applied behavior analysts to become licensed in the state of Nebraska. I have handed out both the report of the Chief Medical Officer and the Nebraska State Board of Health. And you can see that the proposal to license behavior analysts went through the 407 credentialing review process without opposition. Under LB123, minimum standards for licensure are to be decided by the Board of Behavior Analysts. This will allow for verification of professional, safe treatment for those in need and cause the board to adopt a code of conduct based on the ethics code for behavior analysts to uphold professional integrity. The bill also creates a provision for behavior analysts licensed in other states to apply for a temporary license to practice within the state of Nebraska until the licensure is approved by the board. As the Chief Medical Officer stated in his recommendation, the licensing of behavior analysts meets all the four criteria of the credentialing review program. He said that evidence of harm provided by parents of children who need these services shows that there is a need for the state reg, state regulation of these services and that the public cannot be protected by a more effective alternative than licensure for ABA professionals. Thirty-six other states now license behavior analysts. Of our neighboring states, Colorado is the only one that does not currently license. So this also becomes a workforce issue, as behavior analysts may receive education here in behavior analysis and then go to neighboring states to practice, which provide licensure. Behavior analysts provide important services to children, including those on the autism spectrum. The practice of behavior analysis includes the empirical identification of functional relations between behavior and environmental factors known as functional assessment. The practice does not include diagnosis, psychological testing, psychotherapy, cognitive therapy, psychoanalysis, or counseling. Here to testify today are behavioral analysts who can shed light on their profession and the need to ensure quality services in the state of Nebraska. We were also hoping to have some parents scheduled to testify, including, Senator Cavanaugh, one of your friends, Georgia. However, unfortunately, due to an ill child, she was unable to be here to support, but has submitted a letter online. I ask that you advance LB123 from the Health and Human Services Committee and I'm happy to answer any questions you may have or refer them to the experts behind me. Thank you.

HANSEN: All right. Thank you, Senator. Are there any questions from the committee? Yes, Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Senator Fredrickson. And thanks for the shout out to Georgia. I hope that Joy is doing well and that they're watching at home. And, and she-- I actually have their letters pulled up here. So I just appreciate that you're bringing this letter on behalf of some of these really critical needs for families. So thank you.

HANSEN: Any other questions? I have one question.

FREDRICKSON: Sure.

HANSEN: And maybe you can answer it. You, you look like an expert, though, on this, so. Or maybe somebody behind you. If this bill is passed--

FREDRICKSON: Um-hum.

HANSEN: --is there somebody right now practicing something similar to this in maybe a lower capacity that might be negatively affected? So then, since they are not credentialed or they're not licensed now, would they not be able to practice anymore or help people in similar capacity? Do you know?

FREDRICKSON: That's a good question. I might need to defer that to one of the testifiers behind me in the field. I do know that there's obviously different stages for behavior analysts. And someone's here to testify around the educational component of that and sort of the different levels towards licensure. So this is not going to be the appropriate term for them, but almost like a junior behavior analysis or an apprentice, so to speak. There is a process in place for, for that training to, to be credentialed, but that's--

HANSEN: Sure.

FREDRICKSON: Yeah.

HANSEN: It's like it's-- similarly, we, we hear-- like, when art therapy wants to get licensed--

FREDRICKSON: Um-hum.

HANSEN: --and art people-- it's kind of convoluted. They're practicing art therapy, but they're not art therapists. But then they couldn't practice anymore if we passed that bill so--

FREDRICKSON: Sure.

HANSEN: --I just didn't know if it was kind of a similar situation with this as well. So just maybe behind you can answer too, so. Thank you very much. All right. Yes, Senator Riepe.

RIEPE: Thank you for being here.

FREDRICKSON: Yeah.

RIEPE: Thanks for your commitment to the mental wellness of all of us, I guess. My question gets to be with the board certification. Is that, is that written and orals or how-- what, what-- how-- what's that process? How rigorous is it?

FREDRICKSON: So one of the testifiers will be able to speak to this in detail, but there is an educational component to it. There is an exam that needs to be sat for to be, to be licensed, certified and it also involves supervised training experience as well.

RIEPE: Is there then a requirement for educational credent-- a certain number of credit hours every year or two years for continuing education?

FREDRICKSON: Like a continuing education? That's a good question. I will defer that to one of the experts behind me--

RIEPE: OK.

FREDRICKSON: --on, on what that's proposed for licensure, yeah.

RIEPE: Thank you for being here.

HANSEN: All right. Any other questions? Are you staying to close?

FREDRICKSON: I will be here to close.

HANSEN: All right. Good deal. See you then. All right, so with that, we will take our first testifier in support of LB123. Welcome.

DESIREE DAWSON: Thank you. Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Desiree Dawson, D-e-s-i-r-e-e D-a-w-s-o-n. I'm here today in support of LB123 and will be speaking to the state's need for this legislation. I'm speaking about facts and information that I have compiled during my own time and I represent my own thoughts. I hold a national credential as a board-certified behavior analyst, or BCBA, and I provide and supervise applied behavior analysis, or ABA therapy

for children diagnosed with autism spectrum disorder. The Behavior Analyst Certification Board, which is our national certification board, only holds jurisdiction over providers that hold their voluntary credential. As it currently stands, the practice of ABA in Nebraska is unregulated. Any person without the appropriate education, training and oversight can practice ABA in Nebraska without clear repercussions for harm that is done to consumers who are largely of vulnerable populations. The profession deliberately attempts to change another person's behavior. Think about how powerful that is and think about the harm that's possible when those therapeutic, therapeutic approaches are not properly applied at the hands of someone not upheld to the standards of code of ethics for practice. That harm is currently happening in Nebraska. The first state adopted licensing laws for behavior analysts in 2009 and to date, there are 36 states with licensing laws. State-specific information is on page 3 of the handouts I've provided. Every state that surrounds Nebraska, with the exception of Colorado, currently licenses behavior analysts. This makes Nebraska prime real estate for people who cannot legally practice in surrounding states. We know of people practicing in Nebraska while not physically in the state. We know of families not able to verify the credential of their provider. The number of known independent clinics and practices in Nebraska has increased 150 percent in the last three years alone. Information for this is found on page 4 and 5 of your handouts. So proper systems are needed to ensure that providers are qualified. If you look at the graph on page 6 of your supporting documentation, you'll see a green data path that shows the increasing trend. This represents the number of BCBAs in Nebraska. There are around 200. Now, if you look at the national trends on page 7, there are roughly 60,000 BCBAs nationally with no indication of this trend slowing down. So now why doesn't Nebraska's growth trend more closely reflect that of the nation as a whole? We believe that without licensure in Nebraska, practitioners trained in Nebraska are leaving to practice in states with more secure practice oversights. This directly impacts consumers, it decreases the workforce, and it does not address the state's needs. Speaking in state-- of state need, the heatmap shown on page 8 depicts the number of job postings per state seeking a behavior analyst in 2020 on the top portion of that graph, 2021 on the bottom. And I'll draw your attention to Nebraska. In one year, we experienced a 42 percent increase in job postings and the number of postings in 2021 exceeded the number of current behavior analysts in the state. So the need is clear. Adoption of this bill will also address ongoing-- an ongoing mental health crisis. Eighty-eight of 93 counties are currently designated as mental health shortages, and the

Medicaid waiver to receive ABA therapy is-- states and I quote, unlicensed practitioners of applied behavior analysis must practice under the supervision of a licensed clinician. Clinical supervisors must be either licensed psychologists, provisionally licensed psychologists, or licensed independent mental health practitioners. By licensing behavior analysts who are trained as independent practitioners, this increases the workforce who is able to address behavioral health needs and frees up the resources for mental health professionals to address the mental health crisis of the state. I want to thank you for your time and hearing my testimony and I'm happy to answer any questions today.

HANSEN: All right. Are there any questions from the committee? Yes, Senator Riepe,

RIEPE: Thank you. Thank you for being here. One of the questions I have is, is what's the impact of access to this particular kind of therapy outside of Omaha and Lincoln? I think one of our challenges as a committee is always to look at just because it works in the urban market doesn't necessarily mean it works out in western Nebraska. And do we make it more difficult then for them to access the kind of care that they need?

DESIREE DAWSON: It's a great question. Currently, to address those rural needs, what we're seeing is there are clinics popping up out-- more further west. But with the need being that the practitioner is not there, they're seeking telehealth or consulting or having technicians locally go into those homes while the providers making the calls for those therapy aren't even in the state. And we believe if the therapy is happening in Nebraska, the people overseeing that therapy need to be licensed in this state.

RIEPE: OK. Would you have any provision for grandfathering-- I don't know. You're young so I don't know whether that's a term that's familiar with you-- of current practitioners so that you don't just simply drive them out of the marketplace because they choose not to become board certified or--

DESIREE DAWSON: So what we're proposing with our bill is that the credential and the requirements to become board certified also be the criteria to become licensed. So if someone has met the education, the training and passed the national certification exam to be practicing with vulnerable populations, that is what we are basing the basis of this on. So we see it as if they're already practicing, it's not going to impact it. But what it will do is weed out people who are

not adequately trained to be addressing the needs of people of vulnerable populations.

RIEPE: But it sounded to me like if they are currently practicing, they're still going to have to pass the exam to become licensed.

DESIREE DAWSON: There, there's a national exam to become credential that is required to practice independently.

RIEPE: OK. So it wouldn't put them out of business is where I'm going.

DESIREE DAWSON: No.

RIEPE: OK.

DESIREE DAWSON: No, if anything, in my personal practice, I have to be overseen by a licensed psychologist-- a provision-licensed psychologist or independent mental health practitioner so I can see patients with Medicaid. And when there's not many practitioners in the state to address let alone the mental health need of things, if I was not working where I work, I would not have access to that person and I would just not be able to see Medicaid patients. It increases years that they would be waiting for services.

RIEPE: OK. Thank you.

HANSEN: Any other questions? Yes, Senator Hardin.

HARDIN: Thanks for being here. How are ABA therapists getting paid now in Nebraska?

DESIREE DAWSON: Currently through insurance, mostly. There are-- there's also the option for private pay.

HARDIN: So they're not trained and yet an insurance carrier will write them a check.

DESIREE DAWSON: That is what we are seeing.

HARDIN: Where can I sign up? Thank you.

HANSEN: Are there any other questions? I have a couple.

DESIREE DAWSON: Um-hum.

HANSEN: I'm reading Dr. Anthone's report here. And there was a concern that-- some mental health professionals with concerns about the ABA proposal have stated that licensing ABAs could complicate relationships with other mental health professionals pertinent to such things as the provision of comprehensive mental health evaluation and diagnoses. For example, since many ABAs are not qualified to render comprehensive mental health evaluations or diagnose other patients, he says this might be something that might need to be addressed.

DESIREE DAWSON: So within the training and the scope of practice for behavior analysts, there is no mental health education piece of it, It is strictly behavioral. So we, we are referring mental health concerns to the mental health providers.

HANSEN: Is that something that's in the bill currently? Do you know? OK. All right. Somebody's shaking their head yes behind you. OK and I think I saw something in the memorandum here that-- what is a behavior technician?

DESIREE DAWSON: A behavior technician is the technician level that is providing most of the one-on-one direct therapy. When children are prescribed ABA therapy, it's usually a high dosage of hours, usually anywhere-- 15, in extreme cases, 40 hours a week. One provider cannot meet that need for several kids. So technicians are working direct with the kids while the behavior analyst is designing, implementing the program,--or designing the program and then directly overseeing each technician as they're working with kids and making modifications to therapy as they see needed.

HANSEN: OK. So behavior technician is not ABA?

DESIREE DAWSON: No, no.

HANSEN: And they-- if this passes, that won't affect what they do.

DESIREE DAWSON: No, they would require that-- it wouldn't, it wouldn't change their scope of role. They-- it just means that for them to be providing ABA therapy, they would need direct supervision from a licensed behavior analyst.

HANSEN: OK. So they would be like an ABA's-- I don't want to say subordinate, but you mean their, their--

DESIREE DAWSON: Yes.

HANSEN: --associate, I guess, right?

DESIREE DAWSON: Yes. They're called registered behavior technicians through our certification board.

HANSEN: OK.

DESIREE DAWSON: And they are registered nationally to be providing those services.

HANSEN: How many technicians can an ABA oversee at one time?

DESIREE DAWSON: It really depends on their-- the, the caseload and the number of hours that BCBA wants to work. The national standard is 5 percent of all hours the client is receiving services must be directly supervised by the board-certified behavior analyst. Most insurance companies like to see closer to 10 percent, though.

HANSEN: OK. Because I know sometimes it's pretty typical to put when we start talking about credentialing and licensing, like, how many PAs can one doctor see, right?

DESIREE DAWSON: Um-hum.

HANSEN: Do you know if that's in the bill at all?

DESIREE DAWSON: I know it's-- it-- we, we do have some--

HANSEN: Or somewhere in statute?

DESIREE DAWSON: We're open to the amendments of it and specifying that. I mean, it really depends on the technician. If we have a part-time technician working ten hours a week, 5 percent of those ten hours need to be supervised. If there's a technician working 40 hours a week, at least 5 percent of those hours need to be supervised. So it depends on the number of hours, not necessarily number of technicians. And as long as those supervision requirements, requirements are met within for each behavior analyst, then it's considered good oversight.

HANSEN: OK. I didn't know if, like, a, an ABA could then open a store-- I don't know, a clinic with, like, ten technicians and they just kind of hang out and oversee each one and they make plans--

DESIREE DAWSON: They can if they meet those supervision standards.

HANSEN: OK. All right. Something else. Sorry, almost done. You said that there is currently harm being done in Nebraska without this bill. Do you have any examples of that?

DESIREE DAWSON: Yes. We did have parents submit online testimony who unfortunately were not able to be here today because of the extensive need of their children. Not just anyone can fill in with their child for childcare, which I think speaks to why we need quality people providing services for children of these populations.

HANSEN: OK. And in your opinion, if we do start credentialing or licensing this profession, would you see-- would you expect the incidence of that harm going down or staying the same?

DESIREE DAWSON: I would anticipate it to decrease because there's a clear avenue for reporting those concerns. Right now, parents are left to try to figure out what to do and without a clear avenue for reporting the harm that is happening, it's not being reported. And what's happening instead is parents are forming support groups and then talking about it with each other, which is how I got in contact with most of the families.

HANSEN: OK. All right. And one more question. So I think from your testimony, it seems like you're saying that there is a need for more ABAs in Nebraska.

DESIREE DAWSON: Yes.

HANSEN: And because of an increase in mental healthcare in Nebraska. Why do you think there is an increase or a need for more ABAs in Nebraska?

DESIREE DAWSON: The-- currently, the waitlists for services are extensively long. I know children waiting upwards eight to ten years for services and by that time, they no longer qualify for early intervention. And for what's available in the state right now, the services past that are emerging but still minuscule. So it is an access to early-- the earlier that these children are accessing these interventions, the better long-term trajectory, life span quality is for these children.

HANSEN: OK. Awesome. I appreciate your profession, by the way, and your approach that you do more through therapy first and then pharmacological approach maybe next. Yeah, I mean, so I always appreciate that approach that you do. So thank you for being here and

your testimony. Are there any other questions from the committee? Yes, Senator Hardin.

HARDIN: In terms of those who benefit in addition to the autistic spectrum, who else may benefit from ABA therapy?

DESIREE DAWSON: There's a wide variety of practitioners that practice across several different populations, others being behavioral geriatrics and working with elderly populations. There are behavioral ones that work with traumatic brain injury, rehabilitation, smoking cessation and habitual drug use decrease-- decreasing. There are some within sports medicine and performance and I mean, really there's an extensive list that people will specify-- that people specialize in. But again, that is not within the scope of practice. That's within the-- each provider's scope of competence. So they do receive additional training to specialize in specific populations. So really, anyone seeking behavior analytic care would benefit from passing of this bill.

HARDIN: Thank you.

HANSEN: Yes, Senator Walz.

WALZ: Thank you. OK. I just have a question about the behavior tech. I'm trying to wrap my head around where they, where they work. Is this a person who-- would it include a staff person who works for maybe an agency that serves people with developmental disabilities in a residential day service setting? Would it include-- could a behavior tech work in a school setting? Can you just kind of give me an idea of how the behavior techs-- where they are and--

DESIREE DAWSON: Yeah.

WALZ: --how they work?

DESIREE DAWSON: By and large, most are within a clinical setting or within a home-therapeutic setting. So they are doing most of the hands-on work with the children, implementing the programming that's been designed by the board-certified behavior analyst. And they are to be receiving ongoing supervision of the programs that they are implementing to ensure that any changes that need to happen are happening quickly and to the benefit of the clients.

WALZ: OK. All right. Thank you.

HANSEN: Are there any other questions from the committee? All right, seeing none, thank you very much for your help.

DESIREE DAWSON: Thank you.

HANSEN: Appreciate it. Is there anybody else wishing to testify in support of LB123? Welcome.

MARK SHRIVER: Hi. Good afternoon. Thank you, Senator Hansen and members of the committee for having us present to take the time to hear about the proposed Behavior Analysis Act [SIC]. I am Dr. Mark Shriver, M-a-r-k S-h-r-i-v-e-r, and I am a professor of psychology at the Munroe-Meyer Institute with the University of Nebraska Medical Center. I am the director of the master of science in applied behavior analysis graduate program, which is jointly administered between the University of Nebraska-Omaha and University of Nebraska Medical Center. I am a licensed psychologist and a board-certified behavior analyst, often referred to as a BCBA. My comments here are solely my own personal position on this issue and not reflective of the position of the University of Nebraska Medical Center or University of Nebraska-Omaha. My statement today seeks to provide a brief description of our program and the subsequent qualifications of our graduates to provide behavior analysis services in Nebraska. Our program is the only graduate degree program in Nebraska leading to board certification in behavior analysis. But we are one of hundreds of similar graduate degree programs in behavior analysis across the U.S. and internationally. Our program aligns with requirements outlined by the Association of Behavior Analysis International [SIC] for verified course sequence. Recognition as a verified course sequence combined with supervised fieldwork hours allows our students to sit for the national examination for BCBA, which is administered by the nationally accredited Behavior Analyst Certification Board. Our program is two years in duration for full-time students. Students currently complete a total of 48 to 51 credit hours with the number of courses and credits to increase in the next couple of years to meet requirements for accreditation by the Association for Behavior Analysis International. All students take courses which cover content in the principles of learning, philosophical and conceptual foundations of a science behavior, behavior analytic assessment and treatments, and the application of behavior analysis in educational settings, clinical settings and schools and with the treatment of individuals with autism. Students have courses in research methods, ethical practice and law. Our students take courses in developmental psychology and the foundations of assessment. They complete a thesis or research-other-than-thesis project and must pass a comprehensive

examination Throughout their time in the program, students are engaged in an intensive, supervised fieldwork experience ranging from 1$,500 to $2,000. Within our program, the students select one of three primary tracks: intensive clinical services, clinical outpatient behavioral health, or school-based services. Students may also receive experience in another track, such as a community agency or organization providing behavioral analytic services in the area. All supervised fieldwork experiences include training in effectively collaborating with multiple other disciplines such as psychology, medicine, educators, speech-language therapists, occupational and physical therapist, and others. Similar-- similarly, training includes understanding the scope of practice of the profession, the scope of-- and scope of competence for the individual practitioner, and recognizing when and who to refer to as needed. These topics are also covered in their coursework. After graduating, students must pass the national examination to receive the BCBA credential. On average, we have about eight graduates a year. Upon graduations, our students are highly sought after with all students obtaining employment immediately upon graduation. Our graduates are working in community agencies, providing ABA services for individuals with autism and related disorders, clinics that serve individuals with severe behaviors such as harmful self-injury and physical aggression. Clinics that serve children with significant feeding disorders and in school systems. Most of our graduates remain in Nebraska, but several leave every year to go to other states that have licensure and allow for the independent practice of behavior analysis. This practice act and the behavior analyst licensure is important to allow for the independent practice of behavior analysts and to provide for the regulation of that practice. Most important, this act and licensure are needed to protect individuals receiving treatments. As more companies come into the state to develop clinics to meet the demand for services, it's imperative that consumers have a means, means to report problematic or unethical behavior. In summary, I hope it is evident that behavior analysts are trained consistent with the criteria for coursework in supervised field training that's outlined by our national professional organizations and boards, and they're well qualified to meet much-needed behavioral health services in Nebraska. This bill allows for state-level licensure and oversight that will help regulate the practice of behavior analysis in Nebraska and protect those receiving services. I encourage you to approve its passage. Thank you.

HANSEN: Thank you. Are there any questions from the committee? Senator Riepe.

RIEPE: I have a quick question. I think it's quick. Do you have students that are in essence lined up? I mean, is there a significant number of students that want to go through this process?

MARK SHRIVER: Yeah, we currently have about 25 to 30 applicants each year. We actually don't market heavily because we, we can't handle any more in terms of capacity right now. We, we probably admit 10 to 12 per year and then eight are on average graduating each year.

RIEPE: I know with the labor shortage and everything, I was just curious.

MARK SHRIVER: Yes.

RIEPE: OK. Thank you.

MARK SHRIVER: Yeah. And to--

RIEPE: Thanks for being here.

MARK SHRIVER: And to your question, by the way, related-- earlier to the western half of Nebraska, the Behavioral Health Education Center of Nebraska recently awarded a grant to one of our faculty to develop an autism care for toddlers clinic in Fremont in the western part of the state because there's such a huge need out there.

RIEPE: Fremont is in the western part of the state?

MARK SHRIVER: Well, we're trying-- we're moving, we're moving step by step out there, yes.

RIEPE: OK.

MARK SHRIVER: It's to meet those needs out there because there is a greater need out there and that relies on behavior analysts, that particular clinic.

RIEPE: OK. Thank you.

DAY: It is for some of us.

HANSEN: Any other questions?

BALLARD: I have a question.

HANSEN: Yes, Senator Ballard.

BALLARD: Thank you, Mr. Chairman. Can you kind of outline what kind of questions are on this national certification exam?

MARK SHRIVER: They are questions related to the practice of behavior analysis. They actually cover a lot of the content that we talk about related to the assessment and treatment of individuals, you know, across the board in different contexts with significant types of behavior issues.

BALLARD: OK. Thank you.

HANSEN: I might just have one or two questions. So you say it's a two-year program.

MARK SHRIVER: Full time-- for a full-time student.

HANSEN: OK. On top of-- so is it on top of a bachelor's degree or is it, like-- just like, like an associate's?

MARK SHRIVER: It's a master's degree.

HANSEN: That's-- OK, that's what I thought.

MARK SHRIVER: Yeah, yeah.

HANSEN: OK, I just wanted to make sure I was reading it right because it didn't sound--

MARK SHRIVER: Yeah, it's a master of science degree.

HANSEN: And I don't think we touched on it. How about a behavior technician? What's their training?

MARK SHRIVER: Yeah, that's a, that's a good question. I know those were coming up before. So a board-certified assistant behavior analyst are bachelor's-level individuals. They receive training that's very similar to some of what I described, but at a bachelor's level. So there's-- they have six to seven courses and the number of field work hours, I'm not sure what that is. We're actually developing a train-- a program right now at UNO for that purpose because there's a need for assistant behavior analysts out there to help work with children as well. So we've got the coursework in place. We're working on the fieldwork requirements currently. In fact, I just had a meeting yesterday about that.

HANSEN: OK. All right, well, thank you for your testimony. Appreciate it.

MARK SHRIVER: Thank you.

HANSEN: All right, we'll take our next testifier in support. Welcome.

BETHANY HANSEN: Thank you. My name is Dr. Bethany Hansen, B-e-t-h-a-n-y H-a-n-s-e-n, and I want to thank you for your time and willingness to hear my comments in favor of licensing behavior analysts in Nebraska. My statement does reflect my personal position on this issue and does not reflect the position of the University of Nebraska Medical Center. I'm a licensed psychologist and doctoral-level behavior analyst in the department of pediatric feeding at the Munroe-Meyer Institute. And I would like to convey to the committee that there is a specific role for behavior analysts in providing behavioral health services, with one example being in pediatric feeding. I'm fortunate enough to work with a diverse population of children that all exhibit feeding disorders. Feeding disorders are common in the pediatric population, with the prevalence of 25 percent in the general population and up to 80 percent of children with developmental disabilities. A feeding disorder impacts the daily lives of children and their families and has long-term implications with negative consequences associated with severe feeding problems, including the inability to develop proper motor--oral motor skills, failure to gain weight properly and nutritional deficiencies. Inadequate intake of calories, nutrition or both is associated with attentional and learning difficulties and increases the child's long-term risk of behavior and health problems, which can include failure to thrive, diabetes and heart disease. Severe feeding problems also contribute to caregiver and family and stress and are associated with maternal depression. Children with feeding problems may have difficulty participating in age and developmentally appropriate activities, such as going to birthday parties or to a friend's or to a family member's house. And it limits their ability to participate in typical activities such as going to birthday parties or going to a restaurant. And there's a significant need for services for this population. Access to trained clinicians that specialize in severe pediatric feeding disorders is very limited. Etiologies of feeding disorders are quite unique and complex, but they typically involve medical, physiological, oral motor or behavioral factors. And many children that we work with are dependent on feeding tubes or formula. Others consume foods orally, but they're limited variety results in malnutrition. It's not uncommon for us to work with a child that consumes only one food. Some children are

diagnosed with autism spectrum disorder or other developmental disabilities, but other children have a history of genetic disorders or complex medical issues such as severe allergies, gastroenterology issues, cancer or organ transplants. Given the complexity of treating a feeding disorder that requires a special team of trained specialists of various disciplines such as speech-language pathologists, registered dietitians, gastroenterologists, allergists, psychologists and behavior analysts, a licensed psychologist and behavior analyst with backgrounds in behavior management is crucial to the team. As a clinician who holds both credentials, I can understand and speak to the unique training and background that each receive. My training as a licensed psychologist focused on broader areas of child development, skills acquisition, and behavior modification. I also received comprehensive training on a broad range of mental health disorders, differential diagnosis and comorbidities. My training as a behavior analyst consisted of in-depth training of learning principles, function-based assessments and treatments, data analysis, and systematic evaluation of our clinical outcomes. As a clinician in the field that's utilized all facets of my training, I witnessed the unique and significant contributions of a behavioral analyst and there are decades of support of research supporting ABA-based approaches as a component of intervention for a variety of presenting concerns. Behavior analysts are well-equipped and well-trained to provide services to a diverse population of consumers. Although I focused on describing the role of behavior analysts in treating pediatric feeding disorders, it's important to understand that behavior analysts fill a similar and vital role as providers beyond autism services or pediatric feeding. Lastly, I'd like to note that services for a child with a pediatric feeding disorder requires interdisciplinary collaboration with experts of medical care, swallow safety, behavior management and skill development. Given that-- the medical and safety implications, it's crucial for all providers, including behavior analysts, to be licensed and overseen by a licensing board. And there is-- this is a necessity for the protection of the consumers of our services. Licensing behavior analysts in the state will also benefit the community as a whole by increasing the access to qualified licensed providers for its members. Thank you.

HANSEN: All right, thank you. Are there any questions from the committee? All right, seeing none. Thank you.

BETHANY HANSEN: Thank you.

HANSEN: We'll take our next testifier in support. Welcome.

ANDREA CLEMENTS: Hi. My name is Andrea Clements, A-n-d-r-e-a C-l-e-m-e-n-t-s. I am a board-certified behavioral analyst. And today, I'm actually going to be testifying on behalf, on behalf of Georgia Ryba, who was unable to be here because Joy is not feeling well. I have known Georgia for a number of years and I am honored to be speaking her words for her on behalf of a parent in terms of this bill. Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Georgia Ryba, G-e-o-r-g-i-a R-y-b-a, and I'm here today to support LB123. I'm here represented-- representing my own opinions that are in no way affiliated with any organization. Requiring licensure for board-certified behavior analysts, or BCBAs for short, in the state of Nebraska is a crucial component of protection for the families who need-- in need of applied behavior analysis or ABA therapy. I would like to share my own family's story of how we could have benefited from licensure. When our child was diagnosed with autism spectrum disorder at the age of three, my husband and I had never heard of a BCBA or even ABA therapy, but we were told that it was the gold standard of care for individuals on the spectrum. So we placed our trust in the hands of the first BCBA that had an opening. With waitlists for services at least 6 to 12 months long, we didn't hesitate to go with this provider because we didn't have the luxury of comparing service providers. We found ABA therapy with a company that was owned and operated by a single BCBA. He was the supervisor, the CEO, and he set the training methods for his behavior technicians. It wasn't long before we noticed that the standards of practice he instilled in his techs were actually causing our child's behaviors to worsen. Our child was not able to make it to the end of therapy sessions without severe adverse behavior. And we knew this increase in severe behavior was due to the therapy because the very act of any staff member walking through our door caused our child to get upset and my child's behavior was not impacted in any other aspects of her life. The therapy was not structured to our child's best interests in mind, and they were not taking into account our child's unique needs and skills. We also began to question their competency. I remember one very frustrating occasion when they arrived at our home with no supplies, no toys, binders, or even a pencil and paper. The tech looked me in the eyes and said, what should we work on today? How can you properly collect data for a data-driven discipline when you don't have any tools or direction for what to collect data on? We brought this all to the attention of the BCBA, but our concerns fell on deaf ears. And because there was no oversight board and no other BCBAs on staff, there was no one that we as parents could turn to for help. We ultimately decided to cut ties with this BCBA and took our chances on

another provider's waitlists. We were frustrated, but also extremely, extremely frightened. Having a new diagnosis of a developmental disability for your child is terrifying. You need to be able to trust the professionals you seek out for help, but our BCBA violated our trust through their business practices and only our-- and only our choice to leave this provider and put therapy on hold until we found a different ABA provider that didn't violate our trust. I'm still frustrated because I know that this BCBA is still practicing and is still answering to no one. This was over three years ago. If there had been a licensing board that we as parents could have spoken to, this issue may have been resolved. But think of how many families may have felt our same fear and frustration in the last three years. I ask you to support LB123. Thank you for hearing my testimony today. I'd be happy to answer your questions.

HANSEN: All right. Thank you. Are there any questions? Seeing none, thank you. Anybody else wishing to testify in support of LB123? All right, seeing none, is there anybody wishing to testify in opposition to LB123? All right, seeing none, is there anybody wishing to testify in a neutral capacity? Welcome.

MELISSA KIMMERLING: Thank you. Chairman Hansen and members of the Department of Health and Human Services Committee [SIC], my name is Melissa Kimmerling, M-e-l-i-s-s-a K-i-m-m-e-r-l-i-n-g, and I'm an occupational therapist here in Nebraska. I'm the vice president of policy and advocacy for the Nebraska Occupational Therapy Association and I'm also the mother of a child with autism. Occupational therapy is a science-driven, evidence-based profession that supports an individual's ability to gain or regain the skills necessary for the job of everyday life. We work in practice settings across the life span from neonatal intensive care units to end-of-life care. I'm testifying today on behalf of the Nebraska Occupational Therapy Association, and I also provided written testimony for the Nebraska Speech Language Hearing Association, who could not be here today. The Nebraska Occupational Therapy Association would like to remain neutral on LB123 due to the assurances we receive from Senator Fredrickson that our recommendations will be addressed with an amendment to the current bill. The Nebraska Occupational Therapy Association recognizes that licensing and regulation is a positive direction for ABA providers. Occupational therapists work with many of the same clients as the ABA therapists, assistants and behavioral technicians, and therefore have a great interest in the safety of these individuals and the services provided to them. Children with autism, as you've heard today, are one of the main groups that are served by both professions. According to Autism Speaks, 40 percent of

individuals with autism are nonverbal, making them an especially vulnerable population. Due to the vulnerability of the client served, NOTA recommends that the supervision requirements of the assistants and especially of the technicians be well defined and outlined in order to protect the vulnerable individuals served. For example, we are aware as an association of a school-age children with autism who lives in Cass County who's receiving ABA services from a BCBA who is located in Germany and getting the direct services only from the technician. This technician is receiving supervision via Zoom and again, the only person providing direct services to this child is the registered behavioral technician who, like you mentioned, Senator Hansen, would be in the tiered-service model under the board-certified individual. Nebraska already has precedent set for supervision of assistants and technicians in tiered systems, such as those already outlined for licensed and board-certified occupational therapists and physical therapists in the state. Occupational therapists are licensed and certified, achieving a master's degree or higher and completing a certification exam. We supervised occupational therapy assistants who must receive an associate's degree or higher and complete a national certification exam. And our occupational therapy aides cannot practice without direct supervision in the state. So we recommend that an amendment to LB123 consider the precedent and supervision of other professions in the state and outline a super-- or I'm sorry, a similar supervision regulation. And we look forward to the opportunity to work with ABA therapists to ensure that the vulnerable individuals served by both professions are provided with safe and supervised treatment. Do you have any questions for me?

HANSEN: Thank you. Are there any questions from the committee? I don't see any.

MELISSA KIMMERLING: Thank you, Senator.

HANSEN: Thank you. Is there anybody else wishing to testify in the neutral capacity? Welcome.

VICKY McHUGH: Hi. Chairman Hansen and members of the Health and Human Services Committee, my name is Vicky McHugh, V-i-c-k-y M-c-H-u-g-h. I'm here as a representative of-- on behalf of the Nebraska Chapter of the American Physical Therapy Association Nebraska. I own Key Complete Therapies in Omaha, Nebraska, and have been a practicing physical therapist for 25 years, providing services to children and adults in a medical and educational setting. I employ physical therapists, occupational therapists, speech pathologists and

assistants in each of these three disciplines. I am here representing over 1,400 members of our Physical Therapy Association to share comments regarding the proposed LB123. APTA Nebraska is in support of licensing and regulation of the behavioral analyst because we feel it is necessary for these practitioners to have a scope of practice and board oversight. However, we are taking the position as neutral because as it is written, it lacks the necessary specificity of language to ensure the safety of our Nebraskan citizens. I have had a diverse collection of experiences with behavior analysts from one-to-one sessions within a patient's home to working in collaboration with them in a more specific autistic-specific school setting. From these interactions, I've become familiar with their contributions to the medical treatment of people with autism. LB123 attempts to define the practice of behavior analysts, but uses ambiguous terminology such as functional assessment and analysis, which brings questions, questions about the distinction of professional scopes. These, these phrases make it difficult for patients to understand the difference between the behavioral analyst and physical therapy scope of practice as we are-- excuse me-- in the ambiguity and it is this ambiguity that our association is hoping to see detailed more in specific language to help define and clarify their scope of practice. Additionally, the proposal does not speak to requiring the licensure of the assistant behavior analyst, nor does it define the type of supervision the provider must receive from the licensed behavioral analyst. Neighboring states of Iowa, Kansas and Missouri all require the licensing of the assistant behavior analyst. Licensing helps garner trust from patients by ensuring the individual has achieved the necessary entry-level education, passed the national competency and maintaining continuing education obligations set forth by such board. Furthermore, Nebraska already has, as we spoke about, the-- within the Board of Physical Therapy, as well as other healthcare professional boards' clear precedent for the specific utilization supervision for assistants as well as techs to limit the potential risk of patients in Nebraska. APTA Nebraska is here today to petition the bill's sponsor, Senator Fredrickson, as well as the committee to amend the language of the bill to be more comprehensive and clear in defining the scope of practice to ensure public safety, especially considering the particularly vulnerable segment of our citizens who are receiving these type of services. I think that's it.

HANSEN: All righty. Thank you for your testimony. Are there any questions from the committee? Yes, Senator Riepe.

RIEPE: I'm a recovering hospital administrator, so my sense was and my experience in occupational therapy was that it was not in the

behavioral training side. Now, maybe that's changed over the years, but-- so my question is to be is, is it a competing thing with occupational therapy or is it a complementary kind of a service?

VICKY McHUGH: I would like to answer that question. I just want to clarify, too, though, I'm speaking on behalf of physical therapy.

RIEPE: OK. Well, physical therapy.

VICKY McHUGH: So-- but I do think that the-- hopefully, the comment-- my response will be reflective and, and perhaps apply to both disciplines, physical, physical therapy as well as occupational therapy. In my opinion, it's very complementary. I would say that physical therapists are the experts in functional movement assessment and skill development to gain or regain skills for functional mobility. Occupational therapy is-- or the occupational therapists are the expert, experts in the functional assessment around more fine motor and functional task completion. I think the concern with the language that I'm trying to speak to really is around the very thin line or very important overlapping of skill acquisition versus the behaviors around that skill acquisition. If I may use an example of we're working with one of our clients that we're seeing who has a new prosthesis. It's a four-year-old little boy. He's working on, working on ascending or-- up and down his stairs in his home and a ramp to access his school environment. There are gait patterns. There are strengthening things that need to happen for him to have the capacity within his musculoskeletal system to be able to do that. There's behavior around fear, pain, a variety of things that the behavioral analysts are specializing in, looking at how to help that individual participate in our task. But the comments sometimes are we're just working on his walking skills. Well, that's where there becomes an important and some more clarification in the language around what is the scope of the ABA practitioner? Their-- the behavior is in that mobility skill. They're not-- they shouldn't be addressing the mobility skill or the sequencing of how to do that or the strengthening that needs to be happening to complete that functional skill.

RIEPE: So while everything's moving towards team treatment, you're saying everyone needs to stay in the lane? Is that right?

VICKY McHUGH: I think the, the language around the scope is important to help distinguish where the lanes are. And there are, without question, overlaps. And we-- I, I try very hard to collaborate of, like, I don't know what sort of prompts or what, what behavioral

reinforcement or corrections can help us work toward the development of this gross skill, gross motor skill. But there's still reservation or uncertainty about the functional-- the, the role of each discipline in those skills acquisition.

RIEPE: Trying to legislate lanes is very difficult.

VICKY McHUGH: Sure.

RIEPE: Fundamentally, it biles down-- boils down to personality and interpersonal relationships between team members.

VICKY McHUGH: Certainly--

RIEPE: Thank you.

VICKY McHUGH: --certainly can.

RIEPE: Thank you.

HANSEN: All right. Are there any other questions from the committee? All right, seeing none--

VICKY McHUGH: Thank you.

HANSEN: --thank you. Appreciate it. Is there anybody else wishing to testify in a neutral capacity? All right, seeing no more. Senator Fredrickson, you're welcome to close.

FREDRICKSON: All right.

HANSEN: And while you're coming up to close, I'll just say that we did have 17 letters in support for LB123 and two neutral letters.

FREDRICKSON: Great.

HANSEN: Welcome back.

FREDRICKSON: Well, thank you, Senator Hansen, and thank you to the HHS Committee for taking the time to hear the testifiers on this bill. I also want to thank everyone who came out to testify today. I think-- I want to highlight some of what we heard. I think it's really important to consider the need we currently have in the state. I think Desiree kind of highlighted up to eight-to-ten-year waitlists here, which, you know, we know in the field that early intervention has significant impact on prognosis. So everything that we can be doing in the state is in our best interests to invest to ensure that

these kids, especially in the pediatric settings, are getting the interventions that they need. So I think that's really important to highlight. The other thing I think it's important to highlight is that 36 other states have this mechanism in place to license behavior analysts. So this is not an outlier legislation. This is-- certainly seems to be where we are going as a country in terms of regulation for this field. So those are two things that I want to kind of really highlight. Relating to folks who testified in neutral, I've seen the concerns from the occupational therapists, the physical therapists, and the speech language pathologists. I agree. It's very important to be as clear as we possibly can so there is no confusion with that. And I understand their issues and I'm fully confident that we will be able to come together on an agreement of some of the technicalities here. We plan to begin to work on these amendments quickly, and we'll certainly bring those to the committee as well as soon as we have those. There is clear consensus that we need to move forward on licensure in behavior analysts in Nebraska and follow the recommendations of the State Board of Health, as well as the Chief Medical Officer. The stakeholders seem to be all in agreement with this. Once we resolve the differences, I ask the committee to take swift action by advancing LB123 to General File. And that's all I've got. Thank you.

HANSEN: All right. Thank you, Senator. Are there any questions? Yes, Senator Riepe.

RIEPE: I, as usual, have a question.

HANSEN: That's why I looked at you first.

FREDRICKSON: You keep us on our toes, Senator Riepe.

RIEPE: I hope you get-- get a sore neck, see a chiropractor.

HANSEN: Yep or an occupational therapist or a physical therapist or wherever else in the room.

FREDRICKSON: We can do functional assessments.

RIEPE: I want to talk, I want to talk money.

FREDRICKSON: You want to talk money. OK.

RIEPE: If it was a $500 fee, as I read in there. Is that correct? My-- where I'm going with this is--

FREDRICKSON: Yeah.

RIEPE: --is there a fiscal notice, is there a cost to the state? I see a head shaking no, so maybe--

FREDRICKSON: So there's no impact on the General Fund. There will be a fee for licensure. I think it's a biennial fee of $250.

RIEPE: But that's not a cost to the state.

FREDRICKSON: No, that would be for the license holder. It's-- that's pretty standard for--

RIEPE: OK.

FREDRICKSON: --for licensed professions, yeah.

RIEPE: The only other thing that I have to say is 1-2-3 is the license plates of Donald Duck, but [INAUDIBLE].

FREDRICKSON: When I did get the bill assignment number of 123, it seemed to have--

RIEPE: You have no control over it.

FREDRICKSON: --a nice little ring to it, yeah, yeah.

HANSEN: All right, are there any other questions from the committee? All right, seeing none, thank you very much.

FREDRICKSON: All right, thank you so much.

HANSEN: And that will close our hearing for LB123. And for the record, I forgot to mention on LB202, which was a previous bill, Senator Walz's bill, we did have five letters of support, seven in opposition and one neutral. I just want to mention that for the record. And with that, being a chiropractor, I always believe in moving and not sitting too long. So we--we're going to take a short ten-minute break before we hear the next bill. And so that gives everyone a chance to mull around and get things figured out. And so we'll be back at 3:30.

[BREAK]

HUGHES: --break a leg. No, that's a bad one. Where is everybody?

HANSEN: They'll funnel in. All right, welcome back. So we will begin the hearing now on LB216 and we welcome Senator Hughes to open. Welcome.

HUGHES: Chairman Hansen, members of the committee, thank you for allowing me the opportunity to introduce LB216. A bill intended to enhance access to healthcare for Nebraskans. I am Senator Jana Hughes, J-a-n-a H-u-g-h-e-s, representing, representing Legislative District 24. LB216 would authorize doctors of optometry licensed in our state to perform a procedure called selective laser trabeculoplasty, or SLT, for treating glaucoma. I would like to thank my colleagues, Senators Brewer, DeKay, Halloran, and Ibach for cosponsoring LB216. Glaucoma is a sight-threatening chronic disease involving the pressure inside your eyes. The number of people in the U.S. suffering from glaucoma is expected to reach 6.3 million by 2050. So this bill is relevant for a significant number of people in our state who need medical help in managing this disease over the course of their lifetime. As the doctors of optometry who follow me will explain, treatment for glaucoma often depends on an ongoing regimen of eyedrops that are prescribed by either an optometrist or an ophthalmologist. For many patients, the SLT procedure is a better option and a more cost-effective option. I want to comment that while SLT is an in-office procedure, there are only seven cities in our entire state beyond the Omaha metro area where patients can get SLT. This is my purpose in introducing LB216. The extremely limited access to SLT is not serving the best interest of Nebraskans. Allowing optometrists to become certified for this procedure and offer SLT in their offices will significantly increase access to care for glaucoma patients across our state. For point of reference, there are optometrists in 61 out of our 93 counties. Those optometrists could potentially offer SLT if they underwent the appropriate training as required in LB216. Nebraska doctors of optometry are primary care providers with authority and responsibility for diagnosing and treating diseases, disorders, or abnormal health conditions that affect the eyes, the vision, or the human visual system. This includes the use of instruments for various procedures like foreign body removal, broad perspective-- broad prescriptive authority for topical and oral pharmaceuticals related to medical eye care and vision disorders. Performing a procedure like SLT is not a giant leap into uncharted territory. In fact, it's important to understand the treatment of glaucoma has been well within the scope of practice for Nebraska doctors of optometry for 25 years. They have a long proven record of safely and effectively serving patients with this disease. Optometrists are already responsible for diagnosing glaucoma and

responsible for prescribing medications for the treatment and management of this disease. Optometrists identify and refer their patients for whom SLT would be a viable, beneficial option. Optometrists are responsible for managing patient's care post SLT, including management of any potential complications. LB216 simply amends the scope of care to include SLT to allow doctors of optometry to provide comprehensive care and treatment for their patients with glaucoma. The current limitation in state law, which prohibits laser procedures, dates back to the original adoption of the Optometry Practice Act in Nebraska. At that time, the nature and scope of optometric training, education, and clinical experience had not advanced broadly into the use of lasers. Now, however, the evolution of the profession has brought these procedures into mainstream curriculum for optometrists, and they are used in the clinical practice of many optometrists. As you guys know, there is a 407 credentialing review of this proposal currently underway, and the first two phases of the review process are complete at this time. The Technical Review Committee in a split vote of 3-2 recommended against the proposal. The State Board of Health on a split vote of 7-6 recommended in favor of the proposal. Review by the interim medical director is currently pending. It is worth noting that in each of the first two phases, review bodies have agreed that the proposal would benefit the health, safety, and welfare of the public and that it does not create a significant new danger to the health, safety, or welfare of the public. It's important that the scope of practice of our licensed health professions in Nebraska stays comparable with other states. It's important for our citizens as consumers to have that same kind of access and choices that consumers are getting in other states. And it's important for our state's ability to attract healthcare providers. As the standard of care evolves and as practitioners are learning new skills in schools, they want to go to states that allow them to use their abilities and to provide the highest standard of care for their patients. There are already ten other states that allow licensed optometrists to perform SLT, some with even more authority for, for optometrists than this bill provides. Alaska, Arkansas, Colorado, Indiana, Kentucky, Louisiana, Mississippi, Oklahoma, Wyoming, and Virginia, all currently allow optometrists to perform SLT. Other states, such as California and Utah are considering similar legislation. LB216 ensures that Nebraska optometrists performing SLT will have the highest training requirements, surpassing the standards of other states. Nebraska should not continue to fall behind in the healthcare options that we are providing our citizens. Following me, doctors of optometry will provide additional explanation about the SLT procedure and how it is

used in the glaucoma treatment. They will describe their education and training as well as the additional training that would be required by this bill in order to be certified for this new authority. The optometrists will also provide details about the current accessibility of SLT and the potential increase in access that could occur, and they'll cover how the state would be assured that providers utilizing this new authority would be appropriately and adequately trained. I will defer the rest of my comments to closing. I thank the Chair and the committee for your time and consideration. The testifiers behind me will be able to provide much more detail and answer very specific questions, but I am happy to try to address any questions you have for me.

HANSEN: All right. Thank you. Are there any questions from the committee? Very technical ones, she can't answer. Anybody?

HUGHES: Clearly.

HANSEN: OK. All right.

HUGHES: This is an eye.

HANSEN: You got that down. That's good.

HUGHES: Got it.

HANSEN: OK. Well, seeing no questions, we'll see you at close?

HUGHES: Yep.

HANSEN: OK. All right. All right. So with that, we'll take our first testifier in support of LB216. Welcome.

ANDREW BATEMAN: Thank you. Good afternoon, Senator Hansen and committee members. My name is Dr. Andrew Bateman, A-n-d-r-e-w B-a-t-e-m-a-n. I'm a doctor of optometry providing optometric physician services in Lincoln, Nebraska for the last 15 and a half years. As a past president and current member of the Nebraska Optometric Association, I'm here in support of LB216 that the State Board of Health has endorsed for your approval. I have been treating patients with glaucoma throughout my career. In optometry school, we receive four years of education focused on the complete treatment and care of the eyes. We learned to evaluate and manage complex eye diseases like corneal ulcers, diabetic eye diseases, glaucoma, neurological impairments, macular degeneration, removal of foreign bodies from the delicate tissue on the front of the eye, and to

evaluate patients with systemic diseases, diseases or ocular side effects of systemic medications. I also provide the pre and postoperative care for patients receiving a variety of complex surgical treatments. This bill is not about granting optometrists the authority to manage glaucoma. Nebraska optometrists have proven their ability to treat glaucoma with medications for the last 25 years. Glaucoma is a group of diseases that are sight threatening and can lead to blindness. The disease is caused by pressure increases within the eye, which in turn cause damage to the optic nerve. As optometrists, we have the training, equipment, and medical judgment to manage and minimize vision loss from glaucoma. Currently, the only option we have for doing that involves prescribing eye drops. Selective Laser Trabeculoplasty, SLT, is one specific procedure that is now considered a frontline treatment option for open angle glaucoma. The skill set that is required for administering SLT is something that I do on-- regularly on a day-to-day occurrence. The laser is mounted to a slit lamp that we-- and to align the laser, you must understand how to focus the slit lamp, which we have to do every day. The second part of that is utilizing a gonio lens to view the angle of the eye where the laser is applied. We use a gonio lens in glaucoma patients already to examine and monitor the angle of the eye where the drainage occurs. Once you can perform these two skills, the last step is the application of the laser to the tissue by using the appropriate setting and pressing the button. As for the infrequent, infrequent complications that arise from this specific procedure, Nebraska optometrists already provide post-op care for SLT patients. This bill has nothing to do with our ability or authority to manage the complications. The four-year doctoral education that every optometrist gets today in the U.S. includes training on lasers. To get licensed in Nebraska today, new optometrists must have passed the National Board's exam that includes laser procedures. Under LB216, a licensed optometrist graduating after January 1 of 2025 could be authorized to perform SLT by virtue of passing, passing the National Board examination, including a laser, laser skills portion and by documenting completion of the required number of proctored cases under supervision. Optometrists licensed prior to January 1 of 2025 would be required to show completion of specific laser training before being able to get certified for SLT. The education and training that stipulated in the bill includes a 16-hour refresher course that has been the standard in all other states currently allowing optometrists to perform SLT. Our bill goes even further than other states in requiring successful completion of at least three proctored cases under the direct supervision of a provider. It is important to note that a 16-hour course is not intended to train a

layperson to perform this procedure in 16 hours. It is there as a supplement for professionals who already have a four-year doctoral education consisting of 10,000 hours of training and 2,000 patient encounters prior to graduation. It is also important to emphasize that no one would be certified for SLT just by taking a course. LB216 requires successful completion of at least three proctored cases, and more could be required by the proctor if needed to assure competency. We would like the opportunity to care for our patients in a manner that would allow increased access to a therapy that has many benefits. We ask for your support for LB216 and I would be happy to answer questions.

HANSEN: Thank you for your testimony. Are there any questions from the committee? Yes, Senator Riepe.

RIEPE: Thank you, Senator Hansen. My question is, where are the training centers for optometrists? The schools?

ANDREW BATEMAN: Like every one of the schools? Let's see, we have--

RIEPE: I don't think there's one in Nebraska, is there?

ANDREW BATEMAN: We do not have one in Nebraska. No, no, we have, I mean, there's 23 schools, I believe, 22 schools at this point in time.

RIEPE: And are all those schools now training optometrists in this particular technique?

ANDREW BATEMAN: They all, as an accredited institution, have to train on the laser preoperative, intraoperative, and postoperative care. As far as a state that does not have laser scope at this point in time, the student then would have to go there or they go to a residency where they do actually do the procedure and in visioning which would be controlled by the Board of Optometry, I believe, but if they hadn't received the, the actual on, on the laser training at that point, they would then have to still fulfill the proctoring requirements that, that the current physicians who, who are already licensed would have to do before they could do that.

RIEPE: How long would the residency program be for SLT?

ANDREW BATEMAN: I'm-- I will defer that to later, but I don't believe there is a specific residency program.

RIEPE: OK. Thank you. Thank you, Chairman.

HANSEN: Yes, Senator Walz.

WALZ: Thank you. I-- and I'm just asking this question out of curiosity.

ANDREW BATEMAN: Yeah.

WALZ: You said that Nebraska optometrists already provide post-op care for SLT patients.

ANDREW BATEMAN: Um-hum.

WALZ: Can you explain that a little bit?

ANDREW BATEMAN: Yeah, so just like our, even our cataract referrals that we refer to our colleagues in ophthalmology, after they have the cataract procedure, they come back to us for the postoperative care. So after a patient has SLT, we refer them over to a surgeon to do that. Then we do the follow-up care and examination as they're recovering from that.

WALZ: OK. All right. Thanks.

HANSEN: Senator Ballard.

BALLARD: Thank you for being here, Doctor.

ANDREW BATEMAN: Yeah.

BALLARD: So how long has-- I believe, Senator Hughes said Oklahoma has this expansion. How long have they had this on their books?

ANDREW BATEMAN: I believe 1996, but I-- again, some of my following testimony partners will probably cover that--

BALLARD: OK.

ANDREW BATEMAN: --a little more than I do.

BALLARD: And then in your research, have they had any major incidences?

ANDREW BATEMAN: To my knowledge, no. Again, I think that will be covered in later testimony.

BALLARD: OK. Thank you, Doctor.

HANSEN: I got a couple of questions, too.

ANDREW BATEMAN: Yes.

HANSEN: So, yeah, I was going to ask about the you already are currently allowed to provide post-op care for SLT patients. So if you send, if you send out a patient to an ophthalmologist and they have SLT done, and they come back with complications from the procedure, you'd be able to recognize that--

ANDREW BATEMAN: Correct.

HANSEN: --and treat it appropriately--

ANDREW BATEMAN: Correct.

HANSEN: --or send them back, either one?

ANDREW BATEMAN: We, we would be able to treat it appropriately.

HANSEN: OK.

ANDREW BATEMAN: And we do.

HANSEN: And you have to do three proctored cases?

ANDREW BATEMAN: At least.

HANSEN: Who is a proctor?

ANDREW BATEMAN: It would be somebody who already would, would be licensed to perform SLT.

HANSEN: OK. All right. That's all I had. Any other questions? Seeing none, thank you very much.

ANDREW BATEMAN: Thank you.

HANSEN: All right. We'll take our next testifier in support. Welcome.

TERI GEIST: Thank you. It's a short chair. Good afternoon, I'm Dr. Teri Geist, T-e-r-i G-e-i-s-t, and I'm an optometrist and practicing in Omaha. I also serve on the Board of Trustees for the American Optometric Association. So I'm especially aware of what's happening in our profession across the country and how it compares to Nebraska. In terms of eye care services that patients can receive from their local optometrist, Nebraskans now are at a distinct disadvantage in

comparison to other states. In 23 states, patients can receive more advanced care from an optometrist than Nebraska currently allows. We are falling further behind the rest of the country each year by not updating our scope of practice. As it pertains specifically to this bill, there are ten states, as you've already heard, that already allow optometrists to perform SLT. You can see those states on the first map that I just distributed, distributed. Oklahoma, just to answer your question, have been performing-- have, have performed an estimated 50,000 laser procedures including SLT over the past 24 years. Our colleagues in Kentucky have performed over 40,000 laser procedures since 2011, and there are over 400 optometrists credentialed by the state to offer those procedures to patients. In Louisiana, 60 percent of the state's licensed optometrists are certified for laser procedures, and they have performed more than 14,000 procedures since the authority was granted in 2014. These numbers include more laser procedures than just SLT. But the point is that in every state that allows optometrists to do SLT, they have a proven track record of doing it successfully and safely. The other concern, is Nebraska losing out on the best and brightest new graduates in neighboring states, bordering states like Wyoming and Colorado, that have already passed laser authority for optometrists? Map number two that I distributed shows the only cities in Nebraska where you can have an SLT procedure done today. And in most of those cities there is only one office. I have also provided examples of the distances many Nebraskans must travel today to get the procedure. Keep in mind that for many of these patients there are two visits required and a family member or a friend must accompany them. I grew up in the Sandhills, so I know how hard that is to travel. LB216 will significantly increase patients' access to SLT as a treatment option. There are approximately four times as many optometrists in our state as ophthalmologists. And you can see from map number three the geographic distribution of optometry offices across Nebraska. Ophthalmologists have argued that with their satellite clinics that they provide broad access to care for the state, that access to ophthalmologists is not the same as access to SLTs because it is unreasonable to expect that their satellite clinics will ever be locations for additional SLT care. To be fair, it is true that not every optometric office will offer SLT, but surveys by the Nebraska Optometric Association indicated 72 optometrists throughout Nebraska are likely or highly likely to offer SLT in their practices if LB216 is approved. In, in conclusion, I'd like to point out that during the credentialing review process our opponents have stated that since SLT is a nonemergent procedure patient need to be-- needs are being met by the current locations. What they fail to take into account are

glaucoma patients who choose to forgo SLT because they'd rather not travel or go see another doctor. Those patients are not being seen by an ophthalmologist. They're simply not getting the care. Doctors of optometry provide the vast majority of primary eye care in Nebraska. But our patients and like those of our colleagues in other states around the country can't get the highest standard of, standard of care from us. Those are Nebraska citizens that we are especially interested in helping with this bill. I urge your support for LB216, and I'd be happy to try to answer your questions today.

HANSEN: Thank you for your testimony. Are there any questions from the committee? All right. Yes, Senator Hardin.

HARDIN: Generally speaking, how much pressure does SLT relieve from the eye when successfully performed?

TERI GEIST: Well, that, that's very dependent. You know, pressure is the magic word in glaucoma. And so no two patients are the same. So everyone thinks that glaucoma, the pressure is the, the, the wonderful fix all. And so you can have a patient, normal pressure, say it's from 10 to 21. I've had patients with horrible glaucoma with pressures of 13 and which is normal, right? But I've also had patients that do not have glaucoma at the pressure of 20. So sometimes it's a percentage situation. And so there's-- that's not-- while we try to think that that's the magic number, sometimes you look at the percentage and there's so many more factors than, than two points or three points. So that's a really hard question to answer because I can't say, you know, it's always goes down four points or it always goes down ten. There's just so many more factors that go into that. So I'm sorry that that's a--

HARDIN: I'll ask, I'll ask a follow-up question.

TERI GEIST: --difficult thing to answer.

HARDIN: I'll try to refine it better. Thank you.

TERI GEIST: OK. Sorry. We could, we could-- I could talk to you about that for an hour, and you'd be so bored.

HARDIN: So I'll, I'll ask this basic question.

TERI GEIST: OK.

HARDIN: Does it help?

TERI GEIST: Does it, does it help?

HARDIN: SLT.

TERI GEIST: Absolutely. How's that?

HARDIN: That's pretty short. How about expanding it just a little bit more?

TERI GEIST: Does SLT help--

HARDIN: Yeah.

TERI GEIST: --as far as-- oh, yes, absolutely. It's, it's becoming more, more and more the-- and gold standard, kind of a, a tough one, but that's becoming more standard of care, the first line of treatment, let's put it that way, then drops in a lot of situations.

HARDIN: OK. Thank you.

TERI GEIST: You're welcome.

HANSEN: Yes, Senator Ballard.

BALLARD: Thank you, Mr. Chairman. You said in your testimony Nebraska's losing out on our best and brightest. Can you unpack that a little bit, like in examples?

TERI GEIST: Well, you know-- so when, when young students come out and they want-- they've been trained to do all the things that the SLTs and all the other lasers that they've been trained to do, they're looking at where can I go practice and, and do all the things that I've been trained to do. And if they look at a state that they can't do the things that they've been trained to do, they may not want to come here. And so if you look at, again, we've got bordering states, and you hate to think about Colorado being one of them, I'm just saying, and will they choose to come here and practice? I mean, that, that's a very real situation. Because I travel a lot for our national association, I visit a lot of the schools of optometry. And they-- I've talked to the students and, and that is one of their number one things that they look at. They've just spent, you know, six figures of, of their parents' money or their loan money, and they want to be able to practice the way they were taught. And if they come out and not-- are not able to do that, they-- this absolutely is something that we're losing out on.

BALLARD: Thank you.

RIEPE: I have a quick--

HANSEN: Senator Riepe.

RIEPE: Thank you, Chairman. You point out the ophthalmologists that reside outside of Seward, if you will. Are all of those trained in SLT? All those ophthalmologists or are they two different things, trained and untrained ophthalmologist?

TERI GEIST: Oh, no, they're very well trained.

RIEPE: They all do--

TERI GEIST: All the ophthalmologists are trained.

RIEPE: --and they all do--

TERI GEIST: Yes.

RIEPE: --SLT.

TERI GEIST: Yes.

RIEPE: OK. That was my question.

TERI GEIST: So it may just be the machine that-- I mean, so all the ophthalmologists are very well trained. Absolutely.

RIEPE: What kind of investment--

TERI GEIST: It's the machines that are, that are not--

RIEPE: --you know, if, if--

TERI GEIST: -sometimes available in some.

RIEPE: --one is in practice, what's, what's the cost of a, a laser?

TERI GEIST: That what is the cost of the laser? Oh, you know, I hate to give you the wrong number.

RIEPE: Can you guess?

TERI GEIST: I want to say between $50,000 and $100,000.

RIEPE: Oh, OK. Around here, that's chump change. [LAUGHTER]

TERI GEIST: Yeah, I grew up a little bit west of Seward, by the way.

RIEPE: It's a great place.

HANSEN: I have a couple of questions if that's OK?

TERI GEIST: Yes. Oh, I'm sorry.

HANSEN: And it kind of pertains to your third paragraph in your testimony. You're talking about some statistics about how many optometrists have performed laser procedures, including SLT in certain years in certain states.

TERI GEIST: Yes.

HANSEN: Do you know what the ratio is of optometrists to ophthalmologists performing these procedures? Because you say they've done 40,000 procedures since 2011, but if, I don't know, if ophthalmologist did 400,000, do you know the ratio?

TERI GEIST: I don't have, I don't have the ratio numbers. I'm sorry.

HANSEN: It's just, just kind of a random question. Just more for curiosity sake.

TERI GEIST: Yeah, I'm sorry, I do not have-- I don't have the, the answer to that.

HANSEN: OK. And then just, just the paragraph right after that, you said these numbers include more laser procedures than just SLT. But the point is that every state that allows optometrists to do it, they have a proven track record of doing it successfully and safely. However, in your paragraph previously that you reference, I don't see anything about out of the 40,000 procedures they have done, they've all been successful with no issues.

TERI GEIST: There has not been that we know of, that I personally know of, there has not been a-- you know, first of all, every medical profession has bad outcomes. So I'm not saying there's never been a bad outcome.

HANSEN: Sure.

TERI GEIST: I'm absolutely not saying that. But there has not been a huge amount of, of bad outcomes. I mean, you're going-- you can have bad outcomes in optometry, you can have bad outcomes in

ophthalmology. And I've seen both situations, but there is not a large amount-- percentage wise, there's not a, a large out-- bad outcomes in either one with SLT.

HANSEN: OK. That's what I was kind of curious about.

TERI GEIST: It's a safe, it's a safe procedure--

HANSEN: Sure.

TERI GEIST: --when done properly.

HANSEN: And I think that's why, why I was referencing that paragraph because you're giving the total amount of numbers. And so that's why ratios help when you say out of 400-- out of 40,000 procedures, there's one bad incidence, but ophthalmologists do it out of 400,000, they have ten. So the ratio would be the same, right?

TERI GEIST: Right.

HANSEN: So I'm just kind of curious to see if who's doing it, if there are more, you know, repercussions.

TERI GEIST: Yeah, my point was, I guess, that we've just-- there's just been a lot done--

HANSEN: Yep.

TERI GEIST: --in that amount of time.

HANSEN: And that makes sense. I'm just kind of curious about that. OK. Any other questions? Seeing none, thank you very much. Appreciate it.

TERI GEIST: OK. Thank you so much.

HANSEN: Welcome.

JASON WEBB: Hi. Senator Hansen and committee members, thank you for your time. My name is Jason Webb, J-a-s-o-n W-e-b-b. I'm a doctor of optometry and a board member of the Nebraska Optometric Association. I've been a proud member of the Nebraska Optometric Association for over 25 years. I graduated from the University of Nebraska-Lincoln in 1996 and from Indiana University School of Optometry in 2000. I practiced for four years in Columbus, Ohio, prior to moving to Scottsbluff to start my private practice in 2004. I have offices in Scottsbluff, Alliance, and Bridgeport, Nebraska. I currently have two

associate doctors that work with me, along with 28 staff members. Simply put, we're the primary eye care providers for most patients in western Nebraska. I've been treating glaucoma patients my entire career for over 20 years. My associate doctors and I treat a full range of patients from infants to elderly. However, a large percentage of our patients are elderly. In fact, 22 percent of patients in western Nebraska are over the age of 65 versus 15 percent in the Lincoln and Omaha area. Because of this, travel, especially in winter, is a major obstacle for our patients. Western Nebraska is one of the areas of our country that struggle the most with access to care and especially to specialty care. In the past, we had ophthalmologists from Scottsbluff that would travel to Alliance and many other communities via plane that ended several years ago. Recently in Scottsbluff, we lost two ophthalmologists to retirement in the one ophthalmology clinic that we have. That Scottsbluff clinic ironically filled their patient care need by hiring an optometrist. We used to have an ophthalmologist from Black Hills Regional Eye Institute in South Dakota that would travel once per month to Chadron. This did not involve any surgical services at that location, but even those limited services they provided ended last year. In short, we serve the heart of the area that is most underserved in western Nebraska and one of the most underserved areas in the country. Our offices see patients all the way from Wyoming, north to Chadron, east of Hyannis, and south of Kimball. The doctors at my office are the only eye care providers in many communities in our region. And outside of Scottsbluff, there are no ophthalmology services, really in all of western Nebraska. Patients must travel to Scottsbluff, Colorado, or South Dakota for this care. These patients aren't just going to other towns in Nebraska. They are going to entire states altogether. I believe Nebraska doctors should be able to take care of the patients of our state, and we are here ready to fill the void. I would add, this is not just a problem for eye care. Personally, I have a multi-specialty building, multi-specialty building and I see imaging, orthopedic surgery, and so many other patients leaving our state for care in Colorado and South Dakota. For many of us, this is a three-plus hour drive. In addition, states such as Nebraska and especially rural areas of our state continually struggle to attract professionals-- we touched on this-- to provide services for our citizens. The state funds programs such as RHOP specifically designed to attract and retain healthcare professionals to our area. Limiting the scope of practice and not allowing doctors to practice to the full scope of their training is just another barrier in the battle to get and keep doctors in Nebraska. If this legislation is passed, my associate doctors and I would all pursue

the training to become properly certified to provide these services to our patients in western Nebraska. This is important to me to be able to provide these vision-saving services to the citizens of western Nebraska. And quite simply, I need this to properly take care of my patients. Thank you for the committee members for your time and let me know if I can answer any questions.

HANSEN: Thank you. Are there any questions from the committee? Yes, Senator Riepe.

RIEPE: Thank you, Chairman Hansen. The question I have. What's the duration of eye drops? Because that's as I understand it with glaucoma for you as an optometrist, is now limited to the eye drop routine. Is that reasonably correct?

JASON WEBB: For treatment options?

RIEPE: Yes.

JASON WEBB: Right.

RIEPE: How long is that duration? Like ten days or--

JASON WEBB: No. Generally, when people are started on treatment, they, depending on how they respond to any particular treatment they might be on one drop, they might be one drop once per day. They might be on multiple droughts, multiple times per day.

RIEPE: How many days?

JASON WEBB: For-- generally, they're, they're treated for the rest of their life.

RIEPE: Oh, OK. So it's not a--

JASON WEBB: No, it's a lifetime.

RIEPE: --10 days or 20 days.

JASON WEBB: No, it's a, it's a--

RIEPE: [INAUDIBLE]

JASON WEBB: --chronic--

RIEPE: What's, what's the-- what's been your experience with individuals failing elderly people with glaucoma? What's, what's the

incident of them failing to take their eye drops and, therefore, put themselves at greater risk than what I consider as a laser a one-time procedure?

JASON WEBB: Generally--

RIEPE: One time and then a checkup.

JASON WEBB: Yeah, I mean, sometimes you-- they can talk in more detail about that, but sometimes you might have subsequent procedures if you need more effect over the course of several years later, generally. But, but with eye drops, you know, you might have-- you touched on elderly people, sometimes they can't physically put their drops in--

RIEPE: Yeah.

JASON WEBB: --and somebody has to do it for them. Sometimes we don't get very good response from the drops like we hope, because, you know, like Dr. Geist said, everybody is a little bit different in how they respond. Sometimes you get people on multiple-drop therapy and they're allergic to everything. And, you know, you just can't find a drop that is compatible with them. And so for various reasons, you know, it's, it's not just a secondary option, but now due to its effectiveness, it's really becoming a first-line therapy, not, not just a back-up therapy, I guess.

RIEPE: OK. Thank you. Thank you very much. Thank you. Mr. Chairman.

HANSEN: Yep. Any other questions? All right. Seeing none, thank you.

JASON WEBB: All right. Thank you.

HANSEN: Welcome.

AMY DeVRIES: Good afternoon. My name is Dr. Amy DeVries, and I'm an optometrist practicing in Fremont. And I am here in support of LB216 because Selective Laser Trabeculoplasty, SLT, is a procedure that optometrists are trained and qualified to perform and passing this bill will improve access to care for Nebraskans. SLT is a safe and effective treatment for glaucoma when performed by a provider with the knowledge, education, and training that we have laid out in this bill.

HANSEN: Hey, Amy, real quick.

AMY DeVRIES: Yes.

HANSEN: Can you spell your name for us, please?

AMY DeVRIES: Thank you. A-m-y D-e-V-r-i-e-s. Thank you, Senator Hansen.

HANSEN: Thank you.

AMY DeVRIES: It uses short pulses of low energy laser light to stimulate the tissue and increase the amount of fluid drained from within the eye, which lowers eye pressure. Data shows that there are few side effects and risks to the procedure, which usually involve inflammation or elevated pressures. And these are conditions that Nebraska optometrists already treat as part of our practice. It is important to remember that optometrists in Nebraska have been safely treating and managing glaucoma and performing the pre and postoperative care for SLT procedures for over 20 years. Optometrists are already licensed to perform SLT in ten states: Colorado, Wyoming, Oklahoma, Arkansas, Louisiana, Mississippi, Indiana, Kentucky, Virginia, and Alaska. Despite what you will likely hear from the opposition, there has been no evidence of harm to the public in any of these states. You may hear about isolated examples of patients with poor outcomes, but isolated cases of poor outcomes exist throughout all healthcare professions, including ophthalmology. They are not indicators of a profession's competence or safety. What is relevant is that regulatory bodies in those states, agencies charged with protecting public safety have officially validated that there has been no increase in regulatory actions taken against optometrists since they have received this enhancement to their scope of practice. These states have verified that public safety is not at risk. Our opponents argue at length that there is a high risk that optometrists would endanger the public and they will cite potentially catastrophic consequences that could occur. What do they base those fears on? If you listen carefully, it is simply the fact that optometrists have different training than ophthalmologists. The assumption they want you to make is that the only way one can know how to safely perform an SLT is to be an ophthalmologist. But the experience of ten other states with some of that experience going back 20 years shows that simply is not true. In fact, during the 407 process, our opponents admitted that some of the data they had been citing to show public safety risk did not prove a risk to the public. Rather, they were making assertions about safety that were not supported by the design of the study. This Legislature does not have to speculate about what might happen if you allow this authority. You can look at what has

actually happened and what is happening today in those ten other states. What the opponents predict is not happening anywhere else. The evidence that exists shows that, in fact, optometrists are very capable of safely and effectively providing this care. Why would Nebraska's experience somehow be different? SLT is a safe procedure. It is not without risk, but data proves that it is low risk. Evidence also proves that doctors of optometry would be adequately trained and fully capable of performing this procedure. Our education is not identical to ophthalmologists, but there is nothing, absolutely no evidence to indicate that optometrists in Nebraska would be any less trained or any less capable than our colleagues in other states. And there is no reason and no data to suggest that public safety would be at risk here in Nebraska when it has been shown to be safe in other states. I encourage you to focus on what is happening in our profession and what has been proven in other states and not what opponents say could happen. It is also important to think about the future of healthcare in our state. We need to continue to attract the best and brightest new doctors, but that will be increasingly more difficult if those new doctors cannot practice what they have been taught. The public will benefit from this improved access to care. I, therefore, respectfully ask for your support of LB216 in interest of improving the way our profession can care for our patients with glaucoma. Thank you and I'd be happy to answer any questions.

HANSEN: Thank you for testifying. Are there questions from the committee?

RIEPE: Yeah, I have a question.

HANSEN: I'm taking my time looking over here before I go to you. [LAUGHTER] Yes, Senator Riepe.

RIEPE: I've been known as Curious George, so. With your proximity in, in Fremont of being close to Omaha, do you see a disproportional loss of patients that go down to Omaha, maybe, or maybe even within Fremont-- I'm not saying you don't have ophthalmologists there--

AMY DeVRIES: Right.

RIEPE: --maybe more so than you would out at, out at the Sandhills where there's not an ophthalmologist--

AMY DeVRIES: Could--

RIEPE: --in proximity to their town?

AMY DeVRIES: Thank you for your question. The main, the main challenge I find, my area, obviously, there is access to [INAUDIBLE]-- own a laser that's able to be used for SLT. My patients usually first ask me, do you provide this? Would you do it? I answer, no, I'd be referring you. And then they say, oh. And then we talk about it, talk about it, talk about it. Then they ask, you know, different questions about who the other doctor would be and how many visits would they have to have and all that goes along with it. It's important to remember that in these moments, these patients have already established trust with the doctor who is the person diagnosing their glaucoma or already managing their medication treatment for glaucoma. And patients often don't want to take that next leap to another provider, so they'll choose to just simply continue with their medication treatment. But the medication treatment does come with challenges, instilling the drops, remembering to take them, the cost of them, mild burning, stinging, mild toxic effects of having preservatives if the drops go on their ocular surface day after day after day. And once a patient is being treated for glaucoma, they will continue to be. Glaucoma is never healed. It's simply managed by lowering the pressure and then working to maintain that low pressure. If you see a worsening of the case, you respond with a second medicine or a laser procedure or other type of treatment that will lower the pressure further.

RIEPE: Thank you.

AMY DeVRIES: Thank you.

RIEPE: Thanks for being here.

AMY DeVRIES: Thank you. Yes.

HANSEN: Yes, Senator Hardin.

HARDIN: Thank you, Chairman. Are there any other laser procedures that optometrists perform--

AMY DeVRIES: In--

HARDIN: --besides this one?

AMY DeVRIES: --in Nebraska, no. In other states, absolutely.

HARDIN: OK. Can you give us a range of what those are?

AMY DeVRIES: Sure. In Oklahoma, they have the broadest spectrum. I'm not licensed in glaucoma, so it would probably be more appropriate if we gave you real answers. And that can be done by one of the testifiers coming later who did go to Oklahoma.

HARDIN: Thank you.

AMY DeVRIES: Thank you. And I'd be happy to provide that documentation if you'd like. I can list them all.

HANSEN: All right. Any other questions? All right. Seeing none, thank you.

AMY DeVRIES: Thank you.

HANSEN: Take our next testifier in support.

CHRISTOPHER WOLFE: Good afternoon.

HANSEN: Welcome.

CHRISTOPHER WOLFE: Good afternoon, Chairman Hansen and HHS committee members. My name is Christopher Wolfe, C-h-r-i-s-t-o-p-h-e-r W-o-l-f-e. I'm a doctor of optometry and I am in private practice in Omaha. And I was actually trained in Oklahoma about 15 years ago to provide Selective Laser Trabeculoplasty. And, Senator Hardin, I welcome some of those comments-- or some of those questions afterwards. Thanks for your service as well and your consideration of LB216. In our state, as you know, we have a process called the credentialing review, and it's intended to provide the Legislature with an independent assessment of adjustments in scope of practice. Last week, as part of that process, Nebraska Board of Health voted in favor of our proposal, which mirrors the bill you have before you today. I'd like to comment on three pieces of evidence that were points of contention during that process, which my colleagues have not yet covered, since you may be hearing about these points from our opponents. During our meetings over the last nine months, even though we have our own process, the opponents of this bill have multiple times referred to Vermont's credentialing review, where in 2019 this regulatory body ruled against expanded scope of optometric practice, specifically in Vermont. The Vermont review involved broader authority then just SLT. And I can talk about that as well. However, since 2019, the state of Washington and Colorado, who have similar processes as we have, have ruled in favor of an enhanced scope of practice by optometrists in a much broader scope than we're proposing here as well. The Board of Health in Nebraska essentially agreed with

Washington and Colorado and recommended to enhance the scope of practice for optometrists related to SLT and specific quotes from these other reviews. The first one, Senator Hansen, will kind of go to your, your question previously about the complication rate. And again, as Dr. Geist testified to the rate of complication, we would expect complications and I can certainly talk afterwards about the complications we'd expect and the rates. But specifically, what that review found was, quote, staff found that there was not been the increase in regulatory actions taken against practitioners that ophthalmologists indicate, end quote. Another one is, quote, we reviewed the, the Vermont material and found our research and data did not align with the findings of the Vermont report, the negative report, end quote. Quote, a patient should not be forced by Colorado law to see a different professional for a minor procedure regardless of the distance. This is especially the case when trained-- a trained professional is in the room making the diagnosis, advising the patient, end quote. Another opposition point is a study from Oklahoma in which, which showed that SLTs were repeated more often by optometrists than ophthalmologists. The opposition to this bill assert that this somehow proves that the procedure was not done appropriately by optometrists. So it needs to be repeated more often. But the research methodology for this study does not allow the conclusion to be drawn that our-- by opposition. And they admitted this once pressed about it during the 407 or the credentialing review. I've included more thorough discussion on page one through three of your handout. But the bottom line is that the SLT procedure is expected to be repeated. It has an effect, treatment effect that is expected to last based on the studies about three to five years, and it will lower the pressure. This kind of goes again to the question that you had asked Dr. Geist, and she was absolutely right in having a hard time exactly giving you the numbers. But the studies show us that SLT will lower the pressure in 80 percent of patients by about 20 percent. And so that's typically what we're expecting with topical medications, a 20 to 30 percent reduction in, in [INAUDIBLE] pressure. So if a patient starts at a pressure of 20, we would expect our initial therapy to drop the pressure by about four points. So about 16 is what our initial goal might be, maybe even up to six point-- points, excuse me. Additionally, data in this study does not show an increase in side effects, worse pressure lowering outcomes or patient harm when SLT is performed by an optometrist. It could be confounded in terms of what these outcomes might actually be confounded by is the fact that when an ophthalmologist performs an SLT and the treatment effect wanes as would be expected, they move to more invasive or cutting surgery. And when an optometrist performs an

SLT, again, as would be expected over time the treatment effect-- then the optometrist can offer additional repeat SLT. It's been shown to be repeatable and that's common consensus among both optometrists and ophthalmologists that you can repeat an SLT. It also may underscore the exact points we're making here and that patients may elect to stay under the care of their optometrist and elect for re-treatment rather than establishing the relationship with an unfamiliar provider. On pages four and five of the handout I've provided you, you'll see six-year data from the light trial, which is a-- was a pivotal trial based on SLT compared to drops, and it actually shows that there is a lower need for incisional glaucoma surgery or cutting surgery when patients are treated with SLT than with drops. Finally, I'd like to address a procedure called gonioscopy. Gonioscopy is foundational to the evaluation of a patient with glaucoma and the performance of SLT. It's been in the scope of optometric practice for over 40 years, and there are studies that actually show that optometrists perform gonioscopy with the same proficiency as glaucoma subspecialists. And one such study is included on page six of your handout. And I'll wrap up here that the opponents of this legislation have attempted to point to incomplete Medicare billing data as evidence for lack of optometric performance of this procedure. However, that data does not account for instances where that procedure is billed to private medical payers or patients who don't have medical insurance. So we evaluated the electronic health records of optometrists who manage glaucoma in the state and found that 90 percent of the respondents were regularly performing gonioscopy on their patients with glaucoma and glaucoma suspects. I had the pleasure of sitting through all the 407 review, and I, I can answer any question that, that you'd like. I have some additional clarifying points that some of you had asked already, and I'd be happy to address those as well if I can put a finer point on it. Thank you so much.

HANSEN: Thank you. Are there any questions from the committee? I have one question. I kind of wanted you to finish your testimony because you were going to make a point, I think, Senator Hardin had a question about. I was kind of curious about.

CHRISTOPHER WOLFE: Yeah, so, so Senator Hardin had asked specifically how, how much pressure reduction can we expect? The answer is 20 percent based on the studies for SLT. So that's what we would expect to achieve within one SLT procedure.

HANSEN: And it's five years or--

CHRISTOPHER WOLFE: We would expect a three- to five-year duration of treatment. So as we would always monitor these patients over time to make sure that pressures are under control and their visual field and their retinal nerve fiber layer or the thickness of the tissue that connects them, the back of the eye to the brain, that that wasn't progressive as well. So if it was-- if, if we got a lower in pressure, right, we got a pressure lower that was achievable, 20 percent, 30 percent, we would still monitor that patient on a regular basis. And if we saw advancement of the disease and we say, look, the pressure's not low enough, we may need another drop or we may need a repeat SLT or we may need incisional glaucoma surgery. This all happens right now in optometric practices across the state.

HANSEN: OK. And then one other thing that-- I think-- I'm trying to figure out the graphs that you have here. Are you trying to point out the-- how many services per patient with SLT, an optometrist versus an ophthalmologist is? Like, the-- what's, what's the difference there? So say someone goes see an optometrist versus an ophthalmologist, how many services on average--

CHRISTOPHER WOLFE: Oh--

HANSEN: --per patient will each one of them do? Do you know?

CHRISTOPHER WOLFE: You mean just in general services or SLT services?

HANSEN: SLT services.

CHRISTOPHER WOLFE: Yeah, so we can look at data from Kentucky, and I haven't included that, but we will follow up and we'll make a note of that to follow up with you specific data, but when you look at the data over from 2011-- excuse me, 2014 to 2019, so in Kentucky, they passed their law in 2011. It was fully implemented in 2013, and you saw an increase in number from 2014 to 2019 by 50 percent of optometrists that were performing Medicare billed data and the number of, of-- in 2019, and then you actually saw a decrease by 10 percent in ophthalmologists offering this service over that same time period. So what was happening is what we would expect to happen in a lot of places is in those ophthalmology practices where they're offering this procedure, they're going to use their knowledge, education, and training on a much more delicate or more advanced technique, as opposed to letting somebody else who has the training and the certification to provide that. So we'll, we'll see, we've seen that decline a little bit. And after those five years, you saw Medicare data, again, this doesn't capture private pay, but you saw

optometrists performing about 300 procedures and ophthalmologists performing about 900 procedures specifically in that time at the end of 2019, within that year. So essentially what you saw was, was about a quarter of the total 1,200 patient population was having those services by optometrists. Additionally, there was a really great study from ARVO, which is primarily an ophthalmology published publication, that was used in the 407 process to try to show that average drive times to optometrists and ophthalmologists providing SLT procedures was basically the same. But what you found in every single one when you looked at individual communities across the state that were not only served by optometrists with, with this procedure, there was an improvement. So we don't have to wonder if this is going to happen in Nebraska. It's demonstrable when you look at those states, all three of the first states that allowed this, that communities that were not being served by ophthalmologists were being served by optometrists and, and it's significant.

HANSEN: OK. Thank you.

CHRISTOPHER WOLFE: You're welcome.

HANSEN: Yes, Senator Hardin.

HARDIN: Well, I want to commend you. Did you say that you're from Oklahoma?

CHRISTOPHER WOLFE: I'm from Nebraska so I practice in Omaha. I was trained in Oklahoma. Yes, sir.

HARDIN: OK, because there is a certain football prejudice here against [INAUDIBLE]. [LAUGHTER]

CHRISTOPHER WOLFE: Yeah, I know, I'm prejudiced against it as well.

HARDIN: I'm looking at a study and forgive me if I get this name incorrect from the JAMA Ophthalmology journal.

CHRISTOPHER WOLFE: Yes, sir.

HARDIN: Has the technology changed in the last ten years?

CHRISTOPHER WOLFE: Yeah, great question. So some of the viewing technology in terms of the optics of with which we use has changed. It has become more advanced. And that's just like our slit lamps in our office have become more advanced. But the procedure essentially was, was invented or, or FDA approved in 2002. And so we had that

during my training and, and technique-- technology just as anything is going to improve in terms of the nature of it, but the, the basic procedure of what you're doing, the technical aspects of the procedure are the same.

HARDIN: Thank you.

CHRISTOPHER WOLFE: You're welcome.

HANSEN: Any other questions? All right, seeing none, thank you very much.

CHRISTOPHER WOLFE: Thank you so much. Appreciate it.

HANSEN: And we'll take our next testifier in support. Welcome.

ROBERT VANDERVORT: Thank you. Good afternoon. My name is Dr. Robert Vandervort, R-o-b-e-r-t V-a-n-d-e-r-v-o-r-t, and I'm testifying in support of LB216. I've been practicing optometry in Omaha since 1985, and I serve as the chair of the State Board of Optometry in Nebraska. And although I am not appearing today in an official capacity on their behalf, I'm happy to be a resource to the committee about the Board's role in regulating the profession. I will be addressing the issue of public safety and regulation as it relates to optometry in Nebraska. In a few minutes, representatives from ophthalmology are going to state their opinion that optometric education and the regulatory processes in this bill are inadequate to certify optometrists to perform SLT. Their goal is to make you feel uneasy about the safety and competency of certified optometrists to perform this procedure. There are many facts that their unfounded opinion ignores, but one of the most important is the record of safety that optometry has in safely implementing enhancements to optometry scope of practice and the established regulatory bodies and regulations that are in place to protect the public. The underlying creed of all regulatory boards, including optometry, is, quote, protect the public. If a patient believes they've had a bad outcome due to incompetence or negligence by a healthcare provider, they can file a complaint with the Department of Health and Human Services. In addition, all healthcare providers, including optometrists and ophthalmologists, have a legal duty to report any colleague or provider who is not meeting professional standards of care. Filing a complaint is very straightforward and can be done online. Once filed, the department assigns a professional investigator to investigate the complaint. If the complaint is against an optometrist, the investigator will present their findings to the Board of Optometry,

an Assistant Attorney General will be present, along with representatives from the department who advise the Board as they work through the investigator's findings and determine whether any statute or regulation has been violated. If the Board determines that disciplinary action should be recommended, the Assistant Attorney General and department representatives at that meeting will then guide the Board through available courses of action. Once that recommendation by the Board of Optometry is approved by the department and the AG's Office, it becomes public record. Over the last 40 years, ophthalmology has strongly opposed every single enhancement to optometry scope of practice, arguing the implementation of that scope is unsafe for the public. However, the public record clearly shows that no disciplinary actions have ever been taken against a Nebraska optometrist for exceeding or abusing the scope of practice of optometry. Not one violation. Relative to SLT, we have submitted copies of letters from other state boards of optometry in states that authorize optometrists to perform SLT, documenting that there have been no complaints against optometrists relative to their performance of SLT. You do not need to speculate what will happen in Nebraska if LB216 is passed. You only need to look at our past record of responsibility and what happens in other states. Under the provisions of this bill, the Nebraska Board of Optometry will act to ensure that the educational institutions are in compliance with the statutory standards and that all doctors certified meet those standards. This certification process must occur during the Board of Optometry meetings in compliance with the Open Meetings Act. This brings me to my final point. While our opponents, while our opponents have predicted public harm and lack of confidence by optometrists in the legislative arena with every single update to our scope of practice, they have brought no complaints or even concerns about optometry to the state's regulatory bodies over the last 40 years. To the best of my knowledge, no optome-- no ophthalmologist or physician has ever attended a meeting of the Board of Optometry or the Board of Health to express concerns about safety or competence of, of Nebraska optometrists. Any person or group can easily request to be put on the agenda, yet they never avail themselves of the opportunity to truly engage in a meaningful conversation. Therefore, as you once again hear the same unfounded scare tactics of our opposition, please keep in mind that they are totally inconsistent with the public record within the institutions created and supported by the Legislature. I respectfully ask your support of LB216 to authorize optometrists to take better care of our glaucoma patients. I'd be happy to answer any questions about optometric education, the credentialing review process, or the

regulatory process regarding this bill. Thank you and thank you for your service to Nebraska.

HANSEN: Thank you for your testimony. Are there any questions from the committee? Well, you must have done a good job.

ROBERT VANDERVORT: I got it easy.

HANSEN: Or there's a lot of complicated words and we understand what you said. [LAUGHTER] No, appreciate it. Thank you.

ROBERT VANDERVORT: All right, thank you very much.

HANSEN: We'll take our next testifier in support. Anybody else in support of LB216? OK. Well, we'll take our first testifier in opposition. Welcome.

DANIEL ROSENQUIST: Back. Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Dr. Daniel Rosenquist, D-a-n-i-e-l R-o-s-e-n-q-u-i-s-t. I'm a practicing family medicine physician in Columbus and the current president of the Nebraska Medical Association. The Nebraska Medical Association represents physicians who practice medicine in all-- in outpatient clinics, hospitals, nursing homes, emergency departments, and many other settings across the state. Our physician members across the board-- or across the range of specialties are extremely concerned by this proposal because of the risk it poses to patient safety. While proponents of LB216 may tell you that SLT-- and I'm glad somebody else defined that for me, is a simple and harmless procedure, we have to call it what it is. It's surgery. In my surgical specialties, across all surgical specialties-- colleagues across all surgical specialties remind me there is much more to surgery than the actual procedure. These include the proper assessment of the patient, the correct matching of the procedure and the patient, the shared decision-making regarding risk benefit and complication of the procedures, the correct performance of the procedure, and the-- and then as well as the early identification and management of complications that are adverse events. While the proponents of LB216 have urged support that based on a rules-- rule setting that it will increase the access to care. As a rural resident and rural family physician, I don't feel that standard of care should be any different for rural Nebraska than it should be for urban areas. I think it should be the same. We have-- rural Nebraskans can and they have been safely receiving SLT from appropriately trained ophthalmologists in all locations across the state. It appears, it appears to-- this

appears to justify allowing optometrists to perform SLT, but the reality is this has not been the case in other states that have allowed this scope expansion. The NMA participated in every meeting on this proposal throughout the 407 process, and there was no conclusive support for it. Rather, it was rejected by the healthcare professionals of the Technical Review Committee because of their strong concerns regarding inadequate training and a significant risk to patient safety. To quote directly from the final report of the TRC, one, one member said: The proposal raises public safety concerns. Surgery is a serious procedure and requires excellent education and training. The education and training standards in the current optometric proposal are not sufficient to provide assurance of safe and effective provision of the surgical services in question. Convincing evidence of access to care problems was not provided by the applicant group. The services currently being provided by physicians are successfully addressing the demand for these services. The NMA takes an active interest in proposal to change scope of practice because of our mission to protect patient safety. Earlier today, I testified in support of LB202 because pharmacy technicians have demonstrated that they are properly trained and can safely administer routine vaccinations. LB216 is different, it undoubtedly presents new patient safety risks and includes minimal training and education standards, and there is simply no demonstrated need for it. Over the last four years, the NMA has engaged in over-- in other 407 applications to work with healthcare professions to expand scope when patient safety risks have been properly addressed by education, training, and competency. Permitting this elective nonemergent surgery to perform by optometrists places the health and vision of Nebraska patients at unnecessary risk. For the health and safety of all Nebraskans, I urge you not, not to advance LB216. Thank you.

HANSEN: Thank you. Are there any questions from the committee? Yes, Senator Hardin.

HARDIN: Thank you, Mr. Chairman. How long has SLT been around?

ROBERT VANDERVORT: I can't-- I, I would defer that to my ophthalmology colleagues.

HARDIN: Ten states do it.

ROBERT VANDERVORT: Correct.

HARDIN: Forty don't.

ROBERT VANDERVORT: Correct.

HARDIN: What's the matter with them?

ROBERT VANDERVORT: I don't have an answer.

HARDIN: OK. Thank you.

HANSEN: Any other questions? I got maybe a couple of questions. You're talking about your concern with their ability to detect issues after the surgery is done or pre or post-op care. According to them, they currently already do that. And it seems like, that, like, they're trained to do that, right?

ROBERT VANDERVORT: Yes, that's, that was the testimony. Yes.

HANSEN: OK. All right. But still a concern about their ability to do that.

ROBERT VANDERVORT: Always with all procedures in my group.

HANSEN: OK. All right. To me, when I look more at the procedure SLT, it seems almost-- and maybe the ophthalmology friends behind you can correct me, it seems like to me a noninvasive surgery. Is there other noninvasive surgeries like such as medicine, maybe medical doctors that they do, but they also rely on other people to do for them as well?

ROBERT VANDERVORT: I think, I think a lot of-- depends on what you want to call invasive and noninvasive.

HANSEN: It could be different, yeah. Removing a hangnail from a toe, you know, what I mean. And so that does require some kind of, like, you would say noninvasive surgery, right? Like,--

ROBERT VANDERVORT: I could think a lot of--

HANSEN: --with a lot of cutting or bandaging and, you know, I mean--

ROBERT VANDERVORT: --a lot of dermatologic procedures could be done topically with, with--

HANSEN: Yeah.

ROBERT VANDERVORT: --the nitrogen and other types of treatments, laser destruction, and other types of things. But I don't, but I--

they may defer that. I don't know if they can defer that to a physical-- like a physician assistant.

HANSEN: Yeah.

ROBERT VANDERVORT: I think they can. I would have to--

HANSEN: I'm just trying to find some analogies,--

ROBERT VANDERVORT: Yeah.

HANSEN: --you know, to this, especially in your realm and with your expertise I was just kind of curious.

ROBERT VANDERVORT: And again, I think, I think there are some of those dermatologic procedures that a physician assistant can do under the direction of their supervising physician.

HANSEN: OK. That's what I was curious about. OK. Thank you. And thanks for your testimony.

ROBERT VANDERVORT: Thank you.

HANSEN: All right. And with that, we'll take our next testifier in opposition.

VIKAS GULATI: Good afternoon,--

HANSEN: Welcome.

VIKAS GULATI: --committee members. My name is Vikas Gulati. That is spelled V-i-k-a-s G-u-l-a-t-i. I'm a board-certified fellowship-trained glaucoma specialist and a physician scientist practicing in Omaha, Nebraska. I'm here representing myself as an experienced physician and a content expert testifying in opposition to LB216 dealing with laser eye surgery for glaucoma treatment. My comments are my own professional opinion. I have for training wise, I have undergone two residencies in ophthalmology for a total of seven years and three fellowships in glaucoma for a total of about five years. One of those fellowships was under the tutelage of Mark Latina, the guy who invented SLT, for, for a total period of about two years. That is the laser we are discussing today. I've been in the field of ophthalmology for 25 years, of which approximately 19 have been in care delivery to glaucoma patients. My research work has addressed several diagnostic and therapeutic modalities for glaucoma, including medications, laser surgeries, SLT research was a

significant part of my Ph.D. dissertation, which is research that was funded by American Glaucoma Society and the NIH. I have three peer-reviewed publications on the, on the use of SLT and in, in, in clinical use of SLT and approximately ten meeting abstracts on the same subject. I have been involved with training residents and fellows for the last 13-plus years in the proper, safe, and effective use of this delicate and technically difficult procedure as a tool for glaucoma management. When residents first start to train-- to perform trabeculoplasty, they first have to prove their mastery of the technique called gonioscopy, which is a method of looking and finding a tissue called trabecular meshwork in the eye. Since there is no direct view of the tissue in the clinical setting, you have to look for a reflection of the tissue in a mirror and find, find it in that mirror. So you have to do-- it's one thing to find the tissue, it's another to do a laser to the same tissue. You have to be able to consistently find the tissue, stay focused on it despite all the challenges of eye squeezing, deep set eyes, long lashes, patient movement, etcetera. The task of effectively delivering the laser involves delivering 100 or more sharply focused laser spots while looking in a mirror and contending with all of the unpredictable elements thrown at you by an awake patient on the other side with a lens placed on the surface of their eye. If you have not fully mastered what is called gonioscopy, you will likely not be able to deliver the laser to the 300 micron tissue you are looking for in the eye. It is not unusual for a medical resident to go through an entire treatment of glaucoma rotation and not having accomplished this landmark yet. It's going to take them a little bit longer than that. Once you're competent with gonioscopy, you will typically need to watch an attending physician perform several of these procedures. The first few cases are when the attending would perform the first, first [INAUDIBLE] of the procedure and let you do the last one for it. Just keep, keep doing what I was doing there. In my clinic, a medical resident in the first two years of training will not deliver a single laser spot on a patient without me directly observing the spot being delivered and providing guidance on how to adjust the laser spot, how to [INAUDIBLE] the energy based on the response you're seeing from the patient. Performing three proctored lasers, as stated in the bill, may be enough to pique someone's interest, but does not even scratch the surface when considering adequate training to perform this particular laser procedure. Plenty can go wrong with a laser if it is not appropriately performed. My counseling to my patients when talking about any surgical intervention, including laser, is that surgery is only 20 percent. The other 80 percent is before-- what happens before the laser and what happens after the laser procedure.

The success rate of SLT can be somewhere between 20 and 90 percent depending on who you do the laser for, what circumstances your utilizing the particular laser in. Many of my patients, I'm giving them all the 30 percent success even before doing the laser procedure. I worry that giving everyone a hammer will make a lot of things look like nails and will lead to a lot of unnecessary and useless procedures. It may also lead to use in cases where surgical referral was more appropriate, but SLT was done just because of the bias of it being readily available. SLT, in most cases, will take, take several months to even show a modest effect and will be a poor choice for many patients with high pressure and advanced vision loss, thereby delaying definitive surgery and causing irreversible vision loss in the false hope that this SLT might be doing something. SLT is not a cure for all. Every so often you see a patient where SLT, figuratively speaking, backfires and instead of going down, the pressure goes up. A procedure that could have been done electively in a couple of months now needs to be done on the same day, the pressure goes to a high enough level that there is imminent vision loss, imminent risk of vision loss in the next 24 to 48 hours. And in that case, anyone offering SLT must have ready access to incisional surgery the same day if needed. In the ideal world, SLT should only be performed by a fully trained glaucoma specialist or at least someone with substantial training in angle anatomy and care of glaucoma patients. My advice to a 15-year-old at my home who is, is starting to learn driving is that the most dangerous period in learning any new skill is when you have some skills but no experience at all. I would urge you not to put our cli-- put our citizens at the risk-- at the receiving end of such perils. I'd be happy to entertain any questions.

HANSEN: Thank you for your testimony. Are the questions from the committee? Yes, Senator Hardin.

HARDIN: Thank you. How much specific training in terms of time is dedicated to what you go through? Obviously, you, you have even more training it sounds like than most ophthalmologists have as a specialist and with a Ph.D. How much training does an ophthalmologist go through before they are essentially turned loose to do this?

VIKAS GULATI: So the fact of the matter is every ophthalmologist goes through a residency training. Even in my department, which has a multi-specialty, the multiple ophthalmologist, not every ophthalmologist would venture out to do an SLT. They recognize the perils in there. They would let mostly a glaucoma practitioner or somebody with significant experience in glaucoma provider to do the

SLT. Even though they are all certified to do it, they all can do it if they want to, but that's, that's what it comes down to. So any, any resident at the end of ophthalmology training is competent enough having performed enough procedures. Dr. Havens, who has been a program director for our residency program before, can probably give you the exact AUPO numbers as they stand, what, what the required standards are. I would say maybe 15 to 30 cases would be, would be adequate to know. But then again, there are still many cases where things will go wrong afterwards. You need to be prepared for that possibility. Ideally, it would be not just a residency, even a fellowship, a glaucoma fellowship would, would be perfectly safe be able to deliver SLT and recognize where it is useful, where it's not useful, where you're just wasting your time. Not everybody with high pressure gets glaucoma. Even with people with high pressure, you can do SLT for all of them, only 10 percent of them were ever going to get glaucoma, not say ever, in five years, even if you were not to do anything, any kind of treatment intervention for them. So, yes, a big concern would be if it's available, yes, it would be administered willy-nilly.

HARDIN: Clearly, there must be some cases then where this is not a nonemergent procedure.

VIKAS GULATI: It's never an emergent procedure because it needs three months to have an effect. So you need to-- you can only do it for cases that you can wait. If you come in with a patient and you cannot temporize the pressure to a safe level for the next three months, I would not offer an SLT. There I would say, I, I, I would like to do an SLT, it's less invasive, but I don't have the time to wait for a response. We just need to do something more definitive, like an incisional procedure in those cases.

HARDIN: Thank you.

HANSEN: If I can ask a question?

VIKAS GULATI: Sure, of course.

HANSEN: I'm going to kind of ask because you seem like an expert in this. I don't know. [LAUGHTER]

VIKAS GULATI: I'm, I'm scared of that term, so I wouldn't go there, but.

HANSEN: So you should know everything.

VIKAS GULATI: I have experience with it, but that's all.

HANSEN: I'm going to kind of ask some similar questions I asked of a previous testifier. It seems like, because we're talking about pre and postoperative care or the ability to recognize glaucoma as emerging or what kind of procedure we should do, it doesn't seem like that's in question when it comes to optometrists, because they're saying they're getting referred by ophthalmologists after they get this procedure done. They're saying they seem to have the training and the ability to refer somebody when they recognize something like this. So it seems like the pre and post argument, it doesn't stick too well to me anyway, unless there's something I'm missing.

VIKAS GULATI: My honest answer to that because many times when I asked about what is glaucoma, what I tell people is on the first day of my medical school, I knew exactly what glaucoma was. I don't know anymore, I guess is what it is, because sometimes the hardest part for glaucoma is making the diagnosis. It's four or five years of follow. I can-- I get plenty of referrals which got labeled as glaucoma. They were never glaucoma to start with. They were plenty of cases which were labeled as optic neuropathy, but turned out that this was really glaucoma. We were just missing, missing it other way. To me, the most difficult part for me is making the diagnosis in the first place. Then the treatment is pretty cut and dry afterwards, but that's where the challenge comes in because then I know exactly what to do. But what I think, what, what I, what I worry about and I'm sure I've made mistakes too, is doing harm. I guess doing a treatment to somebody who really didn't even need the treatment in the first place. And that's where we hold back a little more when it comes to surgical interventions. If it was adding an eye drop, sure, what's the big deal, I guess you can think of it that way. But laser, I would think once, think twice, think again, is this really glaucoma every time you come to that point?

HANSEN: OK, that's kind of what, I was kind of getting from your testimony. It seems like you're more concerned about the, the preoperative, you know, or the ability to recognize glaucoma in the first place and then, you know, how to treat it, right, and to make the right kind of treatment decision.

VIKAS GULATI: There's a small percentage of cases who are good candidates for SLT. Not everybody is. I offer it to every single new treatment. When I give a fair discussion of risks and benefits of drops verses laser verses other option, nine out of ten patients of mine would choose drops. They say no to to SLT because they, they

think that's a safer thing to do. Maybe it's fear of surgery. They've shown to be equally effective otherwise. But nine out of ten patients with a fair discussion of the other risks and benefits of laser, the other risks and benefits of eye drops would choose eye drops.

HANSEN: OK, because I haven't heard too many arguments like what you're making, right, from other ophthalmologists or even previously in testimonies, like, they don't seem to concerned about an optometrist's ability to recognize glaucoma and what's, what's the, what's the effect of treatment in their opinion? It seems like-- that doesn't seem like something in question, but you're making that now, which makes sense for some of the stuff that you're saying. And if I can ask maybe one more question, I'm trying to separate subjective from objective--

VIKAS GULATI: Sure.

HANSEN: --kind of testimony here. And so we hear a lot of subjective testimony saying we have a lot of concern about what can happen, also that kind of stuff. But then I hear other objective evidence from both sides. But the ones that have been presented so far from the optometrists from the objective side of their testimony is this has been done a lot in other states by optometrists and there's with little to no problems. Is that, is that probably correct, you think?

VIKAS GULATI: I, I am not aware of the complication data, but complication rate would also depend on what part of the spectrum you are doing these lasers in. And I don't think that we are authorizing a laser, we're authorizing for early glaucoma only or only ones with one, one spot. Once we authorize it, you decide who you want to administer it to. I can say here's the gun shoot whoever you want, I guess is what it is at that point. So that's where the concern would be. If you do this laser in people who had a healthy trabecular meshwork to start with anyway, what I tell them, the highest probability of unwanted outcome in the procedure was useless, they didn't need it in the first place. They didn't do any harm. I guess it what it was. Yes, there was revenue lost, time lost, patient was put through a procedure they didn't need in the first place, but that's the biggest downside. There probably won't be any complications in those cases, but did they even need the procedure in the first place.

HANSEN: OK. All right. Thank you for answering my questions. I appreciate that.

VIKAS GULATI: Sure.

HANSEN: Are there any other questions from the committee? All right. Seeing none, thank you very much. Appreciate it.

VIKAS GULATI: All right. Thank you.

HANSEN: And we'll take our next testifier in opposition. Welcome.

WILL WAGNER: Thank you. Good afternoon. My name is Will Wagner, W-i-l-l W-a-g-n-e-r, and I'm a current fourth year ophthalmology resident at UNMC. I'm here representing myself as an ophthalmology surgeon in training that opposes LB216. I'm here to provide a summary of the ophthalmology residency training involved in learning to perform SLT as a comparison to the 16-hour certification course and three proctored cases proposed by LB216. As interns, our first year of ophthalmology residency, we work in glaucoma clinics staffed by board-certified glaucoma specialist ophthalmologists for one to two months. We begin to improve our examination skills with a special focus on gonioscopy, an essential skill in selecting patients for and in performing SLT. During our second and third year as ophthalmology residents, we spend an additional six months in glaucoma clinics improving further on our gonioscopy skills. After hundreds of clinical encounters and hundreds of hours working side by side with glaucoma staff, we start observing SLT procedures performed by our supervising staff through the teaching scope on our laser microscope. With our supervising ophthalmologist's approval, we start to perform SLTs under direct one-on-one observation. We start by completing either a quarter or a half of the laser, and our supervisor treats the remaining portion. During the laser, the staff provide advice on adjustments to laser energy settings and the location of laser application, intervening when needed to safely complete the laser surgery. While we have studied angle anatomy and learned on models, performing an SLT on a living, breathing, and moving patient is much different than doing the procedure on a model. For this reason, it typically takes around five to ten partial laser treatments before we complete a full SLT treatment on a patient. On average, it takes a total of 15 to 20 complete SLTs to confidently complete the procedure regularly, safely, and efficiently. Because of the extensive time working in glaucoma consultation clinics, ophthalmology residents have the opportunity to learn to identify the trabecular meshwork correctly in patients that have difficult anatomy. Unlike the models, every patient is different, and some patients have several pigmented bands in the angle making identifying the correct tissue to treat with SLT challenging. There were several instances when I was a

second or third year resident that I was preparing to treat the wrong structure in the target tissue. This may have resulted in a lack of efficacy and potential harm to the patient. My observing supervising ophthalmologist was able to redirect my surgical plan in all cases. With more experience and time and supervised repetition, I was better able to identify the variances in anatomy and provide an appropriate SLT treatment. It was not until starting my fourth year of residency, during which I spent an additional six months in glaucoma clinics that I began to feel completely comfortable identifying the trabecular meshwork in patients with difficult anatomy and maintaining the aiming beam on the target tissue during the SLT. Over 12 to 14 months in glaucoma clinic, ophthalmology residents learn expert gonioscopy, appropriate patient selection, nuances of applying a laser to the delicate structure of the eye in the setting of difficult anatomy, challenging positioning, heavy breathing, and managing the post laser patient. This includes the possibility of advancement to needing incisional glaucoma surgery in many cases. Please accept the comparison of ophthalmology's 12 to 14 months in glaucoma consult clinics performing at least 15 SLTs supervised by a glaucoma specialist as the current standard for SLT certification in Nebraska to that proposed by LB216, a 16-hour course and three proctored cases. Thank you.

HANSEN: All right. Thank you. And thanking-- thank you for giving your testimony in such large words so don't have eyestrain. The first one.

WALZ: Yeah.

HANSEN: Are there any questions from the committee? Seeing none, thank you very much.

WILL WAGNER: Thank you.

HANSEN: All right. We'll take our next testifier in opposition, please. Welcome.

BARB JOHNSON: Thank you. Hello. My name is Barb Johnson, B-a-r-b J-o-h-n-s-o-n. I am a registered nurse. I work and lead treatment plans in the veterans, in a veterans wellness clinic. I have severe primary open angle glaucoma in both eyes and wanted to share my experience of care delivery. In 2016, my primary ophthalmologist [SIC] informed me that my eye pressures were too high and that I had damage from glaucoma in both eyes. He referred me to what I understood to be a glaucoma consult that would assume and advance my

care moving forward. I was evaluated and followed up in an optometry glaucoma clinic during which I underwent repeated visual field testing and optic nerve imaging. Over approximately the next year, I underwent glaucoma medication adjustments before being told my glaucoma had continued to worsen. I was then told that I needed SLT was indicated. I was referred to an ophthalmologist for the SLT procedure. I felt confused and misled as I had been seeing the glaucoma consultant for a year and my insurance had been billed for specialty level care. But now I was being referred out for an SLT. I thought was the doctor I had been seeing really a glaucoma specialist at all? I spoke with my coworkers at the Omaha VA about my experience, and they told me about the difference in training between optometrist and ophthalmologist. I immediately asked to have my chart reviewed by a glaucoma fellowship-trained ophthalmologist they recommended-- that they recommend it. He advised me that I would be seen-- I needed to be seen urgently and had me in a clinic the next week. He was immediately concerned with my severity of glaucoma, informing me that I had lost 70 percent of my vision in the right eye and I lost 60 percent in my left eye. My eye, my eye pressure level was still too high on maximum drop therapy. He recommended urgent glaucoma surgery in my right eye because he felt the effect of SLT would take too long to lower my pressure. He also let me know that there was a 20 percent chance SLT wouldn't lower my pressure at all. He completed glaucoma surgery in my right eye later that week, immediately lowering my pressure. My left eye was better suited to allow time for the SLT laser to take effect. So SLT was completed in my left eye during the postoperative visits on my right eye. My vision pressure has since stabilized, but I cannot help but wonder how much of my vision could have been saved if I was referred to an ophthalmologist earlier? I was never offered the option of seeing an ophthalmologist that had glaucoma fellowship training despite living only a few miles away from the ophthalmologist clinic I get my care at today. I feel that if I knew the difference in training and surgical focus of ophthalmology, I would have performed-- or preferred to be evaluated by the ophthalmologist at that time of the initial referral and the delay in pressure lowering may not have been an issue. Many Nebraskans do not understand the difference in training and focus between optometrist and ophthalmologist. The information is not always offered when advancement in eye care is needed. So my main goal in, in being here today is to help ensure that other people with glaucoma do not have the same experience I did and suffer an unnecessary delay in more definite-- definitive eye pressure lowering when needed. LB216 would lower the training standards for glaucoma laser surgery in Nebraska and could result in

harm to Nebraskans with glaucoma. I urge you to oppose LB216 for these reasons.

HANSEN: Thank you for your testimony.

BARB JOHNSON: Thank you.

HANSEN: Are there any questions from the committee? Seeing none, thank you very much. Appreciate it. We'll take the next testifier. Welcome.

MICHELE GLEASON: Hello. Good afternoon, Chairman Hansen and senators, members of the Health and Human Services Committee. My name is Dr. Michele Gleason, M-i-c-h-e-l-e G-l-e-a-s-o-n, and I am here to speak in opposition of LB216. I'm a board-certified ophthalmologist. I live on a farm in rural Carroll, Nebraska. I've been practicing ophthalmology in Grand Island, Nebraska for over 26 years. I have treated hundreds of patients and actually thousands of patient encounters with glaucoma patients in my career. Most of the time I treat them with eye drops, some with laser surgery, some with stents and goniotomies in the operating room. I am here today to discuss rural access and the optometric referrals that we have seen in outstate Nebraska for SLT lasers. Last year, in 2022, I had a total of one referral from an optometrist for this type of laser to treat glaucoma. In all the previous 25 years, I've had no referrals from optometrists for a laser trabeculoplasty. There's two other ophthalmologists in Grand Island. Neither one have ever had a single referral for SLT in their entire career. One of them has been practicing for 36 years, the other one 25. I spoke to my other colleagues in outstate Nebraska, asking them how many they had referred. They stated most that they receive is only a handful, a handful of SLT optometric referrals a year. One stated almost half of the patients deemed to be inappropriate candidates that would be at risk of ineffective SLT and the laser was not done. There is no backlog of cases needing SLT. As stated earlier, the procedure is nonemergent. When I personally have a patient that needs a laser trabeculoplasty, I try to do the laser surgery the same day for the patient's convenience. I emphasize to the patient that the laser procedure is not a cure for glaucoma. It's a treatment option that does not work for everyone. It may not be effective for them, and they may still require drops or maybe even surgery to control their disease. It may take two to three months to see adequate eye pressure lowering. I want the patient to know that even after the laser, they still have glaucoma. And because we do not know how long the laser's effectiveness lasts as it decreases with time, they still require

regular monitoring of their disease. There are ever-- over 45 different medications or eye drops that are options to treat glaucoma. These have been the standard of care for glaucoma treatment. The most commonly used drops are once-a-day drops that can be just as effective or in many cases more effective than laser surgeries. Most patients are well controlled with eye drops, and in my experience, of course, I practice in rural Nebraska, a lot of elderly conservative patients, they choose drops well over lasers. As someone stated, they said 10 percent choose the laser. I don't know if I get that many, but I offer them the options. If a patient's glaucoma is not responding to eye medications, it's a compelling reason for the patient to see a medical doctor or an ophthalmologist who specializes in the surgical management of eye diseases. I live in rural Nebraska. I practice in outstate Nebraska. And as I stated earlier, my personal experience and the data do not support enough demand for SLT in rural or outstate Nebraska to justify the bill. Questions?

HARDIN: Thank you for your testimony. Are there questions from the committee? Senator Walz.

WALZ: I just wanted clarification, please. Your first paragraph, you said I've treated hundreds, and then you said thousands.

MICHELE GLEASON: Well, I'm talking patient visits. You know, you have patients, but you see them three times a year, sometimes four times a year, sometimes-- depending on their glaucoma, sometimes more. So those are patient encounters. It's the same patient, so--

WALZ: OK.

MICHELE GLEASON: --lots of patient encounters.

WALZ: OK. Thank you.

HANSEN: Any other questions? All right. Thank you for your testimony. Welcome.

SHANE HAVENS: Good afternoon, Chairman and members of the Health and Human Services Committee. Thank you for having me. My name is Shane Havens, S-h-a-n-e H-a-v-e-n-s. I'm a board-certified ophthalmologist that specializes in glaucoma. I'm here representing myself as a medical professional. I do not speak for the university or the clinics where I worked. After ophthalmology residency at UNMC, I completed a surgical glaucoma fellowship at Duke University. For the last nine years, I worked in private practice and at the VA Medical

Center Clinic, where I supervise ophthalmology residents and the glaucoma consult clinic for our region's veterans. I have authored textbook chapters on the management of glaucoma and have over 20 peer-reviewed publications in ophthalmology journals, including "Ophthalmology Glaucoma." I presented at national meetings, including the American Glaucoma Society, American Academy of Ophthalmology, and the American Optometric Association annual meetings. I have worked with the UNMC residency program to develop the educational and surgical curricula for ophthalmology residents and then evaluate their confidence and procedural performance. We adhere to and work to exceed surgical minima for each resident during their training. This is the current standard for ophthalmologists performing SLT in the state of Nebraska and around the country. For decades, this model has helped ensure high-quality surgical care during ophthalmology training and beyond. As an expert in glaucoma management with an emphasis on surgical education, I believe that LB216 presents a legislative, instead education or data-based scope expansion. LB216 would essentially create two silos of glaucoma care; the current standard with well-defined safety and efficacy data performed by ophthalmologists, and another with unmeasured safety and efficacy and the potential for patient harm. I'd like to highlight and summarize the eight hours of hearings, votes, and comments from the Technical Review Committee during the 407 proceedings earlier this past year. Criterion 1 evaluates if the health and public is inadequately addressed by the present scope. In evaluating this, we compared the per capita rates of SLT in Nebraska compared to seven of the eight states that allow SLT by optometrists and ophthalmologists. They were equivalent to Oklahoma, the state with over 20 years of optometric laser privileges. More than 87 percent of Nebraskans live within a 30-minute drive of ophthalmology offices, and 97 percent of Nebraskans live within a one-hour drive. Nebraskans that need and desire SLT have access. Criterion 2 evaluates if enactment of the proposed changes would propose-- would produce widespread benefits to the public. And if those benefits would outweigh any danger that might be caused. When we look at data in the eight states that allow optometrists to perform SLT, data shows there's been no improvement in access to SLT compared to ophthalmology alone. Optometry has not presented any data in regards to SLT showing an improvement in access. In fact, based on 2020 Medicare data, the largest database encompassing patients of the age that have glaucoma, only eight optometrists in Oklahoma performed SLT, which is less than 1.5 percent of optometrists in the state. Only six optometrists performed SLT in Kentucky, which is 1.25 percent. One optometrist performed an SLT in Arkansas, and none were performed in Louisiana and, and

Alaska. There's been no improvement in access in states that allow SLT by optometrists, and there's also been no demonstrated cost savings that allow optometrists to perform SLT, especially as reimbursement rates for the physicians and optometrists are the same. Criterion 3 states that the proposed change in scope would not create a new danger to the welfare of the public. During the 407 proceedings, no data presented on the efficacy or safety of SLT performed by optometrists was presented. Instead, data from ophthalmologist-performed SLT was presented. But we know that data can't be assumed to extend to optometry given the training differences relayed in earlier testimony. LB216 would thus create a potential safety risk with an undefined safety and efficacy and no real demonstration of benefit or improved access to the laser. Criterion 4 evaluates if current education and training adequately prepares practitioners to perform the skill. Twenty-one of the 23 schools of optometry are in states that don't allow SLT by optometrists. Approximately 95 percent of optometry students graduate from programs in states where SLT is illegal for them to perform. This is further supported by the very small number of optometrists that perform SLT in states that even have decades of privilege. In Nebraska, based on that Medicare data, 11 of 460 optometrist billed for gonioscopy, 2.4 percent. We've heard the importance of this clinical skill. The final criteria evaluate if post-professional programs and competence assessment exist that ensure the procedure is being performed in a safe and effective manner. The lack of safety and efficacy data from the states that allow optometry to perform SLT suggest that a coordinated program doesn't exist. You can't just say no, no, no bad cases means that we're having great efficacy and no complications. Based on the testimony during the Technical Review Committee, its members voted against optometry scope expansion to include SLT with the concerns with the, the, the training proposed mentioned by Dr. Rosenquist. It's my strong recommendation as a glaucoma specialist that cares about safety and the eye health of Nebraskans that you follow the recommendation of the Technical Review Committee and vote to oppose LB216. I'd be happy to take any questions and if, if it's okay, use some additional time to just clarify a few points that, that maybe bring up differences. The applicants propose that ten states have laser privileges. That's true. But when we're looking at SLT privileges, actually Mississippi and Indiana have an exclusion of SLT. To Senator Riepe's question about the return on investment of a laser, the cost of the laser, wen you look at the average ophthalmology clinic and look at about a half of percent of Nebraska's population would probably desire and want SLT, it would take between 17 and 28 years to get a return on

investment of that $50,000 investment with the, the reimbursement on SLT. With education, the, the 10,000 hours is a little bit confusing. That's 50 hours per week over four years, and, and I believe a year and a half or two years are, are, are didactic education. So most studies that look at clinical experience say it's about 2,000 to 4,000 hours of, of clinical experience for optometric education, where it's more like 17 hours-- 17,000 hours to 20,000 hours with, with ophthalmology.

HARDIN: Thank you, Dr. Havens. For the sake of other folks who may be waiting, questions?

RIEPE: I have a quick question. And I'm just seeking some clarification here, because Nebraska being a rather expansive state, you say and I, quote, more than 87 percent of Nebraskans live within a 30-minute drive of an ophthalmologist office and 97 percent of Nebraskans live within a one-hour drive. I'm going to have to assume that's a one way, and then I'm assuming they go home at night so that's 60 minutes or 2 hours.

SHANE HAVENS: Yeah, that'd be correct.

RIEPE: Yeah, OK.

SHANE HAVENS: And as Dr. Gleason alluded to most of these consults can be done in one visit. The current pattern allows direct access to an ophthalmologist in the case that a rare instance happens where the, the pressure goes very high and then need emergent surgery.

RIEPE: My understanding is, though, the vast majority have a follow-up meeting, which I understand from a practitioner standpoint. If I were the practitioner, and I'm not, I would want to have the follow-up visit just to make sure that things went as I thought.

SHANE HAVENS: The typical workflow for this is to check a pressure 30 minutes to one hour after the laser and then have an additional pressure check a week later and then six weeks later to ensure that everything is safe.

RIEPE: But you don't want to have the local grocery store owner doing that check, they have to come back to the office.

SHANE HAVENS: Correct.

RIEPE: OK. Thank you. That's all I have.

SHANE HAVENS: [INAUDIBLE]

RIEPE: Thank you.

HARDIN: Thank you. Any other questions? If not, I have one.

SHANE HAVENS: Yeah.

HARDIN: It's more of a comment. I would ask you to comment on that. A picture that's emerging for me today, and this is important, we all enjoy seeing. Our optometrist friends seemed to be stating or asking, can we do it? And what I'm hearing the ophthalmologists say is, should we do it? Can you comment on that difference? And I may not be correct in my assessment,--

SHANE HAVENS: So--

HARDIN: --but that's what I'm hearing.

SHANE HAVENS: --the best I can do is provide you educational data from ophthalmology residency. When you look at residents, when do they feel comfortable--

HARDIN: Yes.

SHANE HAVENS: --selecting, performing, and following SLT? It's between 15 and 18 procedures, primary procedures where they're doing the entire case. You've heard testimony before. So in that regard, the, the training proposed, particularly by this, of, of three proctored cases, the big questions that lay, are these proctored cases on models, are they on humans? And then who's selecting the cases? You hear testimony from out state that perhaps patients that are thought to be good SLT candidates half the time maybe are thought not to be by the person that would perform the SLT.

HARDIN: Thank you.

SHANE HAVENS: Thank you.

HARDIN: Anyone else in opposition? If there's no one else in opposition, is there anyone in the neutral? If there's no one else in the neutral, I'll turn it over to our resident chiropractor.

HANSEN: He's been trying to get me to provide free chiropractic care already since he's been here so it's not working out too well for him. He's going to hit you guys up for eye care pretty soon.

_____: He would like to see.

HANSEN: All right. So seeing nobody in the neutral capacity wanting to testify, we will welcome back up Senator Hughes to close. And for the record, we do have one letter in support, 11 opposed, and one neutral. Floor is yours.

HUGHES: OK. Mr. Chairman, members of the committee, I'd like to state in closing that optometrists have, since 1998, been allowed to conduct treatment for glaucoma through such means as eye drops and oral medications. LB216 simply allows our local eye doctors the ability to provide comprehensive care to their patients for glaucoma. This legislation provides safeguards to ensure optometrists have the training needed to safely perform this procedure. And now I'm going off script for a second just from the things I heard. Optometrists are trained in gonioscopy, which is using when you guys go see the eye doctor, it's that microscope you lean your head in and then they use the slit lamp to look into the, into the eye. They use it every day in seeing patients. The SLT treatment, I think, is you use that microscope and you add the laser, they use that slit lamp to then fire the cold laser on that part to, to cut the eye. So I feel like sometimes people are saying that they're not trained at all. They've got to learn how to do gonioscopy and all that. They've got the gonioscopy part. It's the laser part that gets added. I don't know what that sound is. What is that?

HANSEN: I don't know.

HUGHES: Somebody's calling us.

WALZ: Yeah, somebody's calling.

HUGHES: Licensing-- all right. Oh, it is. Somebody's calling us. That's exciting.

HANSEN: OK. You can continue.

HUGHES: OK. Licensing and regulatory bodies in other states that allow doctors of optometry to perform SLT have verified that it is safe and it benefits the public. Why would our experience in Nebraska be any different? Why would this Legislature think that our optometrist license in our state are somehow less competent or capable than their counterparts in other states. Addressing access to care, SLT typically is a two-trip procedure. Billing and coding of SLT supports this as a two-trip procedure. The first is for the examination of the patient and a scheduling of the SLT. The second is

for the actual procedure. The actual time to perform the SLT is an average of ten minutes per. However, it takes around two to three hours with pre and post-procedural care. This does not account for driving time, wait time, etcetera. Potential lodging, meals, time from work, and the time of a loved one or friend to assist in driving are all access to care issues with the status quo. Let us take a moment and consider that a glaucoma patient from Valentine must travel to North Platte, the nearest SLT location, a round trip of 264 miles for one trip. Accounting for the initial SLT exam and scheduling appointment and the second procedure appointment, we're looking at two roundtrips totaling 528 miles. To put that in a little perspective, here in Lincoln, we are 430 miles from Minneapolis, 430 from Oklahoma City, 490 from Denver, and 522 from Chicago. All distances which are closer than two round trips for a glaucoma patient from Valentine trying to seek SLT treatment. I do not-- I fail to see how this is not an access to care issue. This is about access. This is about patient-- or about the care of patients. And it's about our local communities. This is about doing what's right for Nebraskans. Thank you, Chairman, and the members of the committee. I appreciate your consideration to favorably report LB216 from this committee.

HANSEN: All right. Thank you. Are there any final questions from the committee? There are none. So thank you very much. Appreciate it. And that will close the hearing on LB216, and that will close the hearing for this afternoon.