HOWARD: Good afternoon and welcome to the Health and Human Services Committee. My name is Senator Sara Howard, and I represent the 9th Legislative District in Omaha, and I serve as chair of this committee. I'd like to invite the members of the committee to introduce themselves, starting on my right with Senator Murman.

MURMAN: Senator Dave Murman, District 38: Clay, Webster, Nuckolls, Franklin, Kearney, Phelps, and a part of Buffalo County.

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

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

WILLIAMS: Matt Williams, District 36: Dawson, Custer, and the north portion of Buffalo Counties.

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

HOWARD: And we are also joined by our legal counsel, Jennifer Carter, and our committee clerk, Sherry Shaffer. And we have two pages today: Maddy and Nedhal. Nedhal, hey. Thanks, guys. A few notes about our policies and procedures. We ask that you turn off or silence your cell phones. This afternoon we'll be hearing two bills, and we'll be taking them up in the order listed on the agenda outside of the room. On each of the tables near the doors of the hearing room, you will find green testifier sheets. If you're planning to testify today, please fill one out and hand it to Sherry when you come up to testify. This will help us keep an accurate record of the hearing. If you are not testifying at the microphone but want to go on record as having a position on this bill, on a bill being heard today, there are white sign-in sheets at each entrance where you, where you may leave your name and other pertinent information. Also I would note if you are not testifying but have written testimony to submit, this committee's policy is that all letters for the record must be submitted, must be received by the committee by 5:00 p.m. the day prior to the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. We would ask that, if you do have any handouts, please bring ten copies and give them to the page. We do use the light system in this committee. You have, each testifier has five minutes. When you begin the light will be green. When my light turns yellow, you would have one minute left and, when it turns red, we will ask you to wrap up. When you do come up to testify, please begin by stating your name

clearly into the microphone and please spell both your first and last name. The hearing on each bill will begin with the introducer's opening statement. After that we will hear from proponents, opponents, and neutral testifiers. And then the introducer of the bill will be given an opportunity to make a closing statement, if they wish to do so. We have a solid no-prop policy in this committee. And with that, we will begin today's hearing with LB25, Senator Kolterman. Welcome.

KOLTERMAN: Thank you, and good afternoon, Madam Chair Howard, members of the Health and Human Services Committee. I'm Senator Mark Kolterman, M-a-r-k K-o-l-t-e-r-m-a-n. I represent the 24th District in the Nebraska Legislature. I'm here today to introduce LB25 on behalf of the Nebraska Medical Association. LB25 is different from LB1127, which I introduced, introduced last year, as this bill excludes nurses, occupational therapists, pharmacists, physical therapists from being required to pay a fee. The revenue from this fee would be used to support the educational and patient safety activities of a patient safety organization described in Section 71-8701 through 71-8721. This fee would sunset January 1, 2026. In 2005 the Nebraska Legislature passed legislation to form the Nebraska Coalition for Patient Safety. LB446 was introduced by Senator Jim Jensen of Omaha, on behalf of the Nebraska Hospital Association, the Nebraska Medical Association, the Nebraska Pharmacists Association, the Nebraska Nurses Association, the Nebraska Health Care Association, and other healthcare organizations. It was proposed back then to improve the safety and healthcare delivery in Nebraska where stakeholders examine the system and issues that contribute to a patient's harm and eliminate those issues as much as possible. Since 2005 the NCPS has been operating as a funds contribute, operated on funds contributed by the Nebraska Medical Association, the Nebraska Hospital Association, the Nebraska Pharmacists Association, and grants from other entities such as COPIC. COPIC is a company that sells insurance in this state for malpractice. No state funds have ever been allocated to the NCPS and, thus, the NCPS's current ability to support patient safety is limited by its reliance on member fees and grants for financial support. Leaders of, leaders and members of both Nebraska Medical Association and the NCPS have worked together to develop a strategy to improve funding for NCPS that will enhance its efficiency, effectiveness and visibility. These are, these, these efforts are consistent with the Nebraska Medical Association vision to improve the infrastructure for patient safety statewide. LB25 creates a patient safety fee of $50 biennially for a license for physicians and osteopathic physicians and $20 biennially for a license for physician assistants [INAUDIBLE] financial support

for NCPS. The NMA leadership believes that if these healthcare providers have skin in the game by paying this fee each year, then NCPS will have more financial support and providers may be more engaged in the patient safety effort. The NCPS would use these additional financial resources to expand their efforts to nonhospital settings and would provide the same federally mandated protection from discoverability for patient safety events in all settings in which licensed providers practice in Nebraska. Consistent with the mission to improve quality and safety of healthcare in the state, this information will be used to identify the unique and common patient safety needs of all stakeholders. If this legislative initiative is successful, NCPS will convene a strategic planning effort with representatives, all provider groups, in settings to listen and plan a comprehensive needs assessment, assessment for patient safety infrastructure, and infrastructure in this state. This infrastructure includes the four key components of a culture of safety: reporting infrastructure; just, just cultural infrastructure; team training; and organizational learning. LB25 sunsets this fee on January 1, 2026, for the Legislature to determine whether the fee has accomplished the goals that they're proposing. I'd like to highlight Evelyn McKnight's experience, who was unable to join us today. Evelyn is one of the 99 Nebraskans who contracted hepatitis C through a medical error in Fremont in 2002. All 99 individuals were cancer patients who went to a doctor for help but came away with another deadly disease. Six of those 99 have passed away from, from the outbreak, not their initial diagnosis of cancer. The outbreak that occurred in Fremont is the largest outbreak of hepatitis C in the country. This outbreak occurred because nurses at that provide, at that provider used dirty syringes that had previously been used on patients known to have hepatitis C. I've handed out a copy of her testimony, if you wish to read her story in greater depth. The worst part of her story, and every medical malpractice story, is that these errors are preventable. The Fremont outbreak is not the only example of medical malpractice in the state. In 2016 the Heartland Health Research instituted, Institute estimated the number of annual fatalities in Nebraska hospitals due to preventable medical errors ranged from 590-2,620 people. That report is attached to Evelyn's testimony. With greater funding, the NCPS will be able to work with, more diligently to make sure outbreaks such as what happened in Fremont never happen again and to make preventable deaths and injuries much rarer in this state. With that, I'd thank you for your consideration. I'm happy to try and answer any questions. If you don't have questions for me, there will be doctors following me and others that are involved in the industry. We think this is a, is

a-- it's designed to raise some revenue, and it's designed so that physicians and physicians' assistants are the ones that are contributing voluntarily. This is not a tax on anyone. If you go back and you look, since 2005 there's been money raised. The money is harder to raise, but they believe that, if they, if they step up to the plate, money will follow towards this endeavor. So with that, if you have some questions, I'd be glad to try and answer those for you.

HOWARD: Are the questions? Senator Williams.

WILLIAMS: Thank you, Senator Howard. And thank you, Senator Kolterman, for bringing this back again this year. I just want to be sure I understand it, you know. Does this change the current stream of funding or is this in addition to, hopefully, continuing the other funding that you're currently receiving?

KOLTERMAN: It doesn't really change-- well, the problem that we're experiencing is that much of the funding has gone away; much of the grant money that has been there originally has gone away. And so they're, they were looking for ways to spur that, spur that. The program really isn't going to change a lot. The Medical Association just felt if we could step up to the plate, the physicians' assistants said if we could step up to the plate, maybe we can encourage people to follow our lead and continue, continue to contribute.

WILLIAMS: The hospitals continue to--

KOLTERMAN: Correct.

WILLIAMS: --would continue to contribute.

KOLTERMAN: Correct.

WILLIAMS: Thank you.

KOLTERMAN: Hopefully this will serve as a catalyst to promote that.

WILLIAMS: OK.

HOWARD: Other questions? Senator Arch.

ARCH: I've, I've got a question. I don't know if you're the one, and maybe, maybe those who follow you can answer the-- I've got several questions. I'm not, I'm-- I guess I haven't been familiar with the

cash fund, you know, from my own experience. It-- what is a patient safety organization?

KOLTERMAN: From my understanding, it's, it's all of these, it's, it's all of the entities that I talked about early in the bill: the Hospital Association, the Pharmacists Association, the Nurses Association, the Medical Association. They all come together and try and figure out how we can increase patient safety.

ARCH: OK. So it's collaborative amongst the--

KOLTERMAN: It's a collaborative--

ARCH: --providers.

KOLTERMAN: Yes.

ARCH: And then, and then who makes the decision where the money is, is spent?

KOLTERMAN: You'll have to ask them that question.

ARCH: OK, all right. And, and as well, I'll ask, how was past money spent?

KOLTERMAN: OK.

ARCH: Yeah.

KOLTERMAN: Very good.

HOWARD: All right. Other questions? Senator Hansen.

B. HANSEN: You said now this excludes nurses and who else from having to pay and where previously you were trying to get--

KOLTERMAN: Well, in the past-- last year we brought a bill and we had pharmacists, nurses-- let me find it.

B. HANSEN: Yeah, that's fine. It was in your opening statement. I'm trying to remember which one it was.

KOLTERMAN: Last year we, we had included nurses, occupational therapists, pharmacists, physical therapists. We had included all of

them in the bill. There was opposition on their part, so we took them out.

B. HANSEN: OK.

KOLTERMAN: That's the only change that we really made to the bill.

B. HANSEN: OK. Now since they're not going to be paying anything, are they still going to be a part of this collaborative effort and be a part of this standing group?

KOLTERMAN: As I understand it, they'll still be involved, yes.

B. HANSEN: OK, even though this, the incident you reported was caused by nurses? Just wondering.

KOLTERMAN: Yes.

B. HANSEN: OK.

KOLTERMAN: We're-- this does not take-- we're not taking, we're not trying, we're-- patient safety is patient safety.

B. HANSEN: Sure.

KOLTERMAN: Everybody needs to be involved. The doctors and the physician's assistants are taking a lead, a leap of faith, and saying: we think this is important. They regulate their industry very similar to how the insurance industry is regulated. Agents pay a fee, everything is handled through the cash [INAUDIBLE] funds the Department of Insurance. The Medical Association believes very strongly in patient safety, and so they're taking the lead--

B. HANSEN: Sure.

KOLTERMAN: --on this, along with the physician's assistants.

B. HANSEN: OK.

KOLTERMAN: But again it's all voluntary on their part. They brought the bill to us.

B. HANSEN: OK. And then this would, this would, but this makes it mandatory for every physician--

KOLTERMAN: Yes.

B. HANSEN: --to pay it no matter what?

KOLTERMAN: They pay at their licensing time--

B. HANSEN: OK.

KOLTERMAN: --when they renew their license.

B. HANSEN: And so, and I'm kind of like with John, since I'm new, and--

KOLTERMAN: Yeah.

B. HANSEN: --the Patient Safety Cash Fund is going to be created now or it was created in the past?

KOLTERMAN: We already have one. This will just, as I understand it, this will just continue to enhance that.

B. HANSEN: OK. And it was funded by grant money before?

KOLTERMAN: Yes.

B. HANSEN: It was, where was the grant money from? I'm sorry, I don't mean to be picky; I'm just curious.

KOLTERMAN: Yeah, it's, it's industry moneys.

B. HANSEN: OK.

KOLTERMAN: I know insurance, some insurance companies paid into it, some of the associations paid into it.

B. HANSEN: It makes sense insurance would try to because it helps them with their--

KOLTERMAN: Yeah. Well obviously, if you get a malpractice insurer, they want to make sure that patient safety is the utmost.

B. HANSEN: Sure.

KOLTERMAN: I'm sure that's why COPIC was involved.

B. HANSEN: OK.

KOLTERMAN: Good question.

B. HANSEN: Yeah, thanks.

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

KOLTERMAN: Yes, I will.

HOWARD: Thank you. We'll now invite our first proponent testifier. Good afternoon.

KATHERINE JONES: Good afternoon, Chairperson Howard and members of the Health and Human Services Committee. My name is Katherine Jones, K-a-t-h-e-r-i-n-e J-o-n-e-s. I'm the president of the board of directors of the Nebraska Coalition for Patient Safety. I am testifying on behalf of the coalition. I am a physical therapist and a health services researcher who has conducted patient safety research in Nebraska since 2002. Based on the best estimates available, deaths due to medical errors in hospitals may be the third leading cause of death in our country. These estimates are made by extrapolating from observational studies and actuarial reviews to state and national populations. This approach suggests that 40,000-68,000 people may be harmed annually while receiving care in Nebraska hospitals, and that 600-2,600 may die. Because adverse event reporting to the coalition is voluntary, we receive just a fraction of this estimated number of reports. Senator Kolterman briefly described the hepatitis C outbreak that took place in Fremont from 2000-2002. Why did this largest known outbreak of hepatitis C in U.S. history happen? For the very same reasons that the majority of adverse events occur. We, healthcare professionals, inadvertently harm patients because we learned very little about the nature of human error, systems thinking, and learning organizations during our training. Learning organizations ensure that front-line staff are trained to speak up to those with more authority. In Fremont, it is likely that nursing staff were not trained, were not empowered to speak up and advocate for safe injection practices. We harm patients because we are fallible human beings caring for patients within complex systems. We must have a way to rapidly learn when technological innovation collides with human fallibility. Human factors, such as multitasking, memory failures, lack of leadership, poor communication, are the most frequently identified root causes of all adverse events. Finally, we harm patients because the organizations in which we work too often review harmful events in isolation. Due to fear of litigation and adverse publicity, many

healthcare organizations remain reluctant to share the number and the nature of these events with others for learning purposes. The state of Nebraska sought to improve patient safety in 2005 by protecting reported events from discovery and establishing a private, nonprofit patient safety organization to receive those events. However, that Patient Safety Improvement Act of 2005 did not provide any funding to support this new patient safety organization. The coalition has sought to achieve the goals of the founding legislation. We have encouraged a culture of safety by training hundreds of nurses in Nebraska to conduct root cause analyses in support of organizational learning. We have trained hospitals to use the principles and tools of just culture and teamwork in support of organizational learning. We assist hospitals to measure and improve their culture of safety, we share lessons learned from reported events, and we conduct education to address knowledge and skill deficits revealed in reported events. The problem is that these efforts have to be limited to our 59 member hospitals that pay that subscription fee. Relying on voluntary member and sponsor fees limits our capacity to understand the scope and nature of patient safety risks across the continuum of care. If LB25 is enacted, the coalition will expand legal protection from discovery for reported events from hospitals to ambulatory care, where the majority of healthcare services are provided. We will conduct a patient safety needs assessment, develop a strategy, a strategy to address cross-cutting priorities, medication safety, opioids. And we will evaluate the effectiveness of our efforts to be prepared for that sunset provision. We will hire additional staff with knowledge and skills in clinical care, informatics, human factors, and organizational culture. We will implement a communication plan to provide feedback to healthcare professionals and the public to describe the patient safety hazards we identify and the resources needed to address them. And we will expand our efforts to ensure all healthcare professionals have the skills and the language needed to advocate for patients. In summary, if LB25 is enacted, the Nebraska Medical Association and the Legislature will send a powerful message to healthcare organizations, providers, and governing boards that more needs to be done to keep Nebraskans safe while receiving care that is intended to help them. Thank you.

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

B. HANSEN: You want to go first? OK. So you guys' organization has been established since 2002, right?

KATHERINE JONES: 2005.

B. HANSEN: 2005, OK. OK. Oh, OK. So since 2005 until today, have medical errors gone up or down?

KATHERINE JONES: You know, medical errors are a problem in measurement because it's-- you can-- as a researcher we may know the denominator of something, like you may know the number of doses dispensed in a hospital, but we will never truly know the numerator. A saying among patient safety researchers is that if you're afraid to report, you only really report the things you can't hide, like the patient who's fallen on the floor. So it's a problem in measurement of knowing a true numerator and a denominator. What we do know is that, very typically, when an organization embraces a culture of safety, and what you embrace is learning about your system, that oftentimes reporting goes up. So what we have to look at are those types of things that we can measure in a knowable way, like healthcare-associated infections that are mandated to be reported, like central line infections and catheter-associated urinary tract infections, and falls. So what's gone on in Nebraska, I can't tell you. But I know what the national trends are. There have been some decreases in healthcare-associated infections, particularly those in which hospitals no longer are paid for events that occur: Health, healthcare associated infections. You come into the hospital, you didn't have a urinary tract infection, they put a catheter in, and now you have one. That's a healthcare-associated infection, a surgical infection. Things that healthcare causes, those things have gone down because they no longer get paid for those by Medicare.

B. HANSEN: And I agree with that. I think health-- I think medical error is, seems like it's not a growing trend, but we start to see the plethora of errors that we start to see over time, not just inadvertent medical error or, or ones that could be prevented, but even nonpreventable medical error, like you give somebody the right medication and they still have a, you know, a side effect from it and, and a fatality. Last I saw the statistics, statistics says that the number one killer in United States is preventable and nonpreventable medical error. And so I think something is needed to be done, so I applaud your effort for doing all this kind of stuff. I especially like it when we have some money for this, but we'd like to see private industry get involved-- the grant money that you have. So anytime we have government get involved trying to take money from somebody else and give it towards something, you know, like, like your guys'

organization, I like to make sure we have a return on investment so we can have some kind of "calculatable" way of seeing that this is working or not. And I think that's the purpose of, maybe, the sunset, so we can, after a certain amount of time, see whether this is working or not. And that's kind of why some of the questions I have is if we're going to give money to the organization, how do we know it's working? How do we know it's actually preventing some of this?

KATHERINE JONES: And as a health services researcher, what I would like to do is to carve out a very specific topic where we can measure, have a baseline measurement of types of events. And I would love to do that on something that's, that's highly, that Medicaid sees a lot of. So let's pick an event. Let's focus on it, and let's, let's see if we can carve out a specific event that we can track over time with a specific intervention, is what I would like to do with this part of the additional funding.

B. HANSEN: OK. Can I get just one more quick question?

HOWARD: Sure.

B. HANSEN: The money coming from this, the fee would come from physicians. Right?

KATHERINE JONES: Physicians and physicians' assistants.

B. HANSEN: What is a physician? Is it a medical doctor? Is it a DO? Is it a chiropractor?

KATHERINE JONES: It's just DOs and, and medical, and, and medical doctors.

B. HANSEN: OK. 'Cause I know it's, most of this is going towards hospitals. I'm just kind of making sure it's--

KATHERINE JONES: And that's one of the things that we really want to be able to do, and particularly with the PAs, is the vast majority of healthcare is provided in ambulatory settings.

B. HANSEN: Um-hum.

KATHERINE JONES: And we know that the biggest errors in ambulatory care are missed and delayed diagnoses. Medication errors are the biggest single two things that occur in ambulatory care. Usually when I teach this, I ask for a raise of hands of those who have experienced

a medical error or have a family member that's experienced a medical error. And even with young, young people-- physical therapy students are typically 22-26 years of age-- half the class will raise their hand and relate a story about, particularly, grandparents. So we know that these things happen to everybody.

B. HANSEN: Thank you; appreciate it.

HOWARD: Senator Williams.

WILLIAMS: Thank you, Chairperson Howard. And thank you, Miss Jones, for being here today. Can you tell me a little bit more about the coalition? Who are the members of this coalition?

KATHERINE JONES: So the coalition was founded by five professional associations in Nebraska: the physicians, the physician assistants, the pharmacists, the nurses-- where am I? Who am I missing? Oh, the Hospital Association, yeah. So those were the five founding associations. And they got together in the early 2000s to develop an issue strategy group, and then that initial bill was passed, then, in 2005. Simultaneously, at the federal level, there was legislation passed mandating federal patient safety organizations. So we are also listed as a federal patient safety organization, so that that protection from discoverability of events also is protected at the federal level. So if you violate that discoverability, it's, it's a civil rights, the civil rights that follow up on that. So there are out there 83 federal patient safety organizations in the country. We are currently the, we are the only one in Nebraska. And the only one-- Kansas does not have one. South Dakota does not have one. Wyoming does not have one. Montana does not have one. So we, we try to reach out to hospitals in those surrounding Great Plains states where we have a high proportion of critical access hospitals. So of the 84-85 general community hospitals in the state, 64 are critical access. I'm originally from Holdrege; I was born in Holdrege. So I seek to provide resources to those providers who have to be able to deliver a baby. You have a nurse that has to run down to that emergency room, and now she's an expert in frostbite or she's an expert in a, an agricultural accident. They have to be all things to all people. And we seek to be a connector to the best evidence for patient safety for these folks.

WILLIAMS: Thank you for helping me understand that a little better, and I applaud your efforts. The statistics that you have shown and that Senator Kolterman has brought forward are, are scary, to say the least, and especially when they are preventable. I have a question

about your testimony. When you say if this legislation is enacted, the coalition will expand legal protection from discoverability, do you have that ability?

KATHERINE JONES: That, that, that's probably not the best way to put it. We by-- as a patient safety organization, anything that, any event that is reported to us-- lay people call us and report events. As soon as something is reported, all of the information about a provider, information about that patient that would be protected health information, becomes protected by law. So what we mean by expansion is expanding, say, to an ambulatory clinic, so that clinic would be able to report to us then; that would expand our ability. So that was probably poorly worded on my part so that, that that ability exists by virtue of our being designated as a patient safety organization by the Agency for Healthcare Research and Quality.

WILLIAMS: I just want to make it abundantly clear that, if this Legislature passes this legislation in its current form, it doesn't change legal responsibilities that are currently in existence.

KATHERINE JONES: No, no, no. It's-- everything reported to the coalition is voluntarily reported. Some states mandate reporting, but Nebraska does not. So everything is voluntarily reported, which goes back to Senator Hansen's question about how do we measure improvement, when the people who really want to be safe are the ones that are reporting and those that want to hide don't report.

WILLIAMS: Thank you.

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

KATHERINE JONES: Thank you.

HOWARD: Our next proponent.

BRITT THEDINGER: Good afternoon, Chairperson Howard and members of the Health and Human Services Committee. I'm Dr. Britt Thedinger; Britt, B-r-i-t-t Thedinger, T-h-e-d-i-n-g-e-r. I'm a private-practice ear physician and surgeon in Omaha, and I have the distinct pleasure and honor of being the current president of the Nebraska Medical Association. So I'm here on behalf of myself and as the, from the NMA, speaking in strong support of LB25. And we also want to thank Senator Kolterman again for his introducing the bill and championing patient

safety. Dr. Jones did her usual excellent job in describing the Nebraska Coalition for Patient Safety, its mission and the benefits of increased funding. And I don't want to be redundant. It's important to remember that most medical errors can be prevented. All healthcare individuals need to work hard every day to protect our patients from errors, injuries, accidents, and infections. As the Institute of Medicine defines safety, it's the freedom from accidental injury. The Legislature, as you now know, created the Nebraska Coalition for Patient Safety. The coalition, actually in 2006, in response to the Nebraska Patient Safety Improvement Act of 2005, but again with no funding. And currently the coalition serves, survives on a limited budget, supported by the founding members and the 59 hospitals. The information now collected never reaches physicians and most all other healthcare providers. So several years ago we went to Dr. Jones and the board of the coalition to see how we could better fund the coalition to make it more effective, and not only to include hospitals, but to include physician offices, ambulatory care centers, and surgery centers. This would allow the coalition to gather information from the greatest number of patient contacts. Also, it would enable an increase in data collection, reporting systems, and the consistent and regular dissemination of this information to all physicians and PAs, keeping patient safety first and foremost. The coalition came out with a plan of additional staff and an expanded budget. And we took that dollar amount and divided it by the number of physician licenses and PA licenses. And that's how we came up with the $50 every two years for physicians, MDs, and DOs, and $20 for the PAs every two years. And we're proud to have the PAs join us on such an important issue. Even with this very modest increase, we will still have the lowest cost of a license in the region. We have discussed finding funds within the state budget with the Governor and the Legislature but nothing has happened. We feel very strongly that patient safety is the number one priority now. After all, we are all patients, now or sometime in the future, and none of us expect to be harmed. We physicians are committed to patient safety and thus want to help fund the coalition ourselves. We see this as an investment. We're not asking you to come up with any money; we want to pay for this ourselves. Again this participation and subsequent information collected will be shared with every license holder every quarter, keeping patient safety constantly on everyone's mind. We owe this one to one of Nebraska true heroes, and that's Evelyn McKnight. So thank you for the honor of testifying here today.

HOWARD: Thank you, Doctor. Are there questions?

B. HANSEN: I've got one.

MURMAN: Oh.

HOWARD: Senator Hansen.

B. HANSEN: I think this is, comes back to my questions I asked Mrs. Jones, and you kind of even just touched on it in your testimony, is I do have a problem any time the government has to get involved on creating a fee or taking money from somebody who may not agree with that, but that's one of the questions I had of her, was like where's this where's this money going to and who are we taking it from. And that's why I was asking the question about what, which physicians we're taking it to, because that's where the money is going to go. So just like you just said, this, you guys want this to happen, it is going towards you for patient safety. And, and so that's one of, one of the questions why I had that, and so--

BRITT THEDINGER: And that's where we really came up with this specific number and we tried to say: Look, what is the budget? Let's not have excess. Let's hone this in. And what's, where do we get the most for our money?

B. HANSEN: Sure.

BRITT THEDINGER: Because yes, it's my $50. I'm going to go from $121 every two years to a whopping $171 every two years, which is still probably a third of most every state that surrounds us.

B. HANSEN: Sure. And it just, maybe it's just I'm a-- you know, because I'm a chiropractor.

BRITT THEDINGER: Right.

B. HANSEN: I was just asking that 'cause I'm like, am I going to be paying $50 and it's going right towards the hospital?

BRITT THEDINGER: Just MDs, DOs, and PAs.

B. HANSEN: OK, and that's, that's cool with me then. So that's what I was-- I want to make sure we're not taking it from somebody where

they're not going to get any return on investment for their, for their $50.

BRITT THEDINGER: Correct.

B. HANSEN: And, and just one more. Is there any other way, before we have to create a law, to increase funding for this maybe from your guys' own associations? Or is this kind of the best way you guys see fit for this?

BRITT THEDINGER: We've thought about this extensively, saying: Hey, why don't we just go to every medical staff and every hospital and just raise the med staff dues. But that requires every hospital to do that-- every facility, every office. We've gone to the Governor many times, and we've asked for is there any funding that we could ever get this [INAUDIBLE]. This really comes out to about $400,000-- the fee. So we just really have exhausted any possibility. And we think this is probably the most equitable thing. And we, as physicians, we have buy-in now. And, and the coalition-- if we are sending the money, then we're going to get the information every quarter, 'cause right now we're not getting this. They do great work but we never-- I bet if you ask most physicians in the state, do you know about the Nebraska Coalition for Patient Safety, and they'd say no.

B. HANSEN: I think I applaud-- I applaud the efforts you guys are doing. Thank you.

BRITT THEDINGER: You're welcome.

HOWARD: Any other questions? Senator Arch.

ARCH: Dr. Thedinger.

BRITT THEDINGER: Yes.

ARCH: Thank you for doing this; this is great. I, I would, I would say though that, as far as physician's fee, certainly in the Omaha-Lincoln area, would you say the majority of those physicians are in an employed, in an employed position where the organization will end up paying the additional fee?

BRITT THEDINGER: In Omaha probably more than 50-60 percent. Lincoln is still a very independent--

ARCH: OK.

BRITT THEDINGER: --town.

ARCH: OK.

BRITT THEDINGER: And then, of course, when you go out in greater Nebraska, that's going to be still a lot of employed physicians.

ARCH: I think the challenge, the challenge would always be making sure that the hospitals, that while this is coming with a physician fee, that the hospital gets that information to the physicians.

BRITT THEDINGER: Correct. And right now the NCPS sends the information to the hospital, but the hospital administration never gets that down into the physician level. And that's why we feel like we're not getting this. We need to be stakeholders. We need to be investors. I mean if we can prevent just a fraction of, of errors, we cut medical costs. So it's an investment in trying to reduce harm to patients, which reduces healthcare costs. So I think it's a win-win for everybody.

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

BRITT THEDINGER: Thank you.

HOWARD: Our next proponent? Good afternoon.

MICHELLE WEBER: Good afternoon, Chairman Howard and members of the Health and Human Services Committee. My name is Michelle Weber, M-i-c-h-e-l-l-e W-e-b-e-r. I' m testifying in support of LB25 on behalf of our client, the Nebraska Academy of Physician Assistants, also known as NAPA. NAPA is the state professional organization for physician assistants with PA members across the state. NAPA greatly appreciates the efforts of Senator Kolterman to enhance patient safety activities. As has been mentioned, NAPA is one of the five founding organizations of the Coalition for Patient Safety and remains committed to ensuring safety and quality of healthcare in our state. NAPA believes a modest patient safety fee for healthcare providers is appropriate to increase funds for the coalition. NAPA supported LB1127 last year and is working collaboratively with NMA on this year's bill which is, of course, limited to physicians and PAs. If funding is provided to enhance coalition activities, NAPA would be interested in having the coalition provide PA-specific information regarding patient

safety events that would provide valuable improvement specific to our profession. Thank you for consideration of this legislation, and we respectfully request your advancement of the bill.

HOWARD: Thank you. Any questions? Seeing none, thank you for your testimony today. Any other proponent testifiers? Seeing none, we do have one letter for the record from the Nebraska Hospital Association, from Andy Hale and David Slattery. Is there anyone wishing to testify in opposition to LB25? Seeing none, is there anyone wishing to testify in a neutral capacity? Seeing none, Senator Kolterman, you are welcome to close.

KOLTERMAN: Thank you again, Senator Howard and members of the committee. I would, I would ask if-- everybody should have a copy of the fiscal note. And in the fiscal note, Senator Hansen, it does break down the three different organizations, or the three different occupations and it kind of gives you an idea--

B. HANSEN: Um-hum.

KOLTERMAN: --of where the money's coming from. I think it's just remarkable that this organ, these organizations would step forward and say patient safety is number one, something that we've talked about a lot in this committee over the years. So I, I, I think they, they garner a lot of respect. And the other idea is, I think in doing this they will get some more traction; they will get some money from insurance companies, as well as the different organizations. I also appreciate the fact that the nurses last year opposed this simply because they don't have the kind of revenues, possibly, that the physicians and the assistant-- or the, the other, the other people involved-- physician assistants. But at the same time, they are all interested in patient safety. So with that, I would try to answer any other questions, but I encourage you to support this bill and move it to the floor.

HOWARD: Are there questions for Senator Kolterman? Seeing none, thank you.

KOLTERMAN: Thank you.

HOWARD: And this closes the hearing for LB25, and we will move on to Senator Hilkemann's LB37.

SHERRY SHAFFER: On his way.

HOWARD: He's on his way, OK, all right. We'll, we'll wait for him.

[BREAK]

HOWARD: They're here.

ARCH: You're here. [INAUDIBLE].

HOWARD: Good afternoon, Senator Hilkemann.

HILKEMANN: Good afternoon, Senator Howard.

HOWARD: This opens the hearing for LB37, and you are welcome to open whenever you're ready.

HILKEMANN: All right, thank you. Good afternoon, Chairwoman Senator Howard and members of the Health and Human Services Committee. I'm Robert Hilkemann; that's R-o-b-e-r-t H-i-l-k-e-m-a-n-n. And I represent the Legislative District 4 in west Omaha. And for total transparency here, I'm also a life member of the American Podiatry Association and I'm a retired podiatrist. I'm here today to introduce LB37, which would provide for the supervision of physician assistants by doctors of podiatric medicine. Prior to my career with you, as you know, I spent 37 years as a podiatrist. And during my course of years, it was my working with the association that propelled me to be where I am today here as a legislator. I appreciated coming before the Health and Human Services with several bills that we had at that time, and then I was part of the State Board of Health. We brought some other additional things and worked with the Legislature and appreciated the process. And I'm part, I'm glad to be part of that process. And during my time in podiatry, we, this was never a consideration. And as I think back to it, it would have been a tremendous asset. I know I would have probably had been able to utilize that in my own practice, having assistants, more than what you can have for your training of a, of a nurse or a medical assistant, to have the advantages of a, of a, a physician's assistant would have been of tremendous value. I know in my own practice there are certainly times it would have been available. I'm sort of an old fossil. Podiatrists today are trained in some of the finest medical centers around this country. They're used to working with the physician extenders and have worked with the physicians' assistants and know the benefit that they have and provide. And so that's why the podiatrists came to me with this idea of we would like to be able to employ physicians' assistants in our practice. As I was preparing for this hearing today, I began to

question-- some ways when you read the regulations, is there anywhere in the statutes, rules, or regulations that would prohibit a podiatrist from super-- thank you so much-- from supervising a physician's assistant now? And to my knowledge-- and maybe that'll be corrected, corrected when Dr. Greenhagen gets up here-- I do not know of any podiatrists who have actually contracted with a physician's assistant or have they been denied that and-- or presently supervise a physician's assistant. I don't want you to begin to-- give you the impression that this bill is not necessary; however, I do want to think about-- I think it warrants a closer look and perhaps clarification in our law. As the hearing progresses, we may find this clarity from the testimony and can move forward from there. For now though, in reviewing Nebraska statutes, the rules and regulations for physicians' assistants, the rules and regulations for podiatry, and the rules and regulations for the licensure of medicine and surgery and osteopathic medicine and surgery, there is no reference to a podiatrist acting as a supervising physician to a physician assistant. The language neither provides for nor exempts from the practice thereof. Now the Department of Health and Human Services has brought several technical concerns to me, and I believe that there is a letter that has been submitted to the committee addressing those issues. I think that most of them, if not all of them, do make some good sense. And if, in fact, the committee feels that further clarification of this issue is needed at all, we'll certainly be happy to work with them. I am also aware of the 407 review that the Nebraska Academy of Physician Assistants has requested and believe that they will have testimony, or at least they have their letter, to the effect today. I did not want LB37 to come into conflict with their requested credentialing review, but I do hope that we can take a look at this issue at the heart of the bill. I'm proud to have been able to bring this issue forward, provided, to having physicians' assistants to be able to work under the supervision of a podiatrist is going to make better access of care, particularly, particularly in areas like rural Nebraska. I can see physicians' assistants being a tremendous asset in wound care, which is an area where the podiatrists are excelling at this time. And the whole thing of lower extremity wound care, it's another whole area that has just mushroomed. Actually it was at, toward the end of my profession and certainly has, it has grown even to a much greater extent. So I look forward to the remainder of the testimony and working with this committee on LB37. And with that, I would be happy to answer any questions that you may have.

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

ARCH: You're familiar, obviously, with the national-- what's happening across the United States with podiatry. Are they using PAs in surgery, as well as clinic? Or is this primarily clinic? Or what, where would the use the PAs be?

HILKEMANN: A physician's assistant in surgery would be absolutely fabulous, Doctor-- or Senator, and--

ARCH: Closing, closing and that type of thing?

HILKEMANN: Exactly. And assisting, right.

ARCH: Right.

HILKEMANN: There's tremendous benefit in there because when you, particularly if you're working in multiple hospitals and to have the same physician's assistant that worked with you at facility A, when you go to a facility B right now you're, you're dependent upon, a lot of times, the nurse that they have at that-- you can't move a nurse from one facility to the next facility. But yes, that would be an outstanding advantage-- yes, particularly of the fixation devices that we're using today and the technical qualities, yeah.

ARCH: Um-hum.

HOWARD: Senator Walz.

WALZ: Yep. Thank you. Thanks for coming today. I just have a question about the supervision piece. Would that physician's assistant have to be in the same office? Or could you supervise a physician's assistant if you are in Omaha, somebody in Arlington or something like a smaller area?

HILKEMANN: Yes, you could.

WALZ: So that's--

HILKEMANN: That's correct.

WALZ: OK.

HILKEMANN: Um-hum.

HOWARD: All right. Senator Hansen.

B. HANSEN: Can, do you see like a-- you mentioned a greater need for wound care, especially the lower extremities, you say it's because of an increase in diabetes.

HILKEMANN: Right.

B. HANSEN: Yeah. And so that'd, it would make it more of a need to have somebody to help you and --

HILKEMANN: Absolutely, the--

B. HANSEN: Yeah, that makes sense.

HILKEMANN: That's, that can be so labor intensive, that wound care. And to have someone that you work with and train in that area, it would, would, would really help, particularly when I think about-- we have so many of our podiatrists now that are doing remote-site care; they're going to some of the hospitals out in some of the smaller communities. This would, this will certainly improve the access to care.

B. HANSEN: It's not like we're seeing diabetes get less, too, you know, so--

HILKEMANN: Right. Yeah, yeah, it's--

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

HILKEMANN: I will be.

HOWARD: Thank you, Senator.

HILKEMANN: All right.

HOWARD: All right. We'll now invite our first proponent testifier for LB37. Good afternoon.

ROBERT GREENHAGEN: Good afternoon. Thank you, Senator, for having me and for the chair people. My name is Robert Greenhagen, R-o-b-e-r-t G-r-e-e-n-h-a-g-e-n, and I'm a podiatrist from Omaha, Nebraska, and the president of the Nebraska Podiatric Medical Association. Full disclosure: The gentleman behind me is actually one of my mentors and I actually worked with him, and he's the reason I got back to Omaha.

So it's an honor to be up here with him. I wanted then, a little amendment to my statement that I'm going to read, is that Dr. Wienke, who is a Nebraska podiatrist, could not be here so I'm going to give a little of my experience instead of Dr. Wienke. Good afternoon and thank you for allowing me to address the committee today on Senator Hilkemann's proposed legislation, LB37. My name is Dr. Robert Greenhagen, and I'm a podiatric surgeon who practices in the Omaha metropolitan area and the current Nebraska Podiatric Medical Association president. Earlier this month, our organization voted unanimous, unanimously to support the current bill as submitted. It is important to our organization to be clear that our support of the bill is not a request to extend or expand our scope of practice, only to allow us to oversee physician, physicians' assistants within our current legal scope. We feel that the bill provides significant value to the citizens of Nebraska in a number of ways. First, many parts of our state have little to no pediatric coverage. Areas such as Omaha and Lincoln are well supported, but the vast majority of the state is not. In the support material, I actually included a map which outlines where podiatrists are in our area. In comparison, the state of Iowa has 172 podiatric surgeons that are registered under the American Podiatric Medical Association. In the state of Nebraska, in fact, we only have 60 to cover the entire state. Our ability to provide care to our citizens is extremely limited and brings us to reason one to support this bill: improve medical care and access to the citizens, especially in the rural areas of our state. We do not believe that this will negatively change or negatively affect primary care coverage in rural Nebraska. Approximately 20 percent of PAs work within the primary care area, compared to 50 percent of nurse practitioners. The same percentage, 20 percent, works within the surgical subspecialties, such as podiatry. Therefore, PAs provide the most logical extension for podiatric surgeons with the least disruption to primary care. Second, it serves as an economic stimulant and cost savings to healthcare. Physicians' assistants indirectly increase physician productivity. This is seen in a number-- I'm sorry-- this is seen by the number of patients being seen and thereby increasing revenue. The positive economic impact to increase revenue and increase employment support the local and state economies. I also mention that PAs save money. Currently physicians' assistants are reimbursed 85 percent of the supervising physician's fee in the office and 13.5 percent of, for the assistance in the operating room. We can then combine these savings with overall savings of proper podiatric care. Access to podiatric providers has been shown to significantly reduce the cost to health systems. Access to podiatric-- I'm sorry-- there has been no

better example of this than what recently occurred in the state of Arizona. In 2009 the state of Arizona legislature excluded podiatrists from Medicaid services in an attempt to reduce costs. This change went into effect in the year 2010. For each $1 of savings that they, for each $1 of savings, they actually saw an increase of $44 in actual costs. This is especially true due to the increasing load of diabetic foot care and complications. Arizona reinstated podiatric care in 2016 due to this failed experiment. The third and final point is improved care. As podiatric surgeon, as surgery has advanced, advanced treatments, such as limb salvage due to traumatic injuries or diabetes, advanced reconstruction, such as total ankle arthroplasties, and amputation prevention and wound care have increased the demands on surgeons. The ability to have a physician assistant within the OR will improve outcomes and reduce complications. My colleague, Jeff Wienke who was supposed to be here, unfortunately is actually working today now; and I will provide some personal testimony once I have completed. In conclusion, the Nebraska Podiatric Medical Association fully supports LB37. We feel that the use of physicians as physician extenders, within current podiatric scope, will provide improved care, especially in areas of significant need such as rural Nebraska, economic stimulation by creating new jobs and revenue, as well as healthcare cost savings through reduced fees and improved outcomes. I appreciate your attention, and I have brought the informational packets that I've provided. I'd be happy to ask, answer any questions that you may have now.

HOWARD: All right. Are there any questions? I'll let Senator Williams--

WILLIAMS: Go ahead.

CAVANAUGH: Oh.

HOWARD: Senator Cavanaugh.

CAVANAUGH: Thank you, Doctor, for coming today. And I think that maybe you have your family here with you?

ROBERT GREENHAGEN: I do.

CAVANAUGH: That's wonderful.

ROBERT GREENHAGEN: Since it's a snow day, I have-- they got to work on legislation today.

CAVANAUGH: It's a freeze day. Well, I hope they're enjoying watching you testify for us. So I've had, I have little ones myself and have a lot of experience in the, in the doctor's room with the physicians' assistants.

ROBERT GREENHAGEN: Um-hum.

CAVANAUGH: And it's always been a wonderful experience. So I'm not familiar enough with the processing here, but I'm a little surprised to find that they're not allowed to practice podiatry. Is there a reason that this hasn't happened? Or is this just because you've come together and realized, hey, this would be a great partnership?

ROBERT GREENHAGEN: So it actually, as included in this, there's the APMA's position. In some states it is included. But the primary reason that this has not occurred is just from a historical standpoint, especially in the state of Nebraska. Since we have a separate scope and generally are not listed under DOs and MDs, the same thing has occurred because-- just of omission as Doctor, you know, Senator Hilkemann has pointed out.

CAVANAUGH: OK, that's very helpful. And I just-- one more question was--

ROBERT GREENHAGEN: Um-hum.

CAVANAUGH: --probably not something you can answer, but I'll still put it out there-- the cost savings, 'cause the fiscal note has no expenditures or revenues. But it sounds like there actually could potentially be some significant savings, especially through Medicaid. Would that be your assumption?

ROBERT GREENHAGEN: That-- and it, it should be. In any fee schedule-- now, the one thing I will point out is that-- and it's actually in here. There's a wonderful article that what we call in, incident to services. So there are situations in which PAs are in the same office as the physician at the same time. Under those situations, if the patient has been evaluated by a physician and then is being followed with a physician in the room and is consulted, then in theory it doesn't necessarily save. But especially in rural areas where Medicaid may be true and the physician may not be on site, then yes, it's a 15 percent cost reduction within that service.

CAVANAUGH: Thank you.

ROBERT GREENHAGEN: Certainly.

HOWARD: Senator Williams.

WILLIAMS: Thank you. And thank you, Doctor, for being here. Just very quickly, you mentioned in your testimony nurse practitioners--

ROBERT GREENHAGEN: Um-hum.

WILLIAMS: --along with PAs. Has there been any thought that they should be included in this also?

ROBERT GREENHAGEN: There has been, but the-- I think the biggest reason is traditionally, and it's really kind of played out with even how the distribution within, kind of, healthcare is, that nurse practitioners traditionally are not in the operating room. And that is one of the biggest elements that has a benefit. And that's really where my experience with Dr. Wienke, so when we do a lot of limb salvage, we use very large external fixators and, many times, intramedullary nails. And is very difficult because you actually have to hold a device, hold the leg or hold something that's been osteotomized, in place as you drove wires or other fixation. And Senator Hilkemann very correctly pointed out that sometimes you'll have great help at hospital A, but hospital B does no podiatric care. So then you're using someone who actually does eye surgery to try and assist you. And, and it becomes very, very difficult to be in both places. My own personal experience was at Creighton. When I first came here I was doing a lot of these, what's called Charcot reconstruction; it's a condition that occurs to diabetic patients. And I had asked for temporary privileges for one of my partner, for someone to come in who is now my business partner. He was real new to the area and hadn't been processed by Creighton, and they denied it. And so I asked if I could have a medical student, and they didn't want to provide me with a medical student. So I ended up having to do it by myself. Now the great thing was I learned how to do by myself and it went very, very well but it took longer. The patient was under anesthesia for probably an extra hour because I had to struggle to figure out how exactly to do it.

WILLIAMS: Thank you.

HOWARD: Senator Hansen.

B. HANSEN: Do you know-- again, maybe a question I don't know if you can answer not-- what, or if there will be any Medicaid or Medicare coverage for the PA then, 'cause you referenced like, I think, Arizona a little bit there?

ROBERT GREENHAGEN: Yes. I would anticipate-- now the one element is it was never forced. I don't believe the state of Nebraska requires all to participate in Medicaid and Medicare. But I do not know of any of our members in the NPMA that are not current providers within Medicaid and Medicare services.

B. HANSEN: Yeah, 'cause that's part of the cost savings you were saying, so--

ROBERT GREENHAGEN: Yes.

B. HANSEN: --with Medicaid, we're going to pay a PA, as opposed to a doctor, right?

ROBERT GREENHAGEN: That's exactly right.

B. HANSEN: Do it. You know--

ROBERT GREENHAGEN: Yeah.

B. HANSEN: --as long as they do their job like they're supposed to.

ROBERT GREENHAGEN: Um-hum.

B. HANSEN: And so you know when the 407 review process is going to be due? Or do you-- have you guys gotten that yet? Or--

ROBERT GREENHAGEN: I do not. I know I spoke with Dr. Vest, who is a podiatrist that's on the board, and he-- they had their meeting on Monday. And I know that they, he believed it would be very short because there's not as much change--

B. HANSEN: Sure, not as big a scope.

ROBERT GREENHAGEN: But I do not know that.

B. HANSEN: OK. And do, do the, would the PA need any extra training at all if they worked for the, the podiatrist instead of--

ROBERT GREENHAGEN: I, I would think that you would need in-office training; you would need experience within the specialty. But that's

true in general. It's very difficult to come out--that's true if actually, if you're a doctor, too.

B. HANSEN: Yeah.

ROBERT GREENHAGEN: But you come out and you just aren't necessarily know everything that, that is--

B. HANSEN: Yeah, it's more on-site training [INAUDIBLE}--

ROBERT GREENHAGEN: Yeah, that's exactly right. Right, yeah.

B. HANSEN: So just wanted to make sure. OK, cool.

HOWARD: Other questions? Senator Arch.

ARCH: Are you familiar with the practice, with the practice of orthopedics and the use of PAs in orthopedics?

ROBERT GREENHAGEN: I am, yes.

ARCH: What-- could you tell us a little bit about that? What, what, what, what do you know about that?

ROBERT GREENHAGEN: So I actually trained at the University of Pittsburgh Medical Center, and our residency was under the orthopedic division. And so we actually worked all, almost exclusively with ortho pods. We had PAs. Now generally, we, the, all of the PAs within the UPMC system very rarely worked in the operating room. So it was a little bit unique unless the physician chose not to work with a resident, because you can't be paid for a PA--

ARCH: Yeah.

ROBERT GREENHAGEN: --if you have a resident.

ARCH: And they had residents available, so--

ROBERT GREENHAGEN: Yeah, but the-- my experience was it is very positive. It actually hones hand-- kind of goes hand in hand with what we do for the most part. And I will tell you that Dr. Wienke also-- his group here, that's here in Lincoln, they work a lot with Bryan. And Bryan has talked to him a number of times about having them join and said we'll get you a PA. And, as Senator Hilkemann mentioned, no one has attempted to hire a PA-- inquired-- and there is no one so far. But I think some of the hospitals are not aware that they could

not oversee a PA. We're going to be working at the VA in Omaha and through the western Iowa Division, and the leadership there told me that they also have a PA that works in podiatry. Now I know that's a little bit different because that's a federal set, area. But I also educated him, I don't know if you, am I supposed to sign? But I don't think I can. So I think there's some confusion even within the systems now.

HOWARD: Other questions?

ARCH: Thank you.

HOWARD: All right. Seeing none, thank you for visiting with us today.

ROBERT GREENHAGEN: Thank you very much.

HOWARD: Our next proponent testifier? Seeing none, is there anyone wishing to testify in opposition to LB37? Seeing none, is there anyone wishing to testify in a neutral capacity?

MICHELLE WEBER: [INAUDIBLE] paper.

HOWARD: Good afternoon again.

MICHELLE WEBER: Good afternoon, Chairman Howard. Members of the Health and Human Services Committee, again my name's Michelle Weber, M-i-c-h-e-l-l-e W-e-b-e-r. I'm testifying in a neutral capacity on LB37 on behalf of the Nebraska Academy of Physician Assistants. NAPA's goals include transforming health through patient-centered, team-based medical practice. NAPA respects the important role that DPMs play in healthcare delivery and in increasing patient access to needed services. Additionally, NAPA fully supports the benefits of the interdisciplinary team approach to care delivery, and we appreciate the additional team-based approaches that this bill envisions. NAPA has submitted a letter of intent and an application for a credentialing review, seeking removal of mandates related to PA employment and practice, specifically addressing supervising agreements and on-site supervision requirements. While the details of this proposal are still in the works, NAPA's aim is to optimize team practice. We believe this model will allow more opportunities for practice models in which MDs, DOs, PAs, and DPMs can work together to advance patient care and increase access to that care. As NAPA's proposal moves forward, there will likely be additional opportunities how to best structure a PA-DPM team; and we look forward to working

with podiatrists on that. Specifically, NAPA is interested in moving toward a more collaborative model rather than a model for increased supervision. And while we certainly understand that this bill is modeled after the current statutes for PAs and MDs and DOs, we're concerned that with advances, with the advancement of this bill we'll then be back to working towards changing this relationship almost immediately. Furthermore, there are specific considerations related to training models, scopes of practice, and reimbursement limitations that must be considered when establishing a PA-DPM relationship. As to Senator Hansen's question about reimbursement, Medicare will only reimburse for services provided by a PA practicing with an MD or a DO. And that's a consideration that we want to take a look at as we move forward. We look forward to considering these issues and stand ready to work with podiatrists to improve healthcare delivery for Nebraskans.

HOWARD: Thank you. Are there questions? So your neutral testimony is predominantly around your 407, to remove your supervision in the first place?

MICHELLE WEBER: That's correct.

HOWARD: OK, thank you. All right, last call? Thank you for your testimony today. Our next neutral testifier?

BRITT THEDINGER: Good afternoon again.

HOWARD: Good afternoon.

BRITT THEDINGER: Chairperson Howard and the rest of the committee, I'm Dr. Britt Thedinger; Britt, B-r-i-t-t Thedinger, T-h-e-d-i-n-g-e-r, and I am testifying, on behalf of the Nebraska Medical Association, in a neutral capacity. Our primary focus is always patient safety, and our legislative, legislative committee meets tomorrow night so we're gonna be discussing this. And then we'll let you know our thoughts on this, but as of right now we're neutral. But just a couple of things to mention. Currently physician assistants are covered by the Hospital-Medical Liability Act under their supervising physician. If PAs are working under the supervision of a podiatrist, they will not be covered by the Excess Liability Fund. Podiatrists will need to make sure they have insurance coverage for their PAs under their supervision. A couple other points real quickly. The NMA has a great relationship with NAPA, and we are continually in communication with them as to team-based care. Six states currently have a mention of

podiatrists in regards to PAs. That's California, Michigan, Ohio, Rhode Island, Virginia, and West Virginia. However, these states recognize podiatrists as supervising physicians; and that's not the case in Nebraska. And finally, we would recommend the 407 process. Thank you.

HOWARD: Thank you. Any questions for the doctor? Seeing none, thank you. Anyone else wishing to testify in a neutral capacity? Seeing none, we do have one letter from Bo Botelho from the Department of Health and Human Services. Senator Hilkemann, you are welcome to close.

HILKEMANN: All right. Thank you very much again for this opportunity. I think you, I think through the testimony, you can understand where there's just this little bit of an ambiguity here. We want to kind of get these grey areas taken care of and see if we can improve the status for PAs and their advancement in their careers. This will also help the podiatry and help the public. And so with that I would, if there are any final questions? I want to, once again, thank Dr. Greenhagen for being here. If he weren't here, I would still be practicing at 73rd and Dodge, so--

HOWARD: Any, any final questions for Senator Hilkemann? Seeing none, thank you so much.

HILKEMANN: Thank you; thank you very much, Committee. Thank you.

HOWARD: And this closes the hearing for LB37, and we will be going into Executive Session, so we'll--