

BEFORE THE SURGICAL TECHNOLOGISTS' TECHNICAL REVIEW
COMMITTEE, DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
STATE OF NEBRASKA

_____))
IN THE MATTER OF) TRANSCRIPT
A PUBLIC HEARING REGARDING THE) VOLUME I of I
SURGICAL TECHNOLOGIST LICENSURE) (Pages 1 through 117)
APPLICATION.))
_____))

Nebraska State Office Building
14th and M Streets
Conference Room Lower Level D
Lincoln, Nebraska

Convened, pursuant to notice, at 9:00 a.m.,
January 5, 2016,

BEFORE:

Dr. Douglas Vander Broek, Chairperson.

COMMITTEE MEMBERS PRESENT:

Christine Chasek, Dr. Gregory Gaden, Jeffrey
Howorth, Jane Lott, Dr. Robert Sandstrom, and
Dr. John Tennity

- - -

DHHS STAFF PRESENT:

Ron Briel, Administrator
Matt Gelvin, Administrator
Marla Scheer, Administrative Staff

I N D E X

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REPORTER'S CERTIFICATE:

State of Nebraska)
) ss
County of Lancaster)

I, LINDA W. ROHMAN, reporter for GENERAL REPORTING SERVICE, and a Notary Public duly commissioned, qualified and acting under a general notarial commission within and for the State of Nebraska, certify that I reported the proceedings in this matter; that the transcript of testimony is a true, accurate, and complete extension of the recording made of those proceedings; that the transcript consists of:

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and, further, that the disposition of the exhibits is referenced in the index hereto.

IN TESTMIONY WHEREOF, I have hereunto set my hand officially and attached my notarial seal at Lincoln, Nebraska, this _____ day of January, 2016.

Reporter

- - -

1 PROCEEDINGS:

2 CHAIRPERSON VANDER BROEK: I think, since it's
3 nine o'clock, we'll go ahead and get started promptly. This
4 is the third meeting of the Surgical Technologists'
5 Technical Review Committee. And we'd like to draw your
6 attention to the fact that this is a public meeting. The
7 Open Meetings Law is posted. And whenever you're ready --

8 Marla, whenever you're ready for roll call.
9 Whenever you're ready.

10 MS. SCHEER: I'm sorry.

11 CHAIRPERSON VANDER BROEK: That's okay. So, we
12 have more on the way yet?

13 MS. SCHEER: Yes.

14 CHAIRPERSON VANDER BROEK: Okay. That's fine.

15 MS. SCHEER: I was pulling the sheets up, and I
16 put them back.

17 CHAIRPERSON VANDER BROEK: Okay. Well, it's time,
18 so we'll go ahead and get started with the roll call
19 whenever you're ready, Marla.

20 MS. SCHEER: Chasek?

21 MS. CHASEK: Here.

22 MS. SCHEER: Gaden?

23 DR. GADEN: Here.

24 MS. SCHEER: Howorth?

25 MR. HOWORTH: Here.

1 MS. SCHEER: Lott?

2 MS. LOTT: Here.

3 MS. SCHEER: Sandstrom?

4 DR. SANDSTROM: Here.

5 MS. SCHEER: Tennity?

6 DR. TENNITY: Here.

7 MS. SCHEER: Vander Broek?

8 CHAIRPERSON VANDER BROEK: Yes.

9 And I would entertain a motion for approval of
10 today's agenda.

11 MR. HOWORTH: So moved.

12 DR. GADEN: Second.

13 CHAIRPERSON VANDER BROEK: All in favor, say aye.

14 COMMITTEE: Aye.

15 CHAIRPERSON VANDER BROEK: Okay. I'd like to have
16 a -- any comments on the -- or a move for approval of the
17 minutes of our second meeting, our second and most previous
18 meeting.

19 MR. BRIEL: There have been several corrections.
20 John had some corrections that he wanted to make. And so,
21 we could move to approve the minutes as corrected.

22 CHAIRPERSON VANDER BROEK: Okay. I'd entertain a
23 motion in the same.

24 DR. GADEN: So moved.

25 MR. HOWORTH: Second.

1 CHAIRPERSON VANDER BROEK: And all in favor of
2 approving the minutes of our last meeting, as corrected, say
3 aye.

4 COMMITTEE: Aye.

5 CHAIRPERSON VANDER BROEK: Opposed, same sign.

6 (No response.)

7 Okay. This morning we're here for a public
8 hearing regarding the surgical technologists' application
9 for licensure, the 407 process. And just so we are clear,
10 the procedures and format for this public hearing are
11 available -- there's copies available in the back of the
12 room. But I just wanted to briefly review those so
13 everybody is clear on how we proceed here. First of all, we
14 have the proponent testimony, and we have one hour total
15 time for all the proponents' testimony. And, of course,
16 during those allotted hours, the proponents' opponents can
17 use that time as they wish. And then, we'll have an hour,
18 total, also for opponents' testimony. And then, we'll have
19 neutral testimony of 10 minutes, total time. At the end of
20 that entire period, we'll have a summary period, again,
21 proponents first and then opponents. And that summary
22 period, we'll have 10 minutes for each proponent and
23 opponent.

24 MR. BRIEL: And that can include rebuttal of
25 testimony from the other groups, if you wish to do that.

1 CHAIRPERSON VANDER BROEK: Yes. Thank you, Ron.

2 And as far as time management, the time allotted
3 for each of those can be extended at the discretion of the
4 Committee. Questions from the Committee members are not
5 taken out of the time allotted for those one-hour periods.

6 Now, I do ask that, if at all possible, the
7 Committee have their questions held to the end of the
8 testifier, so that we try not to interrupt the testifier.
9 And so, just make a note of things and you can ask it when
10 the testifier has completed their particular testimony.

11 The Chair, at my discretion, I may limit testimony
12 that I deem to be duplication, so let's try to avoid that.

13 And the testifiers, of course, are asked to
14 provide sufficient printed copies, at least 10 copies, of
15 any written comments to be handed out. Avoid duplicating
16 testimony. Sign the sign-in sheet before you testify. And
17 then, before you begin to testify, clearly state your name
18 and spell your name for the transcriptionist.

19 And with that, we will go ahead and proceed,
20 unless there is any questions. We will start with the
21 proponents' testimony, and the staff will be recording the
22 time for each area.

23 CASEY GLASSBURNER

24 Chair Vander Broek and members of the 407
25 Technical Review Committee, I am Casey Glassburner,

1 C-a-s-e-y, G-l-a-s-s-b-u-r-n-e-r. And I'm currently serving
2 as the President of the Nebraska State Assembly of the
3 Association of Surgical Technologists. I'd like to thank
4 you for the opportunity today to testify in support of the
5 surgical technologists licensure application that has been
6 submitted by the Nebraska State Assembly.

7 Nebraska's 800 surgical technologists are an
8 integral part of the surgical team. Surgical technologists
9 work under the supervision of a licensed independent
10 practitioner as well as the registered nurse to facilitate
11 safe and effective invasive surgical procedures. Surgical
12 technologists ensure that the operating room environment is
13 safe and sterile, that equipment functions properly, and
14 that the procedure is conducted under conditions that
15 maximize patient safety and minimize the patient's risk of
16 contracting a surgical site infection.

17 Unqualified surgical technologists can cause harm
18 to patients by poorly maintaining the sterile field, which
19 can result in an increased number of surgical site
20 infections; poorly assembling sophisticated surgical
21 equipment that will be utilized during the surgical
22 procedure; and by slowing down procedures, which results in
23 unnecessary risk caused by extended anesthesia time and the
24 potential to experience excessive blood loss. Swift
25 surgeries depend on effective and efficient surgical

1 technologists.

2 The surgical technologist is the professional in
3 the operating room that's charged with the responsibility of
4 maintaining the integrity of the sterile field. This refers
5 to the surfaces that sterile objects, such as surgical
6 instruments, may contact and includes the area immediately
7 around the patient that's prepared for the surgical
8 procedure. Protecting this sterile field involves carrying
9 out specific techniques that are referred to as a sepsis or
10 sterile technique that will protect the integrity of that
11 environment. A 2013 article in the *Journal of the American*
12 *Medical Association* estimated that the average surgical site
13 infection costs \$20,785 and that surgical site infections
14 amount to a price tag of \$3.3 billion annually.

15 Thus, ensuring that every surgical technologist is
16 properly trained through standardized educational programs
17 and has demonstrated a minimum level of competency through
18 passage of the national surgical technologist certifying
19 exam could reduce surgical site infections, which would not
20 only reduce hospital readmissions and associated costs, but
21 also reduce overall health care costs and save lives.

22 The establishment of a license for surgical
23 technologists will also protect the public by creating a
24 mechanism of discipline for these practitioners who engage
25 in unprofessional or unethical conduct. These practitioners

1 will be required to adhere to the conditions of the
2 mandatory reporting law, which will require disclosure of
3 these types of conduct that will become public record and
4 may be accessed by future potential employers. Disciplinary
5 actions may also be taken following the reporting of such
6 events, which may lead to the loss of the license and the
7 inability of the professional to continue to perform the
8 duties of that profession, therefore, protecting the public
9 by future -- or from future harm that may be inflicted by
10 that individual.

11 In addition to these patient safety concerns that
12 exist related to the lack of regulation of the profession,
13 the current delegation by the surgeon to the surgical
14 technologist, which occurs every day in operating rooms
15 across the state, is contrary to the 1898 ruling from the
16 *Howard Paul v. State of Nebraska* case, which states that a
17 licensed physician cannot delegate to an unlicensed
18 personnel, which the surgical technologist is currently
19 considered. Some have argued that this ruling is outdated
20 and does not apply to current practice. However, if *Howard*
21 *Paul* has been applied once, as it was in relation to the
22 practice of the surgical assistant, it does have the
23 potential to be applied again to any number of the tasks
24 that are perform by the surgical technologist that are
25 delegated by the surgeon.

1 In fact, through this application of *Howard Paul*,
2 resulting in ceasing and desisting the practice of the
3 surgical assistant, tasks that the surgical technologist is
4 trained to perform, that they were performing prior to the
5 cease and desist, have been restricted on an inconsistent
6 basis from one facility to another throughout the state.
7 Some of the facilities continue to allow these tasks to be
8 performed by surgical techs, while others have restricted
9 them completely. Facilities now, on a daily basis, question
10 the tasks and functions that are performed by surgical
11 technologists and the legality of each of them. This
12 inconsistency further supports the need to adequately
13 establish that the delegation by the surgeon to the surgical
14 technologist is allowed through the creation of a license
15 for surgical technologists in the state.

16 Longitudinal data from the Bureau of Labor
17 Statistics demonstrates that added education and competency
18 requirements in other states have not increased wages.
19 Surgical technologists' wages in states with minimum
20 education and certification laws in place have similar
21 increases in wage trajectories as neighboring states without
22 laws regulating surgical technologists. This data includes
23 states in which laws have been in place for several years,
24 such as Idaho, which enacted their law in 1988.

25 The surgical patient does not pick their surgical

1 team ahead of time. They do not have the option to choose a
2 certified surgical technologist over one who was on-the-job
3 trained. During the procedure, they are under anesthesia
4 and unable to make decisions or act on their own behalf.
5 They're completely reliant on the competency of the surgical
6 team to provide them with the best care possible. Patients
7 assume everyone in the operating room is properly educated
8 and competent, able to provide them with a certain quality
9 of care. Every surgical patient in Nebraska deserves
10 nothing less than a certified surgical technologist.

11 Again, thank you for your time. And, at this
12 time, I am available for any questions that you may have.

13 CHAIRPERSON VANDER BROEK: Thank you.

14 Committee members, do you have any questions for
15 Ms. Glassburner?

16 Go ahead, Dr. Sandstrom.

17 DR. SANDSTROM: I have a couple of questions.

18 CHAIRPERSON VANDER BROEK: Yeah, go ahead.

19 DR. SANDSTROM: Thank you. That was very helpful.
20 I just have a -- I want to clarify a couple of things here.
21 We've talked about these issues before, but just to make
22 sure I understand it. You're asking, going forward,
23 licensure. The only people who will be licensed will be
24 people who have passed the national surgical technologist
25 certifying exam.

1 MS. GLASSBURNER: After the grandfather period.

2 DR. SANDSTROM: After the grandfather period.

3 MS. GLASSBURNER: Correct.

4 DR. SANDSTROM: Okay. And so, in order to sit for
5 the exam, the qualifications are?

6 MS. GLASSBURNER: You have to graduate from an
7 accredited surgical technology program.

8 DR. SANDSTROM: Okay. Okay. And so, we have a
9 graduate of an accredited program. And how many graduates
10 are there each year in Nebraska, roughly?

11 MS. GLASSBURNER: It varies from year to year, but
12 the average was, I think, 32 in the data that we showed
13 between the two programs. Now, we are potentially going to
14 have a third program that hopes to achieve accreditation
15 before the end of the year, and we are working with that
16 grant, as well, to establish the additional lab sites
17 throughout the state that will hopefully allow us to take in
18 more students at Southeast Community College.

19 DR. SANDSTROM: So, it's your judgment, then,
20 that, if the Legislature was to do this, that two or three
21 years or four years from now, we would not have a shortage
22 of surgical technologists in Nebraska?

23 MS. GLASSBURNER: No, I don't believe that we'll
24 have a shortage. Yeah.

25 DR. SANDSTROM: All right. I just have a couple

1 other questions about -- on the scope of practice.

2 MS. GLASSBURNER: Sure.

3 DR. SANDSTROM: Because we've been talking about
4 the scope of practice issue, and the last meeting we were
5 talking about -- we talked, at least, change the scope of
6 practice, duties, things. And I just -- number four and
7 five talks about assisting the surgeon and assisting the
8 circulator, which I believe is the nurse, right?

9 MS. GLASSBURNER: Yes.

10 DR. SANDSTROM: As directed, in the care of the
11 patient. I just wanted -- but one of the things I'm
12 interested in is, are there any limits on this?

13 MS. GLASSBURNER: I think the statement was
14 "according to applicable law." That was on the end of that,
15 right?

16 DR. SANDSTROM: Yeah. Well, applicable law, I
17 guess, is federal law, maybe, if it's the CMS or whatever,
18 but I want to go through a couple of things with you.

19 MS. GLASSBURNER: Sure.

20 DR. SANDSTROM: Did you think surgical techs can
21 administer medications or fluids?

22 MS. GLASSBURNER: Absolute- -- well, they can't
23 inject. Is that what you're asking?

24 DR. SANDSTROM: I'm just talking about, can they
25 administer medications or fluids to a surgical patient --

1 MS. GLASSBURNER: No.

2 DR. SANDSTROM: -- in the operating room? Okay.
3 That should be -- that could be a limit. Okay. Can they
4 assess the patient?

5 MS. GLASSBURNER: No.

6 DR. SANDSTROM: Patient status. Okay. Can they
7 interpret orders of physicians?

8 MS. GLASSBURNER: No.

9 DR. SANDSTROM: They can't work in the pre-op or
10 post-op areas?

11 MS. GLASSBURNER: No.

12 DR. SANDSTROM: So, okay. All right. So --

13 MS. GLASSBURNER: You mean, in the capacity of a
14 surgical nurse? Is that what you're asking, or --

15 DR. SANDSTROM: As a surg- -- as -- well, I'm
16 talking about whatever capacity it is. Because, right now,
17 it says "assist the surgeon." I mean, I don't think we want
18 -- I mean, there doesn't seem to be -- I mean, we went -- we
19 kind of went from a laundry list of tasks, right?

20 MS. GLASSBURNER: Right.

21 DR. SANDSTROM: Now, to -- I like this better.
22 It's --

23 MS. GLASSBURNER: Right, absolutely.

24 DR. SANDSTROM: We're going to have a scope of
25 practice, I guess, that's the case. But I want to know if

1 there's any specific limits, you think, that need to be
2 placed on hospitals or physicians that are not using
3 surgical technologists inappropriately for procedures
4 they're not prepared for in the operating room?

5 MS. GLASSBURNER: I would say surgical techs
6 sometimes assist with the transportation of patients, maybe,
7 from the pre-op area to the operating room. In smaller
8 facilities, I know, that they do assist more with the
9 patient interaction than they would in a larger facility.
10 Absolutely. So, I think that's a good point about defining
11 where the limit is. Absolutely.

12 DR. SANDSTROM: Yeah. There might be just a
13 couple of areas to consider for --

14 MS. GLASSBURNER: Sure.

15 DR. SANDSTROM: I'm just saying, "assist the
16 surgeon as directed in accordance with applicable law" is --

17 MS. GLASSBURNER: Pretty broad, absolutely.

18 DR. SANDSTROM: Pretty -- I mean, that could be
19 interpreted about, you know, anything. Which, if people are
20 -- we're talking about safety, so.

21 MS. GLASSBURNER: Yes, absolutely.

22 DR. SANDSTROM: All right.

23 CHAIRPERSON VANDER BROEK: I had just one
24 question. Toward the end of your testimony, you referred to
25 states that have certification laws in place. And so,

1 certification, of course, being different from licensure,
2 and which states currently require licensure?

3 MS. GLASSBURNER: There are no states that
4 currently require licensure. However, there are no other
5 states that have a ruling like *Howard Paul*, that doesn't
6 allow the delegation to unlicensed personnel. Cathy
7 Sparkman, who is our representative from our national
8 organization, will further talk about how the delegation in
9 other states works. And the -- there is a bill in Ohio that
10 is currently pursuing licensure, and she will talk further
11 about that as well.

12 CHAIRPERSON VANDER BROEK: And if you or somebody
13 else from your proponent group could answer the question for
14 me then. So which states currently require certification
15 that you referred to? You referred to Idaho, I believe, and
16 if either you or somebody else can answer that question for
17 me. Which states require certification?

18 MS. GLASSBURNER: Right. And it was in the
19 application as well, the specific states. And it's a long
20 list, so I don't have that memorized.

21 CHAIRPERSON VANDER BROEK: Sure. It's in your
22 application.

23 MS. GLASSBURNER: But it is, I think, on page,
24 like, page 18 and 19 in the application. It does list out
25 the specific requirements from the states for surgical

1 technologists and surgical assistants. But I'm sure Cathy
2 probably has that memorized, so she can --

3 (Laughter.)

4 CHAIRPERSON VANDER BROEK: Sure. Good.

5 Is there any other questions for --

6 Yes.

7 MR. HOWORTH: Talk about delegation. Do you see a
8 difference between delegation and instruction?

9 MS. GLASSBURNER: In this state, no. And, yes, we
10 did talk about that before. But, from what we've been told,
11 in this state, there is no definition of what is the
12 practice of medicine and what is a medical task and
13 function. And so, basically, it's up to whoever wants to
14 determine where the line is. And we talked about this at
15 the last meeting, too, about, you know, what is the practice
16 of medicine? What constitutes that? I think, from other
17 states, they've said that it involves medical judgment, you
18 know, actually having to have that medical background so
19 that you can make the medical judgment. But, in this state,
20 from what we've been told, that there is no difference
21 between a directed medical task and function and the
22 practice of medicine. And so, it's, you know, basically
23 anything could be considered the practice of medicine,
24 depending on who interprets what you're talking about.

25 MR. HOWORTH: So, when it comes to interpretation,

1 which law's going to be used, *Howard Paul* or, back to 1998,
2 and captain of the ship?

3 MS. GLASSBURNER: Captain of the ship, which is
4 what we talked about last time. Yeah, absolutely.

5 MR. HOWORTH: And I have another question for you.
6 It's, of the surgical site infection costs, how many of
7 those were in Nebraska?

8 MS. GLASSBURNER: That was a national study that
9 was done from the *Journal of the American Medical*
10 *Association*. That data didn't break out into specific
11 states, so I don't have an answer to that question. I'm
12 sorry.

13 MR. HOWORTH: No, fair enough. Thank you.

14 MS. GLASSBURNER: Yeah. And that article was
15 included in the information at the last meeting. So, if you
16 would like to take a look at that, you can.

17 MR. HOWORTH: Okay. Thanks.

18 MS. CHASEK: Well, I have a question.

19 MS. GLASSBURNER: Yes.

20 MS. CHASEK: In your testimony here regarding the
21 connection between educational programs and you make a claim
22 that education would reduce infections. Is there anything
23 you have to back that up?

24 MS. GLASSBURNER: I don't have specific data. I
25 hate to say it's common sense that more educated people make

1 less mistakes. But I will tell you that, this morning, I
2 got -- we received a phone call at the college from one of
3 our previous graduates who was very frustrated that her
4 hospital had hired someone who was on-the-job trained with
5 no previous education, and they told her, "You need to train
6 this person." And she called us, and she said, "I don't
7 even know where to start. This person has no background.
8 They -- I don't even know where to start with teaching them
9 the basics." You know, she went through school. She's
10 educated, but she didn't even know what they don't know,
11 because they came with no previous background whatsoever,
12 and her manager basically said, "Go ahead and train this
13 person." And she's very frustrated, because she feels like
14 she's been put in a rock-and-a-hard-place, because she's
15 going to have to work with this person, so she wants to
16 adequately train them and make sure that the patients
17 receive quality care, but, you know, that really, probably
18 wasn't something that she thought was going to be her job
19 responsibility when she got hired for that position. So,
20 like we talked about last time, the people that are on-the-
21 job trained are completely reliant on the training that they
22 receive from the individual who's training them, and, if
23 that person -- which this one was properly educated in an
24 actual, accredited surgical technology program and passed a
25 certification exam. But maybe those on-the-job trained

1 people are being trained by someone else who was on-the-job
2 trained. So, you know, it is a vicious cycle when that --
3 and things fall through the cracks when someone is on-the-
4 job trained.

5 CHAIRPERSON VANDER BROEK: Any other questions?

6 Yes, Dr. Tennity.

7 DR. TENNITY: I don't know who provided it, but
8 the -- this one here does say -- this is with regard to
9 nursing, as they increased the amount of education, the
10 mortality was reduced by six percent. Pretty sure that was
11 the summation of this one.

12 MS. GLASSBURNER: Thank you.

13 DR. TENNITY: I think this was provided by the
14 nurses.

15 CHAIRPERSON VANDER BROEK: Okay. Any other
16 questions of the Committee for Ms. Glassburner?

17 (No response.)

18 Okay. If not, thank you.

19 MS. GLASSBURNER: Thank you.

20 CHAIRPERSON VANDER BROEK: Any other proponent
21 testimony?

22 CYNTHIA KREPS

23 Good morning. My name is is Cynthia Kreps,
24 C-y-n-t-h-i-a, K-r-e-p-s. I'm on the Legislative Committee
25 for the Nebraska State Assembly of Surgical Technologists.

1 I am handing out some surgeon letters of support. That was
2 one of the questions on the last Committee meeting, was the
3 letters in support from surgeons.

4 My first letter that I handed out is from GIKK
5 Ortho Specialists in Omaha. This is Dr. Otterberg. And his
6 letter reads, "I would like to take this opportunity to give
7 my support towards surgical technologists in Nebraska in
8 their 407 process to require licensure to participate in
9 surgery. As key members of the surgical team, it is
10 pertinent that each member has the highest of competencies,
11 and the requirement of licensure would guarantee each
12 technologist would have the proper education and training.

13 "During these times of rising health care costs,
14 the demand for proper sterile technique to reduce the risk
15 of infection is ever increasing and the demand for well-
16 educated, fully invested surgical technologists is one of
17 the keys to this process. I feel licensure will be one of
18 the tools necessary to ensure this pathway to be properly
19 followed.

20 "As a fellow-trained joint surgeon, I recognize
21 the importance for my surgical team to be highly skilled and
22 anticipatory to my and the patient's needs, leading me to
23 the realization that all participants having licensure would
24 create the high level of care I expect. I conclude that
25 licensure of surgical technologists would be a means to

1 achieve this goal. Sincerely, Dr. Otterberg."

2 My second letter is from Dr. Heidrick, here in
3 Lincoln OB-GYN Clinic. "To whom it may concern: It is has
4 come to my attention that there is a discrepancy between how
5 the current law in the state of Nebraska defines how the
6 practice of the surgical technologist is delegated and then
7 what actually occurs in the operating room on a daily basis
8 throughout the state. Currently, the practice of the
9 surgical technologist is delegated by the nurse and the
10 surgeon is not allowed by law to delegate any medical task
11 or function to the surgical technologist, as they are
12 presently unlicensed personnel. The state of Nebraska also
13 does not currently recognize or credential surgical
14 technologists and does now have a clear definition of the
15 role that they are allowed to practice in, nor the tasks and
16 functions they are allowed to perform.

17 "I practice alongside surgical technologists on a
18 daily basis in that operating room. These allied health
19 professionals most commonly function in the sterile role as
20 a member of the surgical team that is scrubbed in at the
21 sterile field created around the surgical patient. In this
22 sterile role, these professionals perform a broad range of
23 tasks and functions that assist in expediting the surgical
24 procedure, as I direct them to perform. At this level of
25 care, it is extremely imperative that all members of the

1 surgical team are certified and have completed acceptable
2 training establishing their competence. It's also necessary
3 to establish a license for the surgical technologist so that
4 I am able to delegate medical tasks and functions to them
5 with the 1898 ruling in *State of Nebraska v. Howard Paul*,
6 which prohibits delegation of the practice of this medicine
7 to unlicensed personnel.

8 "I would urge the Nebraska Medical Association to
9 support forward (sic) with establishing a license for
10 surgical technologists in the state of Nebraska, as well as
11 clearly defining the qualifications that are required by
12 professionals to practice in these roles and establishing a
13 scope of practice defining the tasks and functions of the
14 surgical technologist that (sic) is allowed to perform.

15 "Patients assume that all personnel caring for
16 them are properly educated and have appropriate clinical
17 experience. However, surgical technologists remain the only
18 members of the surgical team who is not required to meet a
19 threshold of educational and certification criteria to
20 practice in their areas of expertise. Regulation of this
21 profession will eliminate the disparity and ensure that all
22 personnel caring for patients undergoing surgery are
23 appropriately educated and meet minimum continuing education
24 standards. It will also legally allow the delegation of
25 medical tasks and functions to surgical technologists which

1 are already occurring daily in that operating room across
2 the state.

3 "Thank you for your consideration to support
4 creation of licensure for surgical technologists which will,
5 in turn, continue to support quality care for the surgical
6 patients in Nebraska. Dr. Gregory Heidrick."

7 The third message is from Dr. Timothy Tesmer.
8 He's an ENT surgeon here in Lincoln. "It has been a very
9 busy time for us in the office, as, last week, we closed out
10 the calendar year. Dr. Rapp has been on vacation for the
11 past several days and will be out this week. My schedule,
12 unfortunately, will not permit me to attend tomorrow's
13 public hearing. I wholeheartedly agree with your thoughts
14 on establishing a licensing avenue for surgical
15 technologists to ensure core competency and skill sets in
16 the OR. This would augment the surgical team approach to
17 delivering proper and exemplary care. Please include my
18 name in support of your efforts. Sincerely, Dr. Timothy
19 Tesmer."

20 Also included in the application were a couple of
21 other letters: reference letters from Dr. Rapp, who is an
22 ENT surgeon here in Lincoln; and, also, six of the partners
23 of the Lincoln Surgical Associates also submitted a letter.
24 And that's in your packet.

25 And I would thank you for your attention and your

1 time. And I'm available for any questions.

2 CHAIRPERSON VANDER BROEK: Okay. Thank you.

3 Any questions for Ms. Kreps?

4 MR. HOWORTH: I guess, according to Dr. Tesmer, so
5 is he assuming that there is not already being proper and
6 exemplary care being delivered?

7 MS. KREPS: It's assists of the assurance.

8 MR. HOWORTH: So, you're not assured now that
9 that's happening?

10 MS. KREPS: Well, I believe that, in some areas,
11 it is not happening.

12 MR. HOWORTH: Has there been any repercussions for
13 that so far?

14 MS. KREPS: There's no way to monitor.

15 CHAIRPERSON VANDER BROEK: Any other questions?

16 (No response.)

17 Okay. Thank you.

18 BENJAMIN GREENFIELD

19 Hello, members of the Committee. My name is
20 Benjamin Greenfield, B-e-n-j-a-m-i-n, G-r-e-e-n-f-i-e-l-d.
21 I come before you today wearing several different hats. I'm
22 the Director of Operations for HEME Management, a perfusion
23 company. It's -- we work in several hospitals here in
24 Lincoln, in Omaha, and 40 hospitals across, mainly, the
25 Midwest; although, we extend from Maui to Florida. I also

1 serve as an Associate Professor and a Clinical Coordinator
2 at UNMC in the College of Medicine. And I was a Committee
3 member for the 407 process for the SFAs, the surgical first
4 assists. I've been involved in several of these 407
5 processes, from presenting our perfusion licensure law and
6 proposal about 10 years ago, I would say, when it was the
7 ULL, the Uniform Licensing Law, and a different process;
8 been a part of several committees; and been in your shoes.
9 Actually, I worked with several of you on committees. So, I
10 say that, but I come to testify today calmly as a public
11 member. I have no stake in this whatsoever, other than the
12 fact that I'm a potential patient here in Nebraska and have
13 access and have worked, and worked daily, in surgery with
14 the surgical technologists, and I will perform between 5-
15 and 600 surgeries this year in Lincoln, working directly
16 with the surgical technologists and the surgical first
17 assists. So, at the end of my testimony, I would welcome
18 some questions about that, or how we teach at UNMC, and how
19 we integrate the surgical technologists into our multi-
20 factorial team approach, and how we teach sterile care and
21 sterile operating-room procedure. I could speak to that as
22 well.

23 I just had a couple of quick points. They're not
24 long. The first point, I spoke a little bit at the first
25 meeting, and I talked to a couple of the nurses and -- in

1 the room at the time. And I want to be clear in the way I
2 feel about nurses and how I look at this issue. In my
3 opinion, nurses run the hospital. Nurses are our front-line
4 care. They are our direct patient communicators and those
5 who take care of our patients with the utmost care. I
6 married a nurse. I believe it's probably the most noble
7 profession in surgery. I don't look at this issue as a
8 nursing issue. I think there is plenty of room in surgery,
9 in the operating suite, for the nurses and their
10 responsibilities, and there's plenty of room for the
11 surgical technologists in there as well and what they do.
12 And though some of their duties do overlap, the majority of
13 their duties are very, very different. And a couple of the
14 questions have focused on that, and Mr. -- Dr. Sandstrom
15 said, when we were defining a scope of practice, "Are these
16 things allowed?" And those are the types of things that --
17 a lot of those things that the nurses in there do, that the
18 circulator does, in the pre-op, in the post-op, or the PACU.
19 Not necessarily what the surgical techs are looking for.
20 So, I wanted to be clear, before I start this out, in no way
21 does anything I say undermine what the nurses do.

22 The second point -- and you guys know this as well
23 as anybody -- we have different levels of credentialing.
24 And, right now, there is no credentialing, basically, that's
25 mandatory for surgical techs. That's scary to me as a

1 patient. I recently had a gallbladder attack and had my
2 gallbladder out. Ms. Glassburner spoke earlier that,
3 sometimes, patients don't get to choose who their surgery
4 team is going to be. Well, when you're on the inside and
5 you know the individuals very well, sometimes you do get to
6 choose. And it was apparent to me in there on who I chose
7 to be in surgery with me at that time what means something.
8 When your safety, your own safety, is at risk, it's a -- it
9 kind of speaks to, hey, do you want somebody who's educated
10 and who is licensed, or do you want somebody who's not? And
11 that's not to say that experience isn't important or valid.
12 It is. But you give me somebody who's educated versus
13 somebody who's uneducated, I'll go with the educated person
14 every single time for my own care.

15 The next point is, I've been through several of
16 these meetings, as well as the entire SFA Committee 407
17 process. I've yet to hear, and I asked this question
18 numerous times at every single meeting we had for the SFAs,
19 I've yet to hear a valid reason why licensure for the
20 surgical technologists is not the best form of credentialing
21 to protect the public safety. We ended up going with the
22 registry with that, even though, as the record will show, I
23 voted no on the criteria that said, "Is this the best form
24 of credentialing?" I voted no, and said that I believed
25 licensure is. Why? Because it establishes a true scope of

1 practice. The other thing, it provides a form of, if
2 something goes wrong, it provides the State an avenue to
3 come back and reevaluate whether the proper steps were
4 followed, because they are able to evaluate a licensed
5 person. It's the highest level of credentialing, and I
6 believe, with what these people do -- you guys have been
7 exposed to what these people do -- they are in charge of
8 sterile procedure in the operating room and, often, they're
9 in there by themselves. Even though they're not technically
10 supposed to be, oftentimes -- I see it every day -- they're
11 in there by themselves setting up a sterile room.

12 There's precedents for the State to come in.
13 Within the last year, out at Sidney Regional Medical Center,
14 which led to the whole issue with the SFAs, that was brought
15 to us by the Nebraska Hospital Association, and it was a
16 financial issue with an orthoped coming from Colorado with a
17 first assist who was no longer to practice, because the
18 State came in and said, "Wait a minute. They're doing this
19 as an unlicensed practitioner." Well, there's 12 SFAs, and
20 the Hospital Association brought a proposal. It's the first
21 one I've ever been a part of or heard where it didn't come
22 from the applicant group themselves. It came from the
23 Nebraska Hospital Association. That they said, "Well, we've
24 got to do something. We've got to act quickly. We've got
25 to move, because the State has come in and put these 12 to

1 14 people out of business of what they were doing." Well,
2 now, you have the potential of 4-, 5-, 6-, 800 people in
3 Nebraska doing these types of things in surgery in -- from
4 Broken Bow to Alliance to Scottsbluff, Lincoln, Omaha,
5 Hastings, Grand Island. All these hospitals that employ
6 surgical technologists, they're doing these types of
7 surgery. All the State has to come in and do is follow what
8 they did with the SFAs and uphold the law from 1898, and
9 surgery's going to grind to a halt in Nebraska. That's a
10 real problem and a real issue. And the hospitals I work in
11 here are worried about that and nervous about that. They're
12 not letting these people do simple tasks that they've been
13 doing all along because they're worried that the State's
14 going to come in a put the kibosh on them. At Lincoln
15 Surgical Hospital, they're not doing things that they're
16 doing at St. Elizabeth and Bryan. Simple manipulation of
17 the skin, putting in staples, and things like that, they're
18 not doing it because they're so terrified that they're going
19 to come -- that the State's going to come back in again, see
20 them doing these things, and deem those things not
21 acceptable. So, the problem is real and it's happened,
22 that's why we need to do something.

23 And the last point is, if we can try our hardest
24 to not make this a political issue about money and finance.
25 You can get into the debate on, hey, is this going to cost

1 us a lot more money as a State, or is it going to save us a
2 lot of money because of the infection? I don't know. What
3 I do know is you have a large group of people that are doing
4 this currently. If you license them, it's going to be this
5 same group of people doing the same thing. It's not like,
6 all at once, hospitals are going to have to pay them \$3
7 more. What drives that is supply and demand of
8 practitioners. It's that way in my profession; it's that
9 way in any profession. Supply and demand of practitioners,
10 it's not whether they're licensed or not. What it's going
11 to allow us to do is create a minimum level of standard.
12 It's going to allow everybody that's working out there to do
13 what they're doing, but it's going to put a cap on that and
14 say anybody coming in the profession at a certain point is
15 going to need an education, they're going to need to meet
16 minimum standards, they're going to need to do continuing
17 education, like all the rest of us in surgery have to do.
18 The nurses have to do it, the perfusionists have to do it,
19 the anesthesiologists, the surgeon, every other group needs
20 to do that, except the surgical technologists currently.

21 So, if we can overlook that. Look at it as, hey,
22 this is one area where, if we go in for surgery in Nebraska,
23 it's going to affect all of us. It's going to affect all of
24 us, because we're going to -- there's going to be a surgical
25 technologist in there. So, we're going to be affected by

1 that. Look at it in those terms, as opposed to -- you're
2 going to hear a lot of straw-man arguments that are going to
3 try to detract from that very point. And try to get to the
4 basics of it. That's all I ask. Get to the basics. It's a
5 safety issue. If you go in for surgery, who do you want in
6 there with you?

7 That's all I have. I appreciate you listening. I
8 would be happy to answer any questions, either from that
9 standpoint of going through it with the SFAs and what our
10 committee felt, or from what I do now currently, or working
11 with them day-to-day. Anything that I could shed light on.

12 CHAIRPERSON VANDER BROEK: Any questions for Mr.
13 Greenfield?

14 DR. SANDSTROM: Ben, thanks for being here.

15 MR. GREENFIELD: Yeah.

16 DR. SANDSTROM: I just have some -- I need some
17 information about your experience with regulators or
18 accrediting bodies, because, years ago, I was a hospital
19 manager. So, I know what it's like when they come for the
20 reviews. Like, when Joint Commission comes, what kind of --
21 what happens in the surgery area, as far as preparing for a
22 Joint Commission visit, as far as, you know, assessing the
23 quality of the staff that's working in the surgery area?

24 MR. GREENFIELD: Number one, when the State comes,
25 it's a mad scramble at every hospital you're in, and word

1 travels faster than the speed of light that the State's
2 here. For those of you that work in medical facilities and
3 get that, it's, like, how it can go from second floor to the
4 basement that the State's here in less than a second, it's
5 quick. And so, people are scrambling to make sure
6 everything is up to record. You're hiding any meds that you
7 have stashed anywhere, you're grabbing those things. From a
8 record standpoint, we have switched to keeping almost
9 everything electronically so that, even if we can't find
10 something last minute, we can go to a printer and print
11 something off, from a licensure, certification, those type
12 of standpoint. Electronic copies have helped a lot, with,
13 like, Google Docs to keep all that stuff in. But your
14 policies and procedures and those types of things, you
15 better have easily accessible.

16 DR. SANDSTROM: Right. And I've looked up and I
17 -- they posted it after the last meeting -- that I looked
18 around on the website and found the facilities regulation.
19 The State has regulations related to hospitals and,
20 specifically, to surgery. And so, I would assume that the
21 surveyor would come in and check the policies or the
22 documentation to see if the facility has met those specific
23 expect- -- the facility level.

24 MR. GREENFIELD: And they come in and they'll also
25 -- if you miss a certain number of things, you kind of go on

1 their list, and they come back way more frequently to your
2 facility. So, it's easier to have kind of all your ducks in
3 a row when they come the first time, as opposed to kind of
4 getting dinged about numerous areas. And some of the
5 regulations that they have are absolutely ridiculous. Not
6 only do you have to have a copy of somebody's license, you
7 also have to have documentation that you went online to make
8 sure it wasn't a fake license, that you actually went online
9 and checked that they were a licensed practitioner in this
10 state. And so, part of my responsibility at those 40
11 hospitals is to make sure all our people have all those
12 things, and I've gone online when they renewed their license
13 to make sure that they just didn't change the date and send
14 me a photocopy or something like that, that they are truly
15 licensed and still credentialed in those different states
16 and things like that. So, there's a lot of double cross-
17 checks that those -- that JCAHO and those places do as well.
18 They have some kind of funny little regulations that you
19 have to know.

20 DR. SANDSTROM: Right. So, I guess, my question
21 is and where I struggle a little bit about the scope of
22 practice and the licensure solution here is, how does that
23 improve the -- we get these assertions that it's unsafe out
24 there.

25 MR. GREENFIELD: Right.

1 DR. SANDSTROM: We get these assertions, it's kind
2 of this nagging thing in the back of my mind. You know
3 what? There's something bad going on out there. But I
4 don't know. I never hear specific examples. No one -- a
5 patient has not come forward and said something to me. You
6 know, today, maybe they will. I don't know. But I'm just
7 saying, what does this add to it? I mean, what does it add
8 that's not currently in place, from a regulatory point of
9 view? Because you just said, that we had -- you had a lot.

10 MR. GREENFIELD: That's the question. Because
11 it's really hard to find a specific case where a surgical
12 tech made a mistake, and then you almost have to say that
13 they wouldn't make the same mistake if there was licensure
14 in place. And so, instead of having that specific case -- I
15 apologize for dominating this -- but, instead of having that
16 specific case, you almost have to look at surgery in
17 general. And say, if you have an entire team -- and this is
18 just my opinion. If you have an entire team that is
19 licensed, is that safer than a team that is unlicensed? And
20 by licensed, you mean that the State goes through and makes
21 sure they meet those minimum criteria and that they are
22 doing their continuing education and keeping up to date.
23 And if you have one group that's not, all the attention kind
24 of falls -- it's kind of like the weak link in a chain. All
25 the attention kind of comes on them. And what we've seen

1 this year is, with the State coming through, they've singled
2 out that weak link and said, "Now, wait a minute. Everybody
3 else in here is licensed. They're not. How are they doing
4 all these things?" And it's a big, broad range.

5 And, Dr. Sandstrom, I know, after working with you
6 on the other committee, that scope of practice is going to
7 be a real stickler, because it always is, isn't it?

8 DR. SANDSTROM: Yeah.

9 MR. GREENFIELD: And one of the reasons with this
10 group is, it's maybe even more so than the last one we did,
11 is a lot of these are so different depending on where
12 they're at. A surgical tech out in Ogallala is probably
13 going to do things far different than a surgical tech in
14 Omaha who does the same case every single time. Where they
15 may see that case once or twice a year in Alliance, and --
16 so a surgeon may be more apt to say, hey, they can do that.
17 They've seen me do this 300 times a year. They do this.
18 It's far easier for them.

19 So, you -- we've gotten into this discussion
20 numerous times. Do we make it very specific and limit what
21 certain practitioners are able to do, or do we leave it
22 broad and leave it up to the surgeon to direct, at their
23 discretion, what they would allow the practitioner to do?

24 DR. SANDSTROM: Well, that's, I guess, my last
25 comment. That's been my question throughout this review,

1 has been: Are some of these really specific, technical
2 decision best left to -- I mean, if you look at the facility
3 regulations; you look at, I think, even the federal
4 regulations; you would say that they have to have --
5 hospitals have to have a medical staff, they have to have
6 privileging, qualifications have to be assessed. I mean,
7 it's basically left at the facility level. And I'm saying,
8 we have to be -- as far as scope of practice, we have to be
9 careful that we're clearly preventing things -- if it's
10 going to be a scope of practice, we have to clearly prevent
11 things that are dangerous people are unqualified to do
12 without writing it so specific that it begins to --

13 MR. GREENFIELD: Exactly.

14 DR. SANDSTROM: -- interfere with people's work.

15 MR. GREENFIELD: I completely agree. I think your
16 best off, in that case, of leaving it up to the individual
17 physician that's working with their surgical technologist,
18 because one's going to be different than the next. And one
19 thing, I've never met a surgeon who won't do the best thing
20 for their patient, as far as delegating tasks. So, you're
21 protected that way. You're -- ultimately, it does fall to
22 the captain of the ship. They're the one. You're not going
23 to have a surgeon who says, "Hey, go ahead and sew that last
24 distal because my hands are tired," or stuff like -- to a
25 surgical tech. I mean, they're not going to do that. "I've

1 got a phone call. Go ahead and close all the layers of
2 skin." I mean, that's not going to happen. And licensure
3 isn't going to protect it. If that was going to happen,
4 that surgeon's going to be doing that regardless, likely,
5 anyway.

6 What you're going to do more harm with, as far as
7 scope of practice there, I think, is creating a limit that
8 will then make it illegal to do things that probably a
9 certain percentage of surgical technologists have been
10 currently doing and are very qualified and able to do.

11 DR. SANDSTROM: Well, I think that's the dilemma
12 that the proponents are stating here, is that they've got a
13 Supreme Court case that's -- they're worried about.

14 MR. GREENFIELD: Yeah.

15 DR. SANDSTROM: That's preventing them from doing
16 anything, potentially.

17 MR. GREENFIELD: Yeah. And that's -- and we've
18 been told, let's just go change that law. Well, that's a
19 lot more detailed than going through a 407 process to get
20 that old law changed. So, any other questions for --

21 CHAIRPERSON VANDER BROEK: Any other questions for
22 Mr. Greenfield?

23 Yes, sir.

24 MR. HOWORTH: Don't get me wrong. I think what
25 the surgical technologists do is very important. But you

1 brought up Sidney, and I don't want to confuse surgical
2 first assistants versus surgical technologists.

3 MR. GREENFIELD: Right.

4 MR. HOWORTH: The administrator who was affected
5 by this most primarily has sent a letter to us stating he
6 does not want the surgical technologists under licensure.

7 MR. GREENFIELD: Isn't that interesting?

8 MR. HOWORTH: It is. I don't -- have you talked
9 to him, and what was his thought process here?

10 MR. GREENFIELD: You know, I've put in here in my
11 thing that I handed out that, when I was on the committee
12 for the SFAs, I actually got the attorney for the Hospital
13 Association who was bringing that SFA proponent -- proposal,
14 he said, "Oh, when that comes, yeah, I'll support licensure
15 for the surgical technologists." Which is why -- I don't
16 know if you remember that first meeting -- I said, "Let's go
17 back and find the public testimony then to see what was
18 actually said, because, now, it doesn't feel like it's the
19 same way."

20 I've yet to hear a reason why not. It's like it's
21 a political question out there that I don't understand why.
22 You'll hear, maybe, that argument later. I've yet to hear a
23 valid one. What -- I mean, it's the same people that are
24 doing the things now are going to be doing the things then,
25 just with a State minimum level of standards set and

1 official scope of practice. It's not going to prevent them
2 from getting people. I know there's a girl from Colorado
3 coming into Sidney Regional Medical Center this week to
4 interview as a surgical technologist. It's not going to
5 prevent people from coming and applying for those. It's --
6 there's plenty of surgical technologists out there. I've
7 yet to see an institution not be able to hire a surgical
8 technologist.

9 I don't know what the argument is. I don't know
10 what the -- I've yet to hear one and --

11 MR. HOWORTH: I just can't understand why he would
12 be against this versus he was the one directly affected.

13 MR. GREENFIELD: I don't know. I don't know. If
14 you're for the very same process that's going to affect 14
15 people, why would you then be against the same process
16 that's going to affect 4- or 500? It's going to be -- then
17 you're not going to have to deal with the same issue that
18 caused you the same problem that you went through before. I
19 have yet to hear a valid reason.

20 MR. HOWORTH: Okay. Thanks.

21 CHAIRPERSON VANDER BROEK: Any other questions for
22 Mr. Greenfield?

23 (No response.)

24 If not, thank you for your time.

25 MR. GREENFIELD: Thank you.

1 CHAIRPERSON VANDER BROEK: Any other proponent
2 testimony in favor of the application?

3 CATHERINE SPARKMAN

4 Good morning, Mr. Chairman and members of the
5 Committee. My name is Catherine Sparkman. That is
6 C-a-t-h-e-r-i-n-e, Sparkman, S-p-a-r-k-m-a-n. I am the
7 Director of Government and Public Affairs for the
8 Association of Surgical Technologists. It's a national
9 37,000-member professional organization in Denver
10 representing surgical assistants and surgical technologists,
11 both nationally and, in particular among individual states.
12 In representing these medical professionals, AST focuses
13 inexorably on the patient, the safety, and the positive
14 health interests of those patients that they serve. *Aegar*
15 *primo*, which is the slogan for AST, means "the patient
16 first." By pursuing and advancing competency initiatives in
17 individual states, that's what I do. To that end, AST has
18 sought legislation assuring, by various means, an objective
19 measure of competency for those practitioners who, as
20 members of the surgical team, are intimately responsible for
21 the safe and effective treatment of surgical patients at
22 their most vulnerable state: sedated; asleep; totally
23 reliant on their surgical team; some, if not most of them,
24 they did not choose.

25 AST has, in the last several years, particularly

1 in the last decade, we have passed legislation in 13 states.
2 I'm going to just roll through them: Massachusetts, New
3 York, New Jersey, Virginia, South Carolina, Tennessee,
4 Indiana, Colorado, Oregon, Illinois, Washington, Idaho, and
5 Texas. This legislation addresses this issue. Some laws
6 are incremental, others are comprehensive; but this campaign
7 continues, certainly into 2016, in Ohio, Florida, North
8 Carolina, Michigan, Oklahoma, and, of course, Nebraska.

9 Our allies in this endeavor extend across the
10 surgical spectrum. In New York, the New York Chapter of the
11 American College of Surgeons vigorously supported this
12 legislation, writing letters, both as an organization and as
13 individual members, and testifying at legislative history --
14 hearings, excuse me. In Massachusetts, the University of
15 Massachusetts Memorial Hospital, one of the preeminent
16 teaching hospitals in the United States, championed this
17 effort. They identified its constituent senator as the
18 legislation's prime sponsor and pursued this legislation
19 throughout the legislative season and, in fact, threw a
20 celebration of this bill's passage in their atrium attended
21 by their entire medical faculty and surgical leadership. In
22 South Carolina, every stakeholder, including the State
23 regulatory agencies, supported this bill. In Oregon, the
24 bill was supported by the Oregon Hospital Association. AORN
25 supported this legislation in Oregon and Texas. And, in

1 South Carolina, Massachusetts, and Indiana, AORN and AST,
2 together, assured final legislation assuring, not only the
3 competency of surgical technologists, but also the presence
4 of qualified RN circulators in all hospital operating rooms.
5 A bill addressing surgical patient safety, the bill was
6 joint. It contained both of those initiatives.

7 I know this because, over this decade plus, I was
8 Director of Government Affairs, first at AORN, and then,
9 later, at AST. Surgical patient safety is part of my DNA,
10 you might say.

11 And now, we are in Nebraska. And the same
12 exigencies exist. Surgical patients deserve a
13 comprehensively competent team. In the old days, we used to
14 talk about the Institute of Medicine's study that showed
15 that 98,000 patients die every year from preventable medical
16 errors. And that was 1999. A study recently, 2010 to 2013
17 data, estimates this number was incorrect, and they put it
18 approximately 400,000 patients. Six of the 29 never events
19 that have been identified by health care quality
20 organizations occur in the operating room. Surgical site
21 infections constitute 21 percent of all hospital-acquired
22 infections. A hundred and fifty-seven thousand, five
23 hundred surgical site infections occurred in outpatient
24 surger- -- excuse me -- in inpatient surgeries in 2011.
25 Differently stated, 1.9 percent of all inpatient surgical

1 patients experience a surgical site infection. There are 16
2 million inpatient operating procedures performed in the
3 United States annually.

4 I juxtapose, in addition to my experience as the
5 Director of Government and Public Affairs in this area, I
6 feel it -- I feel compelled to also state that I am a
7 recovering lawyer. In my former life, I was a medical
8 malpractice attorney. I defended hospitals in claims, among
9 others, arising out of the operating room. In Nebraska, as
10 in Texas where I practiced, surgeons are vicariously liable
11 for virtually all of the actions of their surgical team,
12 often jointly with the hospital or facility, and it is
13 without regard to his or her fault. The captain of the ship
14 doctrine is not based on a delegatory act. It is based on
15 the fact that the surgeon is vicariously responsible for the
16 team, irrespective of the direction that the surgeon gives
17 at the operating table.

18 Surgery is becoming more and more complex. An
19 educated, experienced, and competent surgical technologist
20 is the threshold response, if not the best response, to this
21 complexity in the interest of their patients and in a
22 capable and efficient delivery of quality surgical care.
23 Recently, in Oregon, the hospital association in that state
24 testified in support of the legislation requiring
25 certification and education of surgical technologists. And

1 that individual was asked by the proponent of the bill, who
2 was on the health committee at the time, why, after a while,
3 has the hospital association decided to support this bill
4 when they were, at best, skeptical in the past. And she
5 replied, "We looked at this. Surgery has become so complex
6 it is time for everyone who are serving patients in our
7 hospitals to be appropriately competent."

8 Thank you.

9 CHAIRPERSON VANDER BROEK: Questions by the
10 Committee?

11 DR. SANDSTROM: Just one question. Thanks for
12 being here again.

13 MS. SPARKMAN: My pleasure. Thank you.

14 DR. SANDSTROM: Because you come from Colorado, we
15 -- the opponents -- we furnished this report from the
16 regulator- -- regulators. I'm -- you're all aware of this
17 -- in Colorado. Came out in the fall about sunseting the
18 surgical technologist registry there -- or program --
19 licensure, I guess. I want you to clarify this for me. But
20 I also want to make sure, because I don't think it's been,
21 at least from what I've reading and trying to keep track of
22 things, is that there's a safe harbor that they've
23 maintained in Colorado, correct?

24 MS. SPARKMAN: That's --

25 DR. SANDSTROM: Some form of regulation of

1 surgical technologists. So, it was not just completely
2 sunsetted off the books totally? Can you clarify that for
3 us?

4 MS. SPARKMAN: There's a little history about the
5 Colorado registration statute. The Colorado registration
6 statute arose out of an incident involving a surgical
7 technologist named Kristen Parker. Kristen Parker was a
8 surgical technologist at Rose Hospital in Denver, a highly
9 regarded medical facility. Kristen Parker was a Fentanyl
10 addict. She would slide into various operating rooms, take
11 the Fentanyl off the surgical table, self-inject, replace
12 the Fentanyl in the syringe with saline, and depart the
13 premises. Scrub in, maybe in that room and maybe in other
14 rooms, and go about her business. Unfortunately, Kristen
15 Parker was Hep-C positive and infected 36 patients in Rose
16 Medical Center with Hepatitis C. She is now in prison,
17 serving a 24-year sentence.

18 It is because of that event and the outflow of
19 that event that patient advocacy groups as well as medical
20 groups determined to do three things with respect to
21 surgical technologists and surgical assistants: Make sure
22 they're registered; make sure there is a vehicle to research
23 their pasts, their possible criminal backgrounds; and to
24 have -- well, there's actually four -- to have a disclosure
25 of the qualifications of the surgical technologists/surgical

1 assistants; and, also, provide a mechanism for hospitals
2 and, in fact, mandate that hospitals exchange information
3 about the reasons for terminating surgical staff at the
4 hospitals and give a safe harbor. Meaning that the exchange
5 of that sensitive employment information -- which, as a
6 trial attorney representing hospitals, I will tell you is a
7 very sensitive subject about providing a recommendation or
8 providing information about employees to a prospective
9 employer or even the freedom that a prospective employee
10 might want to enjoy to seek that information. The law not
11 only provided a safe harbor for the exchange of that
12 information, but mandated the information be exchanged and
13 required hospitals to actually access the database.

14 When that bill was passed, surprisingly, DORA, the
15 Department of Regulatory Agencies, opposed that bill. They
16 did not want to regulate the bill. They did, in fact, --
17 the bill did, in fact, pass, overwhelmingly with bipartisan
18 support. And DORA set about their activities of monitoring
19 this. It is sunseting now. DORA -- and I won't make any
20 personal comments about DORA -- is declining to support the
21 renewal of this bill. The renewal, in terms of bill
22 sponsors and support in the legislature, has bipartisan
23 support again. We have -- are intimately involved in
24 assuring that this bill or this process remains intact and
25 robust.

1 During that time, DORA identified -- or the
2 registration process identified a number of surgical
3 technologists who were not allowed to practice in the state
4 of Colorado, due to their criminal backgrounds. And, also,
5 about a dozen surgical technologists self-selected out of
6 practicing surgical technology in that state, declined to
7 register, declined to undergo a background check.

8 So, these issues are certainly not without a
9 variety of opinions that impact them. AST certainly has no
10 expectation that this bill will not be renewed in 2016, and
11 especially accounting for the support that it has among the
12 medical community and, also, among the patient community and
13 the families of those patients who are injured.

14 Every one of us has the likelihood of becoming a
15 surgical patient in a hospital in any state in which we
16 reside. And AST believes that it is the duty of the
17 organization, as the proponent of surgical patient safety
18 and also those who evaluate the delivery of competent
19 medical care, to assure that they get the finest medical
20 care that they can.

21 DR. SANDSTROM: One last question. Do surgical
22 technol- -- in the law that's maybe renewed this year, do
23 they have a scope of practice in Colorado?

24 MS. SPARKMAN: Yes, it's broad like the scope of
25 practice is presented here.

1 I'll be happy to submit Colorado law or any of the
2 laws that were passed. I think that they're summarized in
3 the applicant application. And I will say, parenthetically,
4 that the national office and my very competent manager of
5 government affairs, Vanessa Smucny, participated in the
6 preparation of a lot of -- most all of the data and
7 materials that are before the Committee today. She even
8 prepared, which I'm not going to impose on the Committee, a
9 numerous-page summary of the delegation laws of the 50
10 states, about how that issue, delegatory authority of a
11 surgeon, is treated in the remaining 47 states that have
12 addressed it.

13 CHAIRPERSON VANDER BROEK: Mr. Briel, is there a
14 time limit in when people can submit additional written
15 information as part of the testimony at the public hearing?

16 MR. BRIEL: We recommend a 10-day cutoff period,
17 but there's no actual -- we can't enforce that. So --

18 CHAIRPERSON VANDER BROEK: Sure. So, there is
19 opportunity to submit additional written information.

20 MR. BRIEL: -- there's opportunities to submit
21 after the public hearing, yes. We ask that, if there's --
22 if you have additional comments, that you submit it to us
23 within 10 days. We ask; we can't require.

24 CHAIRPERSON VANDER BROEK: Thank you.

25 Is there any other questions for Ms. Sparkman?

1 MR. HOWORTH: I hear a lot about registry and
2 registration, but not the word licensure. Just for my
3 edification, are we using the word registered synonymously
4 with licensure?

5 MS. SPARKMAN: No, I'm not.

6 MR. HOWORTH: Because all I heard was registry and
7 register, and I didn't hear any word about licensure.

8 MS. SPARKMAN: Correct.

9 MR. HOWORTH: Okay.

10 MS. SPARKMAN: Colorado has a registry. It does
11 identify the -- and these are -- oh, these are subtleties
12 that only lawyers get lost in. I'm sorry. Registry is
13 licensure. Certification that is imposed or that is
14 governed by the State is also licensure. Licensure is
15 licensure. They're just three different levels of it. It
16 depends on what is in the particular statute and what you
17 want to call it, registry or something.

18 The issue here, of course, in licensure, there's
19 one other state where licensure is being pursued, and that
20 is in Ohio. And, again, sorry, I won't get wonky on
21 everybody, but I'm going to Columbus next week. But they
22 have a bipartisan bill that is supported by the Board of
23 Medicine in Ohio for the licensure of surgical
24 technologists. And the reason that licensure is -- has been
25 identified as the best system is because hospitals are not

1 regulated by the State in Ohio. There is no hospital-
2 licensing authority, so there is no mechanism to enforce a
3 hospital's hiring and maintaining qualified, certified
4 surgical technologists. So, licensure is the only
5 opportunity and the best avenue for that.

6 In Nebraska, because of *Howard Paul* and because of
7 the vagaries in *Howard Paul*, the DHHS has opined and, with
8 respect to City Medical Center, that suturing, the mere fact
9 of suturing, which is one of the things that's on the list
10 of tasks and functions -- range of functions of a surgical
11 technologist, is considered the practice of medicine.
12 Because of the uncertainty of what else becomes the practice
13 of medicine, licensure seems to be the best and most
14 efficient -- efficacious, actually -- response to that
15 issue. Having a determination of the delegatory authority
16 of a surgeon, which is in many medical practice acts
17 throughout the United States which contemplates the
18 delegatory authority of a surgeon, not to delegate the
19 practice of medicine, which requires an elevated medical
20 judgment, et cetera, but to delegate medical tasks and
21 functions is actually embedded in many medical practice
22 acts. So, the reason that licensure is before us is because
23 it seems to be the -- not necessarily the best, but maybe
24 the only efficacious way to make sure that surgical
25 technologists are competent, certified, education --

1 educated, competent, and have a mechanism for disciplining
2 them as well. That is the unique position we find ourselves
3 in in Nebraska.

4 Albert Einstein said, "Always look for the second
5 right answer." I'm looking for a second right answer any
6 time I do any of this and would love to engage with the
7 Committee or with others in what the second right answer
8 might be. This is certainly a competent, capable, and
9 easily obtainable answer, to have licensure of surgical
10 technologists in the state in the interest of the safety of
11 their patients.

12 MR. HOWORTH: Thank you.

13 CHAIRPERSON VANDER BROEK: Any other questions?

14 MS. CHASEK: I have a question. So, you talked a
15 little bit about, in other states, the support for the
16 bills. Could you tell me what was kind of categories of
17 opposition and why? So, were -- did you face lots of
18 opposition in other states, and what would be the overall
19 summary or headline of what the reasons for opposition?

20 MS. SPARKMAN: Sure. Thank you.

21 Really interesting. I'll just relate two stories.
22 And anyone who knows me, that I'm a big fan of the anecdote.
23 So, just practicing trial law for 35 years. I have two.
24 One was, when I hired Vanessa Smucny as my government
25 affairs manager and grassroots developer, she came in and,

1 after the fact, she said, "You know, I really didn't know
2 what I was going to do after the third or fourth year I was
3 here." She's been there six years now. She says, "Because
4 we should go down and, you know, in the interest of patient
5 safety, this should be very easy." And it was surprising
6 that it was a challenge, and -- as all legislation is. It
7 is a slog. And I think it surprised her.

8 We also -- the other anecdote was, in California,
9 we went and gave a presentation, and the California surgical
10 technologist woman raised her hand and said, "Well, this
11 shouldn't be so hard. We'll go up to Sacramento, we'll have
12 a show of hands, and we'll be done." And so, legislation is
13 harder than all of that.

14 The opposition pretty much uniformly begins with
15 the hospital association. Not necessarily individual
16 hospitals, but with the hospital association. And I'd say
17 surgeons, not so much. Really hardly ever. Our colleagues
18 at AORN, back and forth. The issue really isn't ever about
19 the competency of surgical technologists. AORN has a
20 national position on certification and education of surgical
21 technologists. So, there are a variety of issues that
22 arise. And, in all candor, I think some of it is, and I'm
23 very sensitive to this, that some of this is under the
24 "don't tell me what to do" rubric. I'm very cognizant that
25 hospitals are regulated and by a panoply of organizations,

1 from JCAHO to state licensing laws, to health laws, to
2 health codes, and everything. And I think that, initially,
3 the perception is that this is just one more thing we're
4 going to have to do. Don't. You know, we can do this.

5 Persistence is the greatest attribute of an
6 advocate. And so, over time, in these 13 states -- I've
7 only been involved with, I think, 11 of them -- over time,
8 talking to the hospital association, talking to the various
9 entities, we come to an accord that this is not going to be
10 as onerous as it appears at the threshold, yet another thing
11 that someone is going to tell us what to do, but that it
12 becomes a joint mission by all of the members -- all the
13 representatives of health care. And when that happens,
14 whether it is, as in Oregon, where the hospital association
15 -- or in Massachusetts -- actually comes out in -- or North
16 -- South Carolina -- in support, or whether in other states
17 where these bills have passed hospital associations remain
18 neutral but not opposed, getting everyone to that common
19 ground results in the passage of patient safety legislation.

20 There's an old saying about Novocaine, you do it
21 long enough and it always works. And I'm not sure how long,
22 with gray hair, this is going to actually continue, but it
23 is certainly the fight of the righteous when AST does it.
24 And we hope that our surgical colleagues, like AORN in South
25 Carolina and in Massachusetts and elsewhere, join with us

1 and do it. And sometimes it is just the education and the
2 gathering of the common folk. When we pass it, there is no
3 one opposed. We have never passed -- we have not 20 -- not
4 two nickels to rub together. So, we pass it because
5 everybody agrees it's a good idea.

6 CHAIRPERSON VANDER BROEK: Any other questions for
7 Ms. Sparkman?

8 (No response.)

9 Okay. If not, thank you.

10 MR. HOWORTH: Thanks for being here.

11 CHAIRPERSON VANDER BROEK: And other proponent
12 testimony?

13 And, Mr. Briel, how are doing on time for the
14 proponents?

15 MR. BRIEL: We're doing fine. There's still 30
16 minutes, if they choose to fill it. They don't have to fill
17 the time available, but they have 30 minutes.

18 CHAIRPERSON VANDER BROEK: If there's other
19 proponent testimony, and then, I think, when we conclude the
20 proponent testimony, we'll probably have a brief break, and
21 then we'll begin the opponents' testimony after the break.

22 Other proponent testimony at this point?

23 (No response.)

24 Okay, if not, I think we'll take a break right
25 now.

1 MR. BRIEL: Fifteen minutes?

2 CHAIRPERSON VANDER BROEK: Yep, a 15-minute break,
3 and we'll reconvene with the opponents' testimony.

4 And if you are speaking as an opponent, be sure
5 that we've signed the sign-in sheet. Because I know a few
6 people came in --

7 MR. BRIEL: If you haven't signed the sign-in
8 sheet yet and you still wish to testify, please do that.

9 CHAIRPERSON VANDER BROEK: I know a few people
10 came in late. I don't know who you represent. If you want
11 to testify as an opponent, please sign the sign-in sheet.
12 Okay? And we'll be back in 15 minutes.

13 (Off the record at 10:12 a.m. to 10:23 a.m.)

14 CHAIRPERSON VANDER BROEK: I think, since it
15 appears that most everybody is back, we're close to the 15,
16 so let's go ahead and reconvene. And we're going to start
17 with the opponents' testimony. And since these are from
18 various individuals and groups, we'll just go in the order
19 in which people signed the sign-in sheet.

20 And you are Elizabeth?

21 MS. SMITH: No.

22 CHAIRPERSON VANDER BROEK: Oh, I'm sorry.

23 MS. SMITH: I'm Sheri Smith.

24 CHAIRPERSON VANDER BROEK: Okay, go ahead.

25 SHERI SMITH

1 Mr. Chair and Committee members, thank you for
2 allowing me to testify today. My name is Sheri Smith. It's
3 S-h-e-r-i, S-m-i-t-h. I'm here representing the Nebraska
4 Association of Independent Ambulatory Centers and Midwest
5 Urology Alliance. The NAIAC represents 16 independent
6 surgery center facilities ranging from endoscopy to surgical
7 facilities. Midwest Urology Alliance is an alliance of 28
8 physicians in Lincoln and Omaha practicing in a clinically
9 integrated network.

10 I did look to see if I could have a physician
11 attend this hearing today. Our physicians are surgeons and,
12 with a week's notice, we were unable to move all of the
13 surgeries. However, in your packet information that I gave
14 you, I have two letters from physicians in my practice.
15 I've a letter from the Urology Center in Omaha and a letter
16 from Lincoln Orthopaedic Center here in Lincoln.

17 I would like to address you just reviewing the
18 criteria that you have used to -- in this 401 -- this 407
19 process. When we look at criteria number one, "Unregulated
20 practice can clearly harm or endanger the health, safety, or
21 welfare of the public," I don't believe that's true. They
22 have been unregulated, unlicensed, up to this point, and
23 there has been nothing that has been presented to you that
24 shows that there's been harm committed by a surgical
25 technologist. Not here in Nebraska, not elsewhere. So, the

1 associations that I represent are asking the question: Are
2 we creating the solution to a nonexistent problem? Are we
3 spending time, effort, and money on a situation that is
4 clearly not causing any issue at the present?

5 On criterion number two, "Regulation of the
6 profession does not impose significant new economic hardship
7 on the public, significantly diminish the supply of
8 qualified practitioners, or otherwise create barriers to
9 service that are not consistent with the public welfare and
10 interest," previous testimony has established that the
11 tuition range for a surgical technology program ranges from
12 9,700 to \$35,000. The requirement of licensure and
13 certification pushes more people into these programs. It is
14 unrealistic to think that there would not be tuition
15 increases over time for these programs. The increasing
16 tuition cost could be a barrier to students wishing to enter
17 these programs. If fewer students are entering these
18 programs or if the number of students graduating is less
19 than the demand, we have a supply and demand issue.

20 It is not inconceivable with a supply and demand
21 issue that there would be an increase in wages for surgical
22 technologists. At last testimony, we talked about this as
23 being a cost that would be borne by the student or by the
24 facility. But I'm here to present to you a different
25 scenario.

1 Surgery centers and, I'm sure, other facilities as
2 well, are facing decreasing reimbursement. Costs increase
3 annually and reimbursement goes down. There is a breakpoint
4 at which it's not fiscally, economically feasible for
5 facilities to remain in practice. Each year, we face, as a
6 facility, payers who come back to us and say, "We're cutting
7 the cost on these procedures." It might be three or four
8 procedures. And the next year, they come back and they pick
9 three or four different procedures. We celebrate a year
10 when we have no change in the Medicare fee schedule, neither
11 up nor down. We haven't had up, we haven't had down.
12 Urology has been fairly fortunate in the fact that we've
13 maintained neutrality.

14 Most patients now have insurance policies with a
15 20 percent to 30 percent, or more, coinsurance requirement.
16 And, as you know, deductibles are increasing as well.
17 Patients are responsible for paying that coinsurance.
18 Surgery centers currently get reimbursed approximately 60
19 percent less than what a hospital would be reimbursed for
20 the exact same procedure. The coinsurance, therefore, for a
21 patient, 20 to 30 percent plus, is less at a surgical center
22 than it would be at the hospital. Likewise, our costs --
23 our fees that we charge are less. So, if the entire charge
24 goes to the deductible, that's still less money out of the
25 patient's pocket. Pushing these surgeries to the hospital,

1 then, can increase the cost of medicine. Shifting,
2 potentially, is not in the patient's best interest. Now,
3 that's something that you hadn't considered in previous
4 testimony, that there are things that happen beyond what you
5 think as a cost borne by the student or by the facility.

6 There are a few things in my testimony today that
7 will not be in my written testimony, because I wanted to
8 respond to some issues that were raised in the previous
9 testimony. One of the things that seems to come about is
10 that surgical technologists are unregulated. They're -- I
11 don't want to use the word "incompetent," but there's no
12 monitoring of their capabilities. Any facility that sees
13 Medicare patients has to be Medicare certified in the state.
14 The State comes in, they do a survey, they go through an
15 entire checklist, and one of the things that they check is
16 are we doing annual competencies for our staff. We are
17 required to do competencies for our staff.

18 We, at our facility, also are AAAHC accredited.
19 They come in with a set of regulations that go beyond what
20 Medicare has put in place, and we have to meet those
21 requirements. We're certified every three years. Much
22 similar to what Joint Commission does for the hospitals,
23 AAAHC does for the ambulatory facilities.

24 So, they're not just rogue employees that are out
25 there running amok. They're trained professionals who are

1 monitored on an annual basis, and we don't want someone in
2 our facility that's a rogue employee, someone that's going
3 to cause infections. That is not good for the facility.
4 That's not something that we would tolerate.

5 One of the other things that was brought up is
6 that -- the statement was that there -- they didn't feel
7 like there was a shortage of technologists in the state.
8 Last week when I was here, someone from CHI-Alegent
9 testified that she had 14 openings for surgical
10 technologists in her facility. That was one facility that
11 testified before you last week about openings. We've been
12 very fortunate. We've been in existence for 16 years the
13 end of February. Two of our surgical techs have been with
14 us since the beginning. One has been there for three years,
15 replaced someone who retired. None of them are certified.
16 They all were at one point in time, and they dropped their
17 certification because of financial cost. It doesn't mean
18 that they're any less qualified than they were. They just
19 chose not to pay out that money that they needed for
20 continuing education and for the cost of certification.

21 One of -- Mr. Greenfield testified that licensure
22 won't prevent certain acts from happening. And that's true.
23 That's true for surgical technologists, that's true for
24 anyone in the profession. There's always going to be
25 someone who's going to step over that line and do something

1 that's not authorized by law or completely illegal. We had
2 a -- there was some conversation about the Colorado case.
3 Well, there was a case in Lincoln, probably three or four --
4 maybe longer than that, where there was a nurse anesthetist
5 that was taking Fentanyl. Well, nurse anesthetists are
6 licensed, certified. It happens. It's not something that
7 licensure is going to prevent.

8 Moving on to criteria number three, "The public
9 needs assurance from the State of initial and continuing
10 professional liability," I would like to go back to my
11 initial statement that there has been no need identified for
12 this. There's been nothing that's happened to require this
13 to progress. There are -- and, additionally, I would like
14 to add that there are numerous people that are in the OR
15 every day. We have a cleaning service that comes in every
16 night and does terminal cleaning in our facility. Do we
17 take this licensure/certification issue to that point?
18 They're a critical part of what happens in the OR, and I'm
19 not saying that to be facetious. I truly am not. I just
20 want you to consider what's happening today, the
21 ramifications, and how far do we go when we say that we're
22 going to protect the public.

23 And the last criterion was, "The public cannot be
24 protected by a more effective alternative." My associations
25 do not believe that's true. We are not opposed to a

1 registry. If there is a surgical tech that truly is
2 unqualified to work in an OR, they should be on some kind of
3 registry where other facilities have access to that
4 information. And we believe that that is the best method to
5 handle this issue, because it is less costly for the State
6 to maintain.

7 Are there any questions that I can answer?

8 CHAIRPERSON VANDER BROEK: Questions for Ms.
9 Smith?

10 DR. SANDSTROM: I have a question. The questions
11 have to do with the educational requirements for on-the-job
12 training. If you look at the registries, okay, for the
13 medication aide, the CNA, and then, I think there's a
14 pharmacy -- at least a couple of them in statute establish a
15 minimum number of hours of education. So, I think CNAs,
16 like, 75 hours; medication aides are 40 hours. You know,
17 and going back to the documents that we had at the first
18 meeting, it seemed like that was something that was opposed
19 by hospitals or somebody that, no, they don't want anything
20 like that. So, I mean, wouldn't it be beneficial to have
21 some sort of -- if you're opposed to -- I can understand the
22 -- I can appreciate what you're saying about the problem
23 with requiring everybody going through a formal program,
24 okay, going forward. But we're just going to leave it,
25 people can do 10 hours, a hundred hours, come on in and just

1 show you what to do and we'll kind of teach you as you go
2 kind of a thing, or shouldn't there be some sort of a
3 minimum that you guys can all agree on?

4 MS. SMITH: Potentially there is. We haven't had
5 that discussion in our association, so I can't speak for the
6 associations at this point in time. I do not have any on-
7 the-job trained surgical technologists. All of my
8 technologists have been through a program, they're just not
9 certified and they're not licensed. I can't speak
10 specifically to on-the-job training. I don't know what it
11 would consist. I don't know that my associations would be
12 opposed to some kind of minimum requirement, but I'm
13 speaking for myself at this point in time.

14 DR. SANDSTROM: Right. I just think, sometimes,
15 it potentially could protect the reputation of your
16 association and your facilities if you don't have, again, a
17 facility that just decides to -- it's in a crunch and just
18 going to do something that they really shouldn't be doing.
19 You know what I mean?

20 MS. SMITH: Sure. Sure.

21 DR. SANDSTROM: Unless there's some sort of legal
22 limit, sometimes that helps people. Kind of a guardrail.

23 MS. SMITH: No. I'm not disagreeing.

24 DR. SANDSTROM: Okay.

25 CHAIRPERSON VANDER BROEK: Anything else?

1 Questions?

2 (No response.)

3 Okay. Thank you, Ms. Smith.

4 MS. SMITH: Thank you.

5 CHAIRPERSON VANDER BROEK: Other opponents'
6 testimony?

7 ELISABETH HURST

8 Good morning. Mr. Chair and members of the
9 Technical Review Committee, thank you for the opportunity
10 to testify today. My name is Elisabeth Hurst,
11 E-l-i-s-a-b-e-t-h, H-u-r-s-t. I am the Director of Advocacy
12 with the Nebraska Hospital Association. We represent 90
13 hospitals across the state and the 41,000 individuals that
14 they employ.

15 You've seen the testimony that's been presented,
16 currently on the website, and I don't want to duplicate that
17 in detail. What I would like to do is go down the four
18 criterion and just provide our basic reasonings for opposing
19 licensure.

20 Criterion one, "Unregulated practice can clearly
21 harm or endanger the health, safety, or welfare of the
22 public." Now, the applicant group has not shown that the
23 current regulatory system poses a harm to public safety,
24 because there is no evidence that it does. The State of
25 Nebraska does not legislate or regulate based on anecdote.

1 The State requires data, reports, even headlines that
2 illustrate a persistent inadequacy in Nebraska policy or
3 regulatory systems prior to creating new or modifying
4 current statutory guidelines. As there are no such reports
5 to substantiate a clear harm to public safety in the state,
6 a vote of no is required for criterion one.

7 Criterion two, "Regulation of the profession does
8 not impose a significant new economic hardship on the
9 public, significantly diminished supply of qualified
10 practitioners, or otherwise create barriers to service that
11 are not consistent with public welfare and interest."
12 Licensure of surgical technology imposes a significant new
13 economic hardship on the public and will significantly
14 impact the supply of qualified practitioners. Requiring
15 formal education and credentialing of surgical technologists
16 will unnecessarily increase health care costs while creating
17 a barrier for high school graduates interested in entering
18 the field. As the availability of licensed surgical
19 technologists is limited under new requirements, labor
20 shortages will increase -- or will result in increased wages
21 and increased health care costs. The cost of education
22 programs and credentialing are prohibitive, and it will be
23 very difficult for rural hospitals, especially, to recruit
24 for this role during a time when hospitals are facing
25 workforce shortages. Now, geographically, Nebraska is much

1 more different than the states that we've discussed today.
2 We are a vastly rural state and are currently facing
3 shortages in our health care personnel. These substantial
4 hardships require a vote of no for criterion two.

5 Criterion three, "The public needs assurance from
6 the State of initial and continuing professional ability."
7 Hospitals and clinics possess rigid and thorough internal
8 policies and procedures in line with federal and State
9 regulations that ensure the initial and continuing
10 professional ability of hospital and clinic personnel. The
11 public does not require an additional layer of regulation
12 as, again, the current regulatory system has not exhibited
13 inadequacies in ensuring that surgical technologists are
14 performing appropriately within their role. Again, I'd like
15 to point out that the list of duties presented by the
16 applicant group does not contain suturing or approximation
17 of the skin, which are functions that would be delegated by
18 a physician. The items in that particular list do not
19 require delegation from the surgeon, but, instead, require
20 direction from the surgeon or supervision of a registered
21 nurse. Without a scope of practice, regulation of the
22 occupation through licensure is unnecessary.

23 Criterion four, "The public cannot be protected by
24 a more effective alternative." An alternative regulatory
25 method exists that would be more effective than licensure.

1 A mandatory registry with a competency requirement, modeled
2 after Nebraska's current medication aide registry, would
3 create a mechanism for employers and the public to file
4 complaints against surgical technologists. The State could
5 monitor the registry, investigate complaints, and maintain a
6 list of employable surgical technologists as an alternative,
7 without the multiple adverse effects that licensure will
8 create. As a more effective alternative does exist, vote no
9 on criterion four.

10 Now, statements have been made that surgery will
11 grind to a halt in Nebraska without licensure of surgical
12 technologists. But the cease and desist order came down two
13 years ago, and surgeries are occurring daily under the new
14 requirements for the State with *Howard v. Paul* -- *Howard*
15 *Paul v. Nebraska*. The State doesn't legislate or regulate
16 based on anecdote or potentials, and I'd like you to,
17 please, keep that in mind as you continue your review.

18 That's all I have. If you have any questions, I'm
19 happy to answer them.

20 CHAIRPERSON VANDER BROEK: Okay. Questions by any
21 Committee members?

22 Dr. Sandstrom?

23 DR. SANDSTROM: I've got a question. Thanks for
24 coming. What's your statement -- comment about the
25 uniformity of education for on-the-job training surgical

1 technologists done by hospitals in Nebraska? For people who
2 are entering the field or coming -- who are entering the
3 operating room, what's provided?

4 MS. HURST: I think, again, keeping in mind that
5 there are different options across the state for the
6 employable pool, the hospitals that are doing on-the-job
7 training are, again, regulated by both federal and state
8 laws. And they are taking the individuals that they have
9 and making sure that they're getting the training they need
10 on the job. Whether they have a formal educational program
11 in mind or not, they're still making sure they get that
12 training. And there are annual, if not biannual, competency
13 assessments that are done by the compliance officers at
14 those hospitals to ensure that they're meeting the standards
15 under the Medicare regulations, JCAHO, et cetera.

16 DR. SANDSTROM: So, you would be opposed to the
17 Legislature establishing a minimum number of hours or
18 training for on-the-job trained surgical technologists?

19 MS. HURST: At this point, because that would most
20 likely require completion of some sort of a formal program,
21 we would support a mandatory competency assessment
22 requirement, as the medication aide does, minus the
23 coursework that would have a licensed health care
24 professional evaluate a minimum list of duties. We had
25 recommended 12 that are the basic functions of, say, a scrub

1 tech. Monitor and make sure that that individual can
2 demonstrate those functions, and then sign off as part of
3 their registry application.

4 DR. SANDSTROM: I just have -- the issue of
5 criminal background checks, because this goes to the
6 unregulated practice, you know, about -- you're well aware
7 of mandatory reporting, right?

8 MS. HURST: Uh-huh.

9 DR. SANDSTROM: And so -- and what's been stated
10 in some of the written material is that we -- that I think
11 you do criminal background checks before you hire people?

12 MS. HURST: Uh-huh. And those are done at the
13 hospitals already.

14 DR. SANDSTROM: Right. And that's very -- that's
15 routine. Okay. So, that would collect or catch just about
16 everything.

17 MS. HURST: Right.

18 DR. SANDSTROM: Most things, many things, anyway.
19 My question has to do with how frequently do you do those
20 after hiring?

21 MS. HURST: My understanding from discussions with
22 Sidney Regional Medical Center is those are done annually.

23 DR. SANDSTROM: So, annually. You think that's
24 done across the state, that you do an annual check on all
25 direct -- all patient-care staff?

1 MS. HURST: I can't confirm that.

2 DR. SANDSTROM: Right. That's, I think, one of
3 the issues with li- -- with some sort of regulation is that,
4 those of us that are regulated, we -- every two years, we
5 have to, at least, tell the State -- they'll ask us, "Are
6 you convicted of a misdemeanor or a felony?" And we have to
7 answer that question, which, if we falsify, if we did and we
8 say no, you know, and then they eventually catch us, we're
9 in trouble. Just because we, you know, we do that. So,
10 there's a mechanism, an ongoing mechanism of background
11 checks with a regulatory system that, perhaps, is not
12 present in the voluntary system, right?

13 MS. HURST: Right. And I think that that would be
14 the benefit of a registry. Not only do you have an entity
15 that you can report inadequacies in performance to, but you
16 also have someone who's going to be able to look into that
17 further.

18 CHAIRPERSON VANDER BROEK: Any other questions?

19 MS. CHASEK: I have a question.

20 CHAIRPERSON VANDER BROEK: Yes.

21 MS. CHASEK: So, who -- you're with the Hospital
22 Association, correct?

23 MS. HURST: Uh-huh.

24 MS. CHASEK: So, lots of hospitals across the
25 state?

1 MS. HURST: Uh-huh.

2 MS. CHASEK: So, who in that system oversees,
3 certifies, is responsible for the surgical technologists in
4 the facilities? Who determines competency and what happens
5 after someone is found incompetent?

6 MS. HURST: Again, my experience with that is it's
7 the compliance officers at the hospitals. And they're the
8 ones who, at the point of employment, are conducting the
9 background checks and whatnot, and also coordinating with
10 the director of nursing to make sure that the competencies
11 are evaluated over time.

12 MS. CHASEK: So, the compliance officer
13 administers a competency review?

14 MS. HURST: They're ensuring that the nursing --
15 what would be the managing nurse would be making sure that
16 that's happening. And they're currently doing that now
17 with, again, the medication registry -- the nurse's aide
18 registry.

19 MS. CHASEK: And somebody who is found to be not
20 competent?

21 MS. HURST: My guess is their employment, if over
22 time they're not able to bring themselves up to competency,
23 their employment would be terminated.

24 CHAIRPERSON VANDER BROEK: Okay. Dr. Tennity?

25 DR. TENNITY: Yeah. Can you explain or expound on

1 why the NHA feels that surgical first assists should be
2 licensed but not surgical technologists?

3 MS. HURST: A surgical first assist has a
4 delineated scope of practice, one that can be identified,
5 because the physician is specifically delegating tasks to
6 them, not simply directing them to perform a function.
7 There are items within the physician's scope that he is
8 instructing the surgical first assist to complete, such as
9 suturing, injecting, those types of things.

10 DR. TENNITY: Those are the two things, yeah.

11 MS. HURST: So, it's specific. It requires a
12 statutory scope of practice for a surgical first assistant
13 to complete those tasks. It's identifiable.

14 DR. SANDSTROM: It's been asserted to us that
15 hospitals are doing things -- interpreting this cease and
16 desist very different ways. We just had a -- earlier this
17 morning, one facility you can't do, you know, you can't do
18 this, other facility's saying yes. So, in that case,
19 wouldn't a scope of practice improve and standardize the
20 situation, clarify it for hospital administrators and for
21 lawyers that work in hospitals to understand what the law
22 really is here?

23 MS. HURST: I think when it comes to any type of
24 law, you're going to have individuals who go outside of it,
25 even if they shouldn't be. Hospitals have their own job

1 descriptions for surgical technologists, and they were
2 modified after the cease and desist went out to make sure
3 that they included the parameters that were allowable under
4 the law. If individuals choose to work outside of that job
5 description or a physician should instruct an individual to
6 do something and they feel that they shouldn't perform that,
7 that's individual discretion which licensure isn't going to
8 fix that situation.

9 CHAIRPERSON VANDER BROEK: Has the NHA provided
10 its member hospitals with any guidelines or written policies
11 regarding these issues?

12 MS. HURST: Uh-huh. When the cease and desist was
13 first issued two years ago, a memorandum went out to
14 everyone. There were also sample job descriptions that
15 individuals contacted us to disseminate. They were wanting
16 to ensure that they were within the law. Does that mean
17 that people aren't working outside of that? Of course
18 that's going to happen. But, again, licensure isn't going
19 to change that situation. It's just going to make it more
20 difficult to fill the role.

21 CHAIRPERSON VANDER BROEK: Okay. Anything else
22 for Ms. Hurst?

23 (No response.)

24 Okay. Thank you.

25 Other opponent testimony?

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KAREN RUSTERMIER

Good morning. My name is Karen Rustermier.
That's K-a-r-e-n, R-u-s-t-e-r-m-i-e-r. My remarks will also
go along with your four criteria.

I've been an OR nurse for the last 45 years. I've
worked in four different facilities in the state, and
trained in a fifth, and one community college where I was
faculty in a surgical technology program. I've functioned
in every role in the operating room. I've been a scrub, a
first assist, a circulator, preceptor, educator, manager.
I've been that compliance person that developed the
competencies and administered them on an annual basis, took
corrective action when competency was not met, developed
education, that sort of thing.

I don't believe there's really been any hard data
provided that there's been any danger to patients. As a
circulating nurse in the operating room, I advocate for the
patient, and patient safety is my main priority. I know the
doctors would like to think that my main priority was to get
them done, but my main obligation is to that patient that is
on that operating room table. I need to assess the patient,
develop a plan of care, communicate that plan, implement
that, evaluate, and continuously evaluate so that changes
can be made to the plan along the way. Corrective action,
if anything is not going as planned or as it should. And,

1 in doing all of that, I am keeping my patient's needs in
2 mind. It's a broad perspective. Part of it has to do with
3 coordinating of care from other departments, maybe X-ray,
4 perfusion, pharmacy, anyone else that may have to come to
5 the operating room for one specific case. It is my job to
6 prevent harm to that patient. It's all of our
7 responsibility to monitor the sterile field and to prevent
8 harm to the patient. And that's everybody, the physician,
9 anesthesia, the nurses, the techs. Everyone participates in
10 that or they're not on our team.

11 I think that we all agree that the surgical
12 technologist is directed by the surgeon during the
13 procedure. The applicant group seems to be using direction
14 and delegation interchangeably. And I -- for the lack of a
15 obviously formal definition of those two things, I think
16 that we've decided kind of, in our deliberations, what those
17 are, what that means. And I think we ought to -- it's one
18 way or the other. It's not both simultaneously.

19 We talked quite a bit about what is the scope of
20 practice or the range of functions, that sort of thing.
21 There's no medical task on that list that starts with the
22 MD's scope. They all start in the nursing scope. In the
23 previous 407, the medical society, you know, we said, let's
24 find out from the Board of Medicine what they think. They
25 agreed to a registry under the Board of Nursing, and they

1 would take the surgical technology first assistants under
2 the Board of Medicine, because they believed that the tasks
3 were more aligned that -- in that direction.

4 As far as on-the-job training, my facility serves
5 as a clinical site. And what we do for our students,
6 whether they be students of a community college or whether
7 they be students being on-the-job trained, and that would be
8 nurses, techs, whichever the case may be, there's classroom
9 work for our employees, then clinical work where we are on-
10 the-job training them. So, we are on-the-job training
11 students from the community college. We are the clinical
12 site. These two people are getting the same training in
13 clinical, whether they came to us as an employee or they
14 came to us as a student. So that portion is the same.
15 Where the difference is, is what education are you giving
16 this person up front, as far as classroom work.

17 Everybody that -- pretty much that I know in a
18 facility, there's a designated person for education, and a
19 lot of that has to do with CMS regulations. And that person
20 is responsible for that. There, again, the people -- and
21 when they get through this training and clinical experience,
22 they have to meet competencies, and they have to continue to
23 meet them every year. I have to take the competencies every
24 year. I've done this 45 years. I've written competencies,
25 but I still have to go through the competencies every single

1 year to prove that I am competent in things that are deemed
2 by my facility as very important. Things in the operating
3 room.

4 As far as shortages, someone else testified that
5 their facility had 14 openings for techs. I personally have
6 five traveling surgical technologists right now in my
7 facility. If there were surgical technologists applying for
8 those jobs, we would not be paying three times the amount of
9 money and getting a traveler. So, obviously, we're short at
10 least 19 that anybody's admitted to. One of my travelers
11 just finished an assignment in Ains- -- or Alliance,
12 Nebraska. So, I know they go elsewhere, not just the big
13 city. The cost for travelers is -- it is literally three
14 times the amount you would normally pay someone, because
15 that company that hires them is going to take their share
16 first.

17 I think that licensing is kind of a barrier to
18 entry here. If you're young, you're 21, and you're a
19 traveler, and you have an opportunity to come to Omaha,
20 Nebraska, and work, and you're going to have -- but you're
21 going to have to buy a license, and you're going to have to
22 prove this, and you're going to have to prove that. Or, you
23 can go to San Diego, and you don't have to prove anything,
24 just that you're an employee of mine. Where are you going?
25 So, I don't think -- that's going to seriously limit the

1 amount of travelers that we will be able to get. You might
2 be able to get somebody that actually lives here and is
3 traveling within the state. But, you know, we've got 1.5
4 million people versus 300 million people, so it stands to
5 reason there's going to be a lot more of these people come
6 from outside the state than are from inside of our state.

7 So, also, at the last hearing, we talked a lot
8 about tissue manipulation by surgical technologists. And I
9 think that was pretty much cleared up that suturing and that
10 sort of thing wasn't really on that list. So, I think that
11 it's -- there, again, it's something that's coming back into
12 the discussion that's been backed out before, and that was
13 appropriate for the surgical first assistant. So, we need
14 to keep those two things separate. These are two separate
15 process- -- 407 processes and not get confused with what is
16 being asked for in the previous 407.

17 As I reviewed, I checked to see any additional
18 things that were listed online. There were letters from two
19 ophthalmologists that were listed just, like, in the last
20 week, and one was Dr. Peter Whitted. And you all should
21 have that -- access to that. It's online. And the very
22 last -- his very last statement that I read really struck
23 me. He said, "I strongly oppose the application for
24 licensure. I've observed the Legislature for over 30 years.
25 In Nebraska, we don't regulate and legislate by anecdote,

1 and that's precisely what the applicant is asking the
2 Committee to do."

3 In everything that we've gone through, we don't
4 really have hard data on anything. It's been so much
5 opinion and, some say, common sense, this, that, and the
6 other, and there's question about who said what and who
7 believes what. So, I just -- I am against the licensure of
8 surgical technologists. I don't think it adds anything. I
9 don't think it will change my responsibility to my patient.
10 I don't think it guarantees any safety in any way.

11 Does anyone have any questions?

12 CHAIRPERSON VANDER BROEK: Questions?

13 MS. CHASEK: Do we have written testimony from the
14 last two --

15 CHAIRPERSON VANDER BROEK: From the last two
16 presenters?

17 MS. RUSTERMIER: I have some to give you.

18 MS. CHASEK: Okay. I don't know about the other
19 one either.

20 DR. SANDSTROM: I have a quick question.

21 MS. CHASEK: But, yeah, then I do have a question.

22 CHAIRPERSON VANDER BROEK: Did you have another
23 question, Christine?

24 MS. CHASEK: Oh, yeah. So, talked about anecdotes
25 and the travelers. One of the things, just driving here

1 today, that I heard on the radio, Nebraska has one of the
2 lowest unemployment rates in the nation.

3 MS. RUSTERMIER: I know.

4 MS. CHASEK: And I think you have a lot of out-of-
5 state people coming who have higher unemployment rates, so
6 we can't hire Nebraskans, but we can hire outstaters. But
7 my question is, what are the qualifications, then, for a
8 traveler when you hire them?

9 MS. RUSTERMIER: We give them an orientation
10 period. We give them -- we only give them two weeks. They
11 come to us with the assurance from their company that they
12 have basic skills, and they have to fill out, you know, what
13 they can do. Maybe they only do ortho. Maybe they do all
14 services. And that would kind of depend on someone's
15 personal experiences. Sometimes people just don't want to
16 do something, so they just say they can't do that. And when
17 we go over applications for travelers, we look at that and
18 where is our greatest need. If we have somebody that's
19 heavy experience in ortho and we need ortho, we're going to
20 probably take that person. We don't have applicants coming
21 from in our state. We have a very few, but a lot more come
22 from out of state.

23 MS. CHASEK: So, what are the qualifications for
24 these people? A high school diploma? No diploma?

25 MS. RUSTERMIER: They are -- the majority of the

1 travelers are going to be people that have completed a
2 program. Some are certified. Some are not. They come with
3 assurance of experience from the company that we are hiring
4 them from. Some --

5 MS. CHASEK: Education or experience?

6 MS. RUSTERMIER: Some hospitals have contracts
7 with a specific company. There's several companies out
8 there that hire travelers.

9 MS. CHASEK: So, it's a mixed bag. We don't
10 really know what we're getting?

11 MS. RUSTERMIER: Correct. And we have found that
12 some just did not work out within their two weeks, and we
13 asked them to leave because we didn't find that they met up
14 to our standards.

15 CHAIRPERSON VANDER BROEK: Dr. Sandstrom?

16 DR. SANDSTROM: Yes, I have a couple of questions.
17 First of all, we haven't touched on the issue of, if this
18 goes forward, the Legislature does this, about which board
19 is -- would be, you know, doing the supervision, you know,
20 handling the cases. In the application, it says the Medical
21 Board. However, I've heard -- we've heard before about the
22 Nursing Board -- the Board of Nursing. So, do you have any
23 comments on that or why -- what you think, one way or the --
24 I assume you're the Nursing Board, but why?

25 MS. RUSTERMIER: Yes, because I believe that the

1 tasks are all -- they're all nursing tasks. And that
2 nursing should regulate nursing. Medicine should regulate
3 medicine.

4 DR. SANDSTROM: Then one last thing. Earlier
5 today, I went through a couple of things about limits on
6 scope of practice, and went through -- and, also, do -- and
7 they all -- the proponents all said that, you know, they
8 didn't -- weren't talking about administration of
9 medications or fluids, assessment of patients,
10 interpretation of orders, or any work outside the surgical
11 room. You know, nothing pre-op or post-op. Do you agree
12 with all that?

13 MS. RUSTERMIER: For the most part.

14 DR. SANDSTROM: For the most part. Okay. So, --

15 MS. RUSTERMIER: A tech may go with me, like, if I
16 have a combative patient on a cart, and I'm trying to
17 transport to recovery. I have anesthesia trying to maintain
18 an airway, and so a tech may be with me --

19 DR. SANDSTROM: Right.

20 MS. RUSTERMIER: -- to help to transport a
21 patient, to get them safely to another location where we can
22 get better control of the situation. So, I can't say they
23 would never do anything outside the OR.

24 DR. SANDSTROM: Well, that's important. Because
25 these -- if this goes forward, these limits become things

1 you have to live with, right?

2 MS. RUSTERMIER: Uh-huh.

3 DR. SANDSTROM: Now, what about -- is there
4 anything else you think that surgical techs -- it's really a
5 nursing role, it's a role of the operating room nurse, and
6 this should not be directed -- a surgical tech should not be
7 directed by a physician to do this. Is there anything else?

8 MS. RUSTERMIER: Directed? There, again, we get
9 into directed and delegated. If a physician is asking a
10 surgical technologist or me to do something that I'm not
11 qualified to do, that is on me -- on the surgical tech or on
12 me to put my foot down and say, "No, they are not doing
13 that." And if I have to call the manager and, in my
14 facility, I'm lucky enough to have a physician that will
15 come to the room and put a stop to inappropriate behavior.
16 Everybody doesn't have that luxury. But, that way, it's a
17 peer-to-peer review. If somebody is asking someone to do
18 something that is outside of their education, training, and
19 abilities, then --

20 DR. SANDSTROM: So, you would be --

21 MS. RUSTERMIER: -- there's a mechanism to say no.

22 DR. SANDSTROM: Okay. So, it would be your
23 position that that's a facility-level policy decision, and
24 the Legislature should not establish a statewide standard
25 that certain tasks should not be delegated, directed, super-

1 -- I mean, to a surgical tech?

2 MS. RUSTERMIER: No, not necessarily. No. I
3 think that the State has to say there's a limit. You can't
4 let -- okay, I've watched surgery for 45 years. I cannot go
5 in and operate on somebody. Just because somebody's going
6 -- you know, somebody's, "I'm going to go have coffee," you
7 know, "Get the trocars in this patient." No. No. That is
8 outside of my training and ability, and I should not be
9 doing that. So, yeah, we have to have a limit that it
10 cannot be delegated, something that is outside your training
11 and abilities.

12 DR. SANDSTROM: Okay. I agree.

13 CHAIRPERSON VANDER BROEK: Jane?

14 MS. LOTT: So, you're in charge. You're an RN in
15 charge of the surgery suites. I am assuming you're not in
16 every surgery that takes place in the surgery suites.

17 MS. RUSTERMIER: I'm doing hands-on patient care
18 at this time. I have done all of these things.

19 MS. LOTT: But do you have other RNs that fulfill
20 the same goal or the same type of position that you have in
21 your facility in a surgery that you are not present at? I
22 guess I'm not understanding --

23 MS. RUSTERMIER: Thirty rooms are going at once.
24 I'm not in every room.

25 MS. LOTT: Exactly. So, what type of training

1 does the person in charge have so that, when a surgeon says
2 to a surgical tech, "Do this for me," has that person in
3 charge been trained, like yourself, to be able to say, "No,
4 this person cannot do that type of procedure"? What's the
5 assurance that I have, if you're across Nebraska, that every
6 RN that's in charge of a surgical tech has been trained to
7 recognize what a surgical tech can and cannot do to be able
8 to say, "No, you can't do that"?

9 MS. RUSTERMIER: The credentialing boards of every
10 hospital delineate what you can do. If you're -- like, if
11 you're applying to be a first assistant, you have an
12 exhaustive list of things that you must prove to that
13 credentialing board so that you are credentialed to do those
14 activities. So, no -- somebody is ultimately responsible in
15 every single facility to credential the people who work
16 there. It's different -- and the bigger the place, the more
17 layers.

18 CHAIRPERSON VANDER BROEK: Okay. Anything else
19 for Ms. Rustermier?

20 MR. HOWORTH: Just a clarification to Dr.
21 Sandstrom's point. You said the Nursing Board should be
22 responsible for the surgical techs, the disciplinary
23 process?

24 MS. RUSTERMIER: Yes. Yes.

25 MR. HOWORTH: All right. Thanks.

1 MS. RUSTERMIER: And we would agree that a
2 registry would be the best way to do that. That it's the
3 least costly, you have a mechanism to report any problems
4 that there are, and the few states that do have this --
5 Colorado, like, you say, have tried to back off their
6 registry, but they have recommended to keep their -- they
7 call theirs their safe harbor. So, we would agree that is
8 the best way to handle this situation.

9 MR. GREENFIELD: Dr. Vander Broek, could I ask
10 Karen a question and just a clarification of what she said
11 earlier about -- can I just ask her a question or is that --

12 CHAIRPERSON VANDER BROEK: Just real briefly.
13 Usually the questions are limited to the Committee.

14 MR. BRIEL: You don't have -- I think you're going
15 to have to -- she has to be able to record this. You don't
16 have a recording mic.

17 CHAIRPERSON VANDER BROEK: And the questions are
18 usually directed from the Committee.

19 MR. GREENFIELD: Right. And this --

20 MR. BRIEL: Yeah, this is kind of unusual. Yes.

21 CHAIRPERSON VANDER BROEK: So, sorry. No.

22 MR. GREENFIELD: That's fine. I just had a
23 question about something she said. No problem.

24 CHAIRPERSON VANDER BROEK: Anything else from the
25 Committee for questions of Ms. Rustermier?

1 (No response.)

2 Okay. If not, thank you.

3 MS. CHASEK: Only could we get the testimony of
4 the last two?

5 CHAIRPERSON VANDER BROEK: On the list, I have
6 Danielle Glover had signed next.

7 DANIELLE GLOVER

8 Good morning. My name is Danielle Glover. That's
9 D-a-n-i-e-l-l-e, G-l-o-v-e-r. And I'm the Government
10 Affairs Manager for the Association of Perioperative
11 Registered Nurses, a professional membership association for
12 perioperative registered nurses. The Committee has a
13 letter, dated from December 20th, from AORN setting forth
14 some of our concerns with adding licensure structure for
15 surgical technologists in this state.

16 AORN works on similar allied health care provider
17 initiatives across all 50 states, working with our
18 perioperative nurse members to ensure that any such
19 initiatives do put patients first. No other state licenses
20 surgical technologists. Of the states that have considered
21 it, either in the legislature or in a committee review
22 process similar to this, none have recommended or chosen
23 licensure as the best means to patient safety in the
24 operating room.

25 In fact, in Ohio, a bill which has been alluded to

1 in this process hasn't even been heard in the committee
2 process. And while the applicants have said that the Ohio
3 bill is pursuing licensure, I'd like to just note the
4 definition of licensure that Ohio uses, which is different
5 than most places. License, in Ohio, in the bill that
6 they're referencing, means, "An authorization evidenced by a
7 license, a certificate, registration, permit, card, or other
8 authority that is issued or conferred by a licensing agency
9 to a licensee or to an applicant for and initial license by
10 which the licensee or initial license applicant has or
11 claims a privilege to engage in a profession, an occupation,
12 occupational activity, or, except in the case of the State
13 Dental Board, to have control and operate certain specific
14 equipment, machinery, or a premise on which -- over which
15 the licensing agency has jurisdiction." So, in this case,
16 it is a very broad definition of "license." It actually
17 includes registration and certification.

18 The applicants have not shown to this Committee
19 that there is an existing harm to patients and the public as
20 a result of the lack of licensure requirement. The
21 applicants have provided anecdotal and hypothetical risks to
22 patients posed by surgical technologists, but have not cited
23 specific incidents of harm, case law, claims records, and no
24 hospital or patient testimony evidencing harm. Similarly,
25 no other State that has looked at this has found actual

1 evidence or harm. They're using Nebraska as a test State
2 without understanding the consequences that come.

3 The reality is the nurses and doctors in the room
4 and the facility itself are already incentivized to ensure
5 their surgical technologists are fully trained and providing
6 high-quality care. And this was even referenced by one of
7 the applicants in his testimony.

8 Adding a licensure requirement will be
9 economically burdensome and create a barrier to entry. One
10 of the things that has been brought up is the report from
11 the Colorado Department of Regulatory Agencies. Regarding
12 Colorado, Mrs. Sparkman mentioned that there was a scope of
13 practice when it was asked. And I would just like to
14 clarify that there is not a scope of practice. It is the
15 performance of duties, which I do have available if needed.
16 And, under this, they -- the surgical technologists perform
17 their duties under the supervision of an RN in the operating
18 room and at the direction of a physician. To the extent
19 that this Committee is concerned with the possibility that
20 an unqualified surgical technologist could move forward --
21 or move from facility to facility harming patients, a harm
22 that the applicants have yet to show, a registry requirement
23 under the Board of Nursing, as recommended by the previous
24 407 Committee, is the least burdensome way to accomplish
25 this goal.

1 There was a question asked earlier about the Board
2 of Nursing, and I wanted to just build on what Karen had
3 mentioned earlier. All other States where there is a
4 certification or registration process, it is not under the
5 Board of Medicine. It is under the Board of Nursing,
6 because the surgical technologists are performing
7 historically nursing functions. And, in fact, nurses are
8 trained in this role and can perform the scrub role if
9 needed.

10 Another question that just came up was about how
11 do you ensure that there's somebody in the room in case a
12 physician does ask something of the surgical technologist
13 that is outside of that person's range of functions. I just
14 would like to reiterate that there is going to be an RN
15 circulator in every operating room that is trained in this
16 role, can perform that role, and understands what the
17 surgical technologist can do with their range of functions.
18 And, therefore, they're able to stand up and can help the
19 surgical technologist if they're put into a position where
20 they've been asked to do something that they are not
21 qualified or trained in.

22 Happy to take any questions.

23 CHAIRPERSON VANDER BROEK: Okay. Any questions
24 for Ms. Glover?

25 DR. TENNITY: Does AORN have a position statement?

1 I stumbled on one last night. Specifically, for licensure
2 of surgical technologists. Do you have a copy of that?

3 MS. GLOVER: We -- I can get you a position
4 statement. We do not have a position statement specifically
5 for surgical technologists. What we do have is a position
6 statement for allied health care providers that work under
7 the supervision of RNs. And I'm happy to provide that for
8 you.

9 CHAIRPERSON VANDER BROEK: Any other questions?

10 DR. SANDSTROM: I have one other question.

11 CHAIRPERSON VANDER BROEK: Yes. Go ahead, Doctor.

12 DR. SANDSTROM: Do you have -- do you know how
13 other States have handled the regulation of on-the-job
14 trained surgical technologists?

15 MS. GLOVER: It does vary from state to state.
16 Again, there's only 13 States that have registries or
17 require certification. As far as on-the-job, again, it just
18 varies. We think that it is helpful for people, if they're
19 working in the operating room, to have some level of
20 competency, and how that is regulated, each State does
21 different.

22 DR. SANDSTROM: So, in the surrounding states of
23 Nebraska, so the only one is Colorado, right?

24 MS. GLOVER: Correct.

25 DR. SANDSTROM: So, Wyoming, South Dakota, Iowa,

1 Missouri, Kansas, do not regulate, in any way, surgical
2 technologists?

3 MS. GLOVER: They do not, no.

4 Thank you.

5 CHAIRPERSON VANDER BROEK: Thank you, Ms. Glover.

6 DON WESELY

7 Thank you. My name is Don Wesely. I'm here
8 representing the Nebraska Nurses Association. We're handing
9 out a letter to you on behalf of the NNA. I'm going to
10 briefly just tell you that the main point of the NNA
11 position is they support the creation of a surgical
12 technologist registry supervised by the Board of Nursing.
13 You've heard that. That's what's being recommended by the
14 other 407. And the key point they wanted to make was that
15 the surgical technologists function under -- they function
16 under a job description or a range of functions, rather than
17 a scope of practice, and, therefore, do not require
18 licensing. So, the NNA opposes licensing, supports a
19 registry under the Board of Nursing.

20 Danielle talked about the national picture here,
21 and I'm very briefly going to just point out, the whole
22 question of regulation of professions is now becoming a
23 national issue. There's the Supreme Court ruling dealing
24 with a North Carolina Board of Dental Examiners, which ruled
25 antitrust functions were going on there and ruled against

1 the Board of Dental Examiners. The White House has recently
2 issued a paper on the question of over-regulation of
3 professions. What's happening is we're regulating too much,
4 too often, when it's unnecessary. It's not just in health
5 care, but across the board. And so, a lot of questions
6 nationally are coming up.

7 And I think that comes back to a point in the
8 current statute and in your policies that regulation has a
9 high standard. You take that step carefully. In the
10 criteria, the key word in the criterion one is "clearly."
11 Unregulated practice can clearly harm or endanger the
12 health, safety, or welfare of the public. "Clearly" places
13 the burden of proof on the applicant that they should be
14 regulated. They have -- the burden of proof is that they
15 meet all this criterion, and that, unless that isn't met,
16 then it's better for the public to not regulate. And so,
17 the burden of proof question is one that I think you need to
18 keep in mind very clearly.

19 The philosophy of the program in the handouts that
20 you guys -- you gave earlier, and I know you are aware of
21 this, but in the philosophy of the 407 program, it states,
22 "Regulate only when necessary to protect the public or
23 advance the public interest via improved access to care."
24 It's a high standard, and it's one that has not been met, I
25 think, by the applicant group. And that's our point, that

1 there's another proposal. There's a registry that's being
2 suggested, and that is preferable to licensure.

3 And that'll end my comments.

4 CHAIRPERSON VANDER BROEK: Any questions for Mr.
5 Wesely?

6 (No response.)

7 Okay. If not, thank you.

8 MR. WESELY: Thank you.

9 DR. MICHAEL BITTLES

10 Good morning. My name is Mike Bittles,
11 B-i-t-t-l-e-s. I'm a general surgeon up in West Point,
12 Nebraska. I work at other rural hospitals. I'm also a
13 member of the Board of Medicine and Surgery. Nothing I say
14 should be construed as representing the Board of Medicine
15 and Surgery. Okay? I am also a member of the Nebraska
16 Medical Association, and I was asked by our Executive
17 Director to make sure it goes on the record that the NMA is
18 in favor of a registry, not in favor of licensure.

19 This entire topic, the first thing that comes to
20 mind for me is, okay, what's broken that we need to fix?
21 And I really don't see that. My standard is, what do we
22 need to do to protect the citizens of Nebraska? What's
23 going on that they need further protection? And, again, in
24 my situation, I don't see that.

25 As a surgeon, it's important to me that what

1 happens in the operating room happens well. Likewise,
2 health facilities, hospitals, have that same concern. I
3 don't want people in my operating room that aren't -- that
4 can't do the job. And I don't think that that requires
5 licensure for surgical techs. I'm all for education. I
6 have no problem with certification or registration. I've
7 worked with certified surgical techs, some good, some not.
8 I've worked with people that were trained solely on the job,
9 some good, some not. I don't see that what a surgical tech
10 does in the operating room, I don't see that that can't be
11 taught on the job.

12 Let's look at an example. RNs come out of nursing
13 school now with almost no surgery training. Almost none.
14 And they get their experience on the job, and we're okay
15 with that. So, to think that a surgical tech can't learn
16 their trade, their skills, on the job, to me, is ludicrous.

17 So, those are my comments. Are there questions
18 for me?

19 CHAIRPERSON VANDER BROEK: Questions of the
20 Committee? Yes, Jeff.

21 MR. HOWORTH: There's been a lot of talk about
22 delegation versus direction versus instruction. What's your
23 thought on that? What do you do?

24 DR. BITTLES: To me, delegate means give my
25 authority, give my responsibility, to somebody else. I

1 don't do that in the operating room. I direct, I instruct,
2 but I don't delegate my authority. Okay? So, to me,
3 they're two totally different things. So, you know, I'm --
4 that's enough said.

5 MR. HOWORTH: Thank you.

6 CHAIRPERSON VANDER BROEK: Other questions for Dr.
7 Bittles?

8 DR. SANDSTROM: Yeah. We've had some assertions,
9 just assertions, anecdotal, you know, assertions that it's,
10 you know, there's lots of variability across Nebraska, you
11 know. And surgical technologists are being asked to do some
12 things that, perhaps, they should not be doing?

13 DR. BITTLES: Asked by who?

14 DR. SANDSTROM: Well, I guess, surgeons or people
15 in the surgery. I really don't --

16 DR. BITTLES: Why would I, as a surgeon, ask
17 somebody to do something in the operating room that I don't
18 think that they're capable of doing? Because I want some
19 harm to come to my patient? I mean, that's ludicrous.

20 DR. SANDSTROM: Right.

21 DR. BITTLES: You know, if there is a surgical
22 tech who has been asked to suture skin at one time or
23 another by a surgeon, I'm sure that surgeon knew that they
24 could do it. Okay? I'm not saying it's right. And I don't
25 think that surgical techs ought to be suturing skin.

1 There's talk about tissue manipulation. Well, I'm not sure
2 exactly what that means. I mean, if it's, "Hold this
3 retractor so that I can see what I'm doing," is that tissue
4 manipulation? You know, honestly, a monkey could do that if
5 they're sterile. You know, it's just not rocket science or
6 brain surgery.

7 So, I don't have an issue with that, because every
8 surgeon, every hospital, wants things to happen well in the
9 operating room. They have every incentive for that to
10 happen. Why would they ask somebody to do something that's
11 going to jeopardize patient safety? I don't get that.

12 DR. SANDSTROM: And from your position on the
13 Board of Medicine and Surgery, you've not seen cases that
14 come before you, since you've served on the Board, related
15 to mishaps related to improper delegation or directions, you
16 know, so far as surgical technologists?

17 DR. BITTLES: I'm not aware of any.

18 DR. TENNITY: Mike, I've got a question for you.

19 DR. BITTLES: Yes.

20 DR. TENNITY: Dr. Vonn Roberts talked to us last
21 time. Had a very opposite opinion. And, obviously, you
22 worked with Vonn.

23 DR. BITTLES: Right. Sure.

24 DR. TENNITY: Why are we getting such a
25 discrepancy between different physicians?

1 DR. BITTLES: Vonn is certainly welcome to his
2 opinion, and he has a lot of them. And that's fine. He
3 stands on the other side of what we jokingly call the
4 blood/brain barrier. But what happens on my side is where
5 the surgical tech might or might not be asked to do
6 something that they shouldn't do. Again, I can't see that
7 they're asked to do something that they shouldn't.

8 DR. TENNITY: No. I guess, his point was that the
9 advances in surgery over the past 25 years has led this
10 profession to be much more technical than it used to be.
11 And he thought there should be a floor. Like you said, the
12 nurses, when nurses come in, they don't have training.

13 DR. BITTLES: Right.

14 DR. TENNITY: But they do have a degree and four
15 years of a bachelor's degree.

16 DR. BITTLES: Right.

17 DR. TENNITY: Now, a surgical technologist in
18 rural Nebraska doesn't have that requirement.

19 DR. BITTLES: Correct.

20 DR. TENNITY: Do you think it's sufficient for
21 that rural hospital to just have an on-the-job training
22 program to suffice for --

23 DR. BITTLES: For what occurs in a rural hospital,
24 the answer to that is yes. I mean, we're not doing liver
25 transplants and cardiac surgery.

1 DR. TENNITY: Well, it's the common orthopaedic
2 things. Wall Street Journal just had an article a week ago.
3 Thirty-five percent higher mortality rate within 30 days in
4 a rural hospital that has critical access versus the bigger
5 hospitals. How do you explain that difference?

6 DR. BITTLES: Well, whether it has to do with the
7 surgeon or the facility or the number of cases that they do
8 or the population that they're addressing, elderly folks in
9 many situations, I don't think it has anything to do with
10 the surgical tech.

11 MS. CHASEK: So, you're saying that the difference
12 between your opinion and the other gentleman's opinion is
13 just a personal opinion difference? I don't understand the
14 -- some of that vernacular you used.

15 DR. BITTLES: Well, you have, not only my opinion,
16 you have other surgeons' opinions that are not in favor of
17 licensure. Dr. Roberts is an anesthesiologist. He's not a
18 surgeon. He stands up above and looks and what goes on.
19 Why he has that opinion, you'll have to ask him. I'm not
20 going to go into that.

21 DR. TENNITY: The gorilla in the room, though, is
22 every letter I have from a physician opposing, outside of
23 you, has a financial interest in the facility that
24 they're --

25 DR. BITTLES: You know, I can understand where

1 somebody might make the argument that having licensure or
2 even registry would impose a financial burden on an
3 institution. That doesn't hold a lot of water for me, quite
4 honestly. I'm not going to stand up here and tell you that
5 that's a big concern of mine.

6 MR. HOWORTH: Who's ultimately responsible in the
7 OR suite?

8 DR. BITTLES: The person that's ultimately
9 responsible for what happens is the surgeon. Okay? But
10 it's a team effort. Surgery is now a team effort. So, as a
11 team, we all have responsibilities. The nurses in the room,
12 the surgeons in the room, we want this team to work, and
13 we're going to make darn sure that the entire team,
14 including the surgical techs, are doing their part. And
15 whether that is because they have formal training or on-the-
16 job training or both, to me, it's kind of irrelevant.
17 Again, looking at what a surgical tech does, I'm all for
18 education, but I've worked with plenty of surgical techs who
19 were taught on the job that are very, very good. Again,
20 every nurse that comes in that operating room who was
21 trained in the last five or 10 years has little to no
22 surgical experience. They just don't get it. So, they're
23 trained on the job, and they do fine, most of them.

24 CHAIRPERSON VANDER BROEK: Go ahead, Dr.
25 Sandstrom.

1 DR. SANDSTROM: What's been your observation as
2 far as what type of training is given, either on the job or
3 in the facility, for -- to get people up to speed?

4 DR. BITTLES: Again, it kind of depends on the
5 complexity of the case, if you will. Usually, folks will
6 start out in Central Supply, learning instruments and that
7 type of thing. They'll spend time in the operating room
8 observing. They'll be taught how to scrub. They'll be
9 taught what a sterile field is and how to maintain a sterile
10 field. And it's kind of an incremental type thing.

11 CHAIRPERSON VANDER BROEK: To your knowledge, does
12 your facility have any kind of written objectives for the
13 training or goals or guidelines, time periods? Is that
14 included in a written job description or is there
15 anything --

16 DR. BITTLES: I don't have any answer to that. I
17 really don't know if our surgical techs have a job
18 description. Kind of guess that they do, but I can't say
19 that.

20 DR. TENNITY: Like, you know, the nursing
21 association just said, if some sort of registry or licensure
22 comes, they would like to see the Board of Nursing
23 administer this. But you just alluded to the fact we're
24 captains of the ship. Would you think the Board of Medicine
25 should have that versus the Board of Nursing?

1 DR. BITTLES: I think the Board of Nursing would
2 do a fine job with a registry for surgical techs.

3 CHAIRPERSON VANDER BROEK: Anything else from the
4 Committee?

5 (No response.)

6 Okay. Thank you, Dr. Bittles.

7 DR. BITTLES: You bet. Thanks.

8 CHAIRPERSON VANDER BROEK: Any other opponent?

9 NANCY GONDRINGER

10 Good morning. I'm Nancy Gondringer, N-a-n-c-y,
11 G-o-n-d-r-i-n-g-e-r. I'm here on behalf of Kevin Miller,
12 the Director of Surgical Services of CHI Service Line of
13 Nebraska. In speaking for Kevin and for our organization,
14 we are very supportive of the surgical technologists and the
15 certified surgical first assist technologists. We feel that
16 they're both vitally important to the surgical care team.
17 We are on record of supporting the surgical first assists
18 being licensed, and we believe that's because they are doing
19 direct, delegated duties. And we had to work through that
20 with the first 407 process, because there was some concern
21 about surgeons leaving the operating room and delegating the
22 closure of wound of the skin at the end. But it's in the
23 process of the licensure, when they get licensed, that the
24 surgeon would need to stay in the room and be under that
25 medical direction of that surgeon at all times when they're

1 doing their first assist work.

2 One of the things that we believe is different
3 with the surgical technologists, the CSTs, is that they are
4 not always working under the direct medical direction of the
5 physician. Because they are assisting in helping to set up
6 and to clean up after the patient is -- either before the
7 patient's in the room or after the patient, and the surgeon
8 is not in the room at all times. So that we believe that
9 they are working under the direction of the registered
10 nurse. And according to CMS section 482.51, Conditions of
11 Participation for Surgical Services, an experienced
12 registered nurse or doctor of medicine or osteopathy must
13 supervise the operating room; that licensed practical nurses
14 and surgical technologists may serve only as scrub nurses
15 only under the supervision of a registered nurse; and that,
16 in accordance with applicable state laws and approved
17 medical staff policies and procedures, LPNs and surgical
18 technologists may assist in circulating duties under the
19 supervision of a qualified registered nurse who is
20 immediately available to respond to emergencies so that
21 there are always that registered nurse in the room. There
22 are times that the nurse is out of the room, but there's
23 usually two or three other people in and out of the room so
24 that the patient safety is always primary.

25 Therefore, we are very supportive of a registry

1 for the surgical technologists. We believe it needs to be
2 under the Board of Nursing. The Board of Nursing has
3 registries, has experience. I've served eight years on the
4 Board of Nursing, and we monitored medication aides and
5 certified nursing assistants and feel that, since this is a
6 nursing-delegated duty, that we believe it should be under
7 the Board of Nursing rather than the Board of Medicine.

8 Any questions I'll answer?

9 CHAIRPERSON VANDER BROEK: Any questions from the
10 Committee?

11 Yes, Dr. Sandstrom.

12 DR. SANDSTROM: I'm sorry. I've got a question,
13 too many questions.

14 We haven't touched on continuing education. So,
15 -- and we've heard today, this morning, again, that some
16 surgical technologists are working at facilities and
17 hospitals in Nebraska who, at one time were certified, but
18 have dropped their certification for cost reasons. And so,
19 they're not getting any continuing education. For whatever
20 reason they've decided to do that. Now, I'm sorry, most of
21 us, right, who are licensed, right? We have got to meet the
22 requirements, so we have to pay the fees and do the CE,
23 right? I mean, and that's -- there's no -- we've kind of
24 crossed the bridge in Nebraska about that, as far as health
25 professionals, quite a while ago about the need for that,

1 right? And so, what -- I mean, what are you providing or
2 what are hospitals providing for ongoing training or, you
3 know, comp- -- besides competency assessment? I know the
4 minimum competencies, sterile, you know, the infection
5 control things, I mean, for surgical techs? And isn't that
6 a need -- important need?

7 MS. GONDRINGER: I am very supportive of
8 education. I can't speak for all hospitals in Nebraska,
9 what they do for continuing education and re-licensure or
10 recertification or registry. But, like, on the registry for
11 the CNAs, the nursing assistants, they must have so many
12 continuing education each year. And we, as a job
13 requirement, require it within our institution. So, we do
14 require it, but I can't say that every hospital in Nebraska
15 does. The issue would be is that a registry would help
16 facilitate making that a reality and that it would be taken
17 care of and we would also have a place that we could report
18 practitioners who aren't maybe making the grade.

19 DR. SANDSTROM: Right. So, you would not
20 necessarily be opposed to some sort of -- like I was saying,
21 you're familiar with the registries require so many hours
22 from the initial certification beyond the registry, right?

23 MS. GONDRINGER: Uh-huh.

24 DR. SANDSTROM: And the CE being included in the
25 registry here?

1 MS. GONDRINGER: CE, definitely.

2 DR. SANDSTROM: Because I think that -- at one
3 time, that was opposed by somebody.

4 MS. GONDRINGER: Oh, I don't remember.

5 DR. SANDSTROM: It's in some documentation that
6 that was brought up, and they said, no, that wasn't going to
7 happen. So, okay, but you'd be okay with it?

8 MS. GONDRINGER: Correct.

9 DR. TENNITY: Would you be okay with requiring
10 certification for your surgical techs?

11 MS. GONDRINGER: Dr. Tennity, I have required
12 certification at my institution before I was -- I'm speaking
13 on behalf of myself now, Nancy Gondringer. But because it
14 became ominous for some of my techs to be able to do that,
15 we said that they didn't have to be. But then, there was a
16 change in their rate of pay, because the people who were
17 doing it. So, I do have surgical certified technologists,
18 and I have surgical technologists, people who have dropped
19 it. But I am very encouraging and do everything we can to
20 help them to continue to be certified, and I work with the
21 school to find out ways that we can work with their
22 organization in finding ways that we are able to keep them
23 all certified if at all possible.

24 DR. SANDSTROM: Just to follow up on that. You --
25 when you were on the Nursing Board, I mean, CNAs and

1 medication aides make less money than surgical
2 technologists.

3 MS. GONDRINGER: Correct.

4 DR. SANDSTROM: Correct? But they were still able
5 to find affordable CE to maintain their registration, right?
6 It was possible for them?

7 MS. GONDRINGER: Yes, it was. And a lot of it was
8 the organiza- -- how the Board of Nursing accepted what was
9 the CEUs. There's a difference between State requirements
10 and their national requirements. And so, it's -- if you
11 want to be certified on the national level -- and I'm not a
12 hundred percent sure. I'm working with some of my surgical
13 technologists, with their national organization, to find
14 ways that we can make it more affordable, and work with the
15 school here in Lincoln so that we can make sure that there
16 are classes that they can maintain. But we've provided a
17 lot of the in-services for the CNAs that help them to get
18 their registry requirements.

19 MR. HOWORTH: You just mentioned, I think, to Dr.
20 Tennity that you have certified and not-certified, and there
21 is a pay-scale difference.

22 MS. GONDRINGER: Yes, there is.

23 MR. HOWORTH: What are we talking? I mean,
24 percentage-wise. You don't have to give me dollars, but
25 percent?

1 MS. GONDRINGER: Probably five percent.

2 MR. HOWORTH: Five percent?

3 CHAIRPERSON VANDER BROEK: Did you say five
4 percent or 25 percent?

5 MS. GONDRINGER: Five.

6 CHAIRPERSON VANDER BROEK: Five percent. Thank
7 you.

8 MS. GONDRINGER: Any other questions?

9 CHAIRPERSON VANDER BROEK: Any other questions for
10 the presenter?

11 (No response.)

12 Okay. Thank you.

13 And that concludes testimony by opponents and
14 brings us to the next item on our format for testimony, and
15 that is neutral testimony. But, seeing none, we will move
16 on to the next item. And the next item, and final item, on
17 under the testimony period is a summary period -- summary,
18 slash, rebuttal period -- which, again, doesn't have to be
19 used, but can be used. A maximum of 10 minutes for both the
20 proponents and the opponents. So, first of all, if the
21 proponents have --

22 DR. TENNITY: Mr. Chairman, before you go do that.

23 CHAIRPERSON VANDER BROEK: Yes. Yes, sir.

24 DR. TENNITY: I can ask staff. Becky Wisell who
25 was here earlier, was she going to provide testimony on

1 potential costs that I had asked for in the last --

2 MR. GELVIN: She said that licensure for a
3 surgical technologist would be \$90, base, for two years,
4 plus some variable costs. It would be between 130 and \$140
5 every two years.

6 DR. TENNITY: Every two years?

7 MR. GELVIN: Yeah. That's --

8 CHAIRPERSON VANDER BROEK: Dr. Sandstrom?

9 DR. SANDSTROM: Yeah. I had a question from the
10 last meeting about whether or not we were going to get
11 somebody from legal to come in to talk about the *Howard*
12 *Paul* decision and the --

13 MR. GELVIN: There's not anyone coming.

14 DR. SANDSTROM: So, we don't have that today?

15 MR. GELVIN: No. Sorry.

16 DR. SANDSTROM: Okay. That -- yeah, that --

17 DR. TENNITY: No one wants to be on that thing, I
18 think.

19 (Laughter.)

20 CHAIRPERSON VANDER BROEK: Jane had a question.

21 MS. LOTT: Is there a difference between
22 registering and licensing, in the cost and the difference
23 between that?

24 CHAIRPERSON VANDER BROEK: So, that cost that was
25 cited would be for licensure?

1 MR. GELVIN: That would be for licensure.

2 CHAIRPERSON VANDER BROEK: So, we don't have an
3 estimated cost of registration?

4 MR. GELVIN: No.

5 MR. BRIEL: I don't think anybody would know.

6 CHAIRPERSON VANDER BROEK: Any other questions at
7 this point?

8 DR. TENNITY: Thank you.

9 CHAIRPERSON VANDER BROEK: Anybody else?

10 (No response.)

11 Then, let's move on to the summary or rebuttal
12 period. First, if the proponents have anything to present
13 during this time, you would have a 10-minute limit.

14 CASEY GLASSBURNER

15 Do I have to state my name again? Casey
16 Glassburner, C-a-s-e-y, G-l-a-s-s-b-u-r-n-e-r. Again,
17 President of the Nebraska State Assembly of the Association
18 of Surgical Technologists.

19 Just a few points I would like to touch on that
20 were testified in the opponents' testimony. There was a
21 comment made that Nebraska is different, being it's a rural
22 state compared to other states. I will let you know that,
23 and I think this was brought up at the very first meeting,
24 the State of Texas does have mandatory certification as a
25 condition of employment for surgical technologists in that

1 state. And there has not been a single complaint from any
2 hospital within that state, and they have very similar rural
3 areas, as we do in this state, that they haven't been able
4 to fill their positions within that state.

5 There was a comment, also, about the cease and
6 desist that was ordered for surgical first assistants, how
7 it hasn't impacted surgery and how that applied to surgical
8 technologists. That cease and desist was specifically to
9 surgical first assistants. It did not affect surgical
10 technologists. So, we do not know what the impact of a
11 cease and desist on surgical technologists would be. So,
12 those are two separate things. That cease and desist for
13 surgical technologists has not happened. The comment that
14 was made was that, if it does happen, it will bring surgery
15 to a halt in this state because of the tasks that are
16 performed by a surgical technologist. Many of the tasks
17 that are performed by a first assistant are performed by
18 PAs. And so, what we've seen is that, as was mentioned
19 earlier, there's only 12 to 14 certified surgical first
20 assistants in this state. What they were doing has been
21 absorbed by the PAs who are practicing within this state,
22 because they do function in a similar role within the
23 operating room. Outside the operating room, their role is
24 different, but in the operating room, they function in the
25 same capacity.

1 I will state there was a comment that criminal
2 background checks are done annually on employees. I will
3 tell you that, at the school for our students that are with
4 us in the program, they only have a background check done
5 once. And then, each year, they are -- they have to sign a
6 self-disclosure statement. And, personally, when I was a
7 surgical technologist, when I was employed at the Lincoln
8 Surgical Hospital here in Lincoln, I had a criminal
9 background check done when I was initially employed. And
10 then, you sign a self-disclosure annually. So, no one is
11 following up on if I lie on that self-disclosure statement
12 that is sent. I do not have a background check done every
13 year to make sure that I haven't had felonies or misdemeanor
14 convictions.

15 And then, there was a statement made from the
16 Government Affairs Manager from AORN that all other states
17 that register or certify surgical technologists have that
18 administration conducted under a board of nursing.
19 Actually, no state administers their qualifications for
20 surgical technologists under a board of nursing. It's
21 always under either the board of medicine or some other
22 regulatory agency. It is not the board of nursing.

23 And the statement that a monkey could do that if
24 they were sterile in the operating room is -- I know that
25 we've talked about the importance of surgical technologists,

1 and, personally, I wouldn't want a monkey scrubbed in in my
2 surgery when I have surgery. So -- and I would like to go
3 back to the point that Dr. Tennity made when they talked
4 about that nurses are on-the-job trained for the operating
5 room. And that's true. We've talked about how -- what the
6 surgical technologist does has been taken out of nursing
7 programs since 1980, and that's true. But, like he
8 mentioned, they're coming in with at least an associate
9 degree nurse, if not a bachelor's degree nursing education,
10 that they come in with, which has the basic foundation of
11 anatomy, physiology, patho-physiology, medical terminology,
12 and all of that base education that someone who is going to
13 be on-the-job trained as a surgical technologist is not
14 going to come in with any of that background information.

15 And I would take any questions that you may have.

16 CHAIRPERSON VANDER BROEK: Questions?

17 MS. CHASEK: I do have a question about the
18 curriculum for your people. So, the equipment is getting
19 more and more sophisticated and technologically advanced.
20 Who is trained or how do people get trained in that actual
21 equipment? Who's responsible for knowing that equipment?

22 MS. GLASSBURNER: The information that you teach,
23 you mean? Like -- so, the individuals who teach in surgical
24 technology programs are required to be surgical
25 technologists. They have to have at least three years of

1 on-the-job experience working as a surgical technologist
2 prior to getting employed as a surgical technology
3 instructor within accredited surgical technology programs.
4 And then, we have to maintain our certification and our
5 continuing education in order to maintain that position as
6 an instructor. So, every year, I have to have continuous
7 education on the new advances in technology so that I am
8 qualified to be teaching what I am teaching in these
9 programs.

10 Because, yeah, exactly like you said. You know,
11 with the advancement of robotics and the technology, you
12 know, some of those things weren't necessarily in play when
13 I was practicing as a surgical technologist seven years ago.
14 So, as those new advances come in, surgical technology
15 instructors have to continue with their continuing education
16 to make sure that they're qualified to teach those. Or we
17 bring in professionals from the hospitals that run those
18 types of areas. For instance, when we teach robotics, we'll
19 ask the head of -- or the surgical technologist that kind of
20 runs the robotic department or area at Bryan East has come
21 in and taught classes for us before, because she's the
22 expert on that because she does it every single day. So,
23 we'll have some of these guest speakers come in that are the
24 experts on that information that's going to be taught.

25 CHAIRPERSON VANDER BROEK: Okay. Good.

1 Any other questions?

2 (No response.)

3 Thank you.

4 And, opponents, if there's any summary and/or
5 rebuttal from the opponent group? Anybody?

6 (No response.)

7 Okay, no. Well, at this point, I think it would
8 be a good point to break for lunch. And so, let's go ahead
9 and reconvene at one o'clock.

10 (Whereupon, at 11:44 a.m. on January 5, 2016, the
11 public hearing was concluded.)

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Chair Vander Broek and Members of the 407 Technical Review Committee,

My name is Casey Glassburner. I am currently serving as the President of the Nebraska State Assembly of the Association of Surgical Technologists. I would like to thank you for this opportunity to testify in support of the Surgical Technologist Licensure Application submitted by the Nebraska State Assembly.

Nebraska's 800 surgical technologists are allied health professionals who are an integral part of the surgical team.

Surgical technologists work under the supervision of a licensed independent practitioner and a registered nurse to facilitate the safe and effective conduct of invasive surgical procedures. Surgical technologists ensure that the operating room environment is sterile and safe, that equipment functions properly, and that the operative procedure is conducted under conditions that maximize patient safety and minimize the risk of contracting a surgical site infection.

Unqualified surgical technologists can cause harm to patients by:

- poorly maintaining a sterile operating room, increasing the number of surgical site infections;
- poorly assembling sophisticated surgical equipment to be utilized during the surgical procedure;
- and by slowing down procedures, resulting in unnecessary risk caused by the patient being under anesthesia for an extended period of time or experiencing excessive blood loss.

Swift surgeries depend on effective and efficient surgical technologists.

The surgical technologist is the professional in the operating room charged with the responsibility of maintaining the integrity of the sterile field. The sterile field refers to surfaces that sterile objects, such as surgical instruments, may contact. The sterile field includes the area immediately around a patient that has been prepared for a procedure. Protecting the sterile field involves carrying out specific procedures using sterile technique. A 2013 article in the Journal of the American Medical Association estimated that the average surgical site infection costs \$20,785 and that surgical site infections amount to a price tag of \$3.3 billion annually.

Thus, ensuring that every surgical technologist is properly trained through standardized educational programs and has demonstrated a minimum level of competency through passage of the national surgical technologist certifying exam, could reduce surgical site infections which would not only reduce hospital readmissions and associated costs, but also reduce overall health care costs and save lives.

The establishment of a license for surgical technologists will also protect the public by creating a mechanism of discipline for practitioners who engage in unprofessional/unethical conduct. These practitioners will be required to adhere to the conditions of the Nebraska Mandatory Reporting Law which will require disclosure of unprofessional/unethical conduct that will become public record and may be accessed by potential future employers. Disciplinary actions may also be taken following the reporting of such events which may lead to the loss of the license and the inability of the individual to continue to perform the duties of the profession therefore protecting the public from future harm that may be inflicted by the individual.

In addition to the patient safety concerns that exist related to the lack of regulation of the profession of surgical technology, the current delegation by the surgeon to the surgical technologist which occurs daily in operating rooms across the state is contrary to the current state law that was outlined in the 1898 case Howard Paul vs. State of Nebraska which states that licensed physicians cannot delegate to unlicensed personnel which the surgical technologist is currently considered. Some have argued that the ruling from the Howard Paul case is outdated and does not apply to current practice.

However, if the Howard Paul case has been applied once as it was in relation to the practice of the surgical assistant, the ruling does have the potential to be applied again to any number of the tasks that are performed by the surgical technologist that are delegated by the surgeon. In fact through the application of Howard Paul resulting in ceasing and desisting the practice of the surgical assistant, tasks that the surgical technologist is trained to perform that they were currently performing prior to the cease and desist order that was issued by the DHHS have been restricted on an inconsistent basis from one facility to another. Some facilities have restricted them completely and others continue to allow them to be performed. Facilities now on a daily basis question the practice of the surgical technologist and the legality of each of the tasks that is performed. This inconsistency further supports the need to adequately establish that the delegation by the surgeon to the surgical technologist is allowed through the creation of a license for surgical technologists in the state.

Longitudinal data from the Bureau of Labor Statistics demonstrates that added education and competency requirements in other states have not increased wages. Surgical technologist wages in states with minimum education and certification laws in place have similar increases in wage trajectories as neighboring states without laws regulating surgical technologists. This data includes states in which laws have been in place for several years such as Idaho which enacted their law in 1988.

The surgical patient does not pick their surgical team ahead of time. They do not have the option to choose a certified surgical technologist over one who was on the job trained.

During the procedure, the patient is under anesthesia and unable to make decisions or act on his or her behalf. They are completely reliant on the competency of the surgical team to provide them with the best care possible. Patients assume everyone in the operating room is properly educated and competent, able to provide them with a certain quality of care. Every surgical patient in Nebraska deserves nothing less than a certified surgical technologist.

Again, thank you for your attention and for your time. At this time I am available for any questions you may have.

Casey Glassburner, CST, F.A.S.T.

President

Nebraska State Assembly of the Association of Surgical Technologists

cglassburner@southeast.edu

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Kimberly A. Turman, M.D.

PHYSICIAN ASSISTANTS

Jason Hadenfeldt, PA-C
Brian Hoelsing, PA-C
Scott Krobot, PA-C

17030 Lakeside Hills Plaza, Suite 200
Omaha, NE 68130

7710 Mercy Road, Suite 224
Omaha, NE 68124

2510 Bellevue Medical Center Drive
Suite 145, Pod 1
Bellevue, NE 68123

Phone (402) 399-8550
Fax (402) 399-8455

www.gikk.com

21 December 2015

Mr. Briel and esteemed committee members,

I would like to take this opportunity to give my support towards Surgical Technologists of Nebraska in their 407 process to require their licensure to participate in surgery.

As key members of the surgical team it is pertinent that each member has the highest of competencies and the requirement of licensure would guarantee each technologist would have the proper education and training.

During these times of rising health care costs, the demand for proper sterile technique to reduce the risks of infection is ever increasing, and the demand for well educated, fully invested surgical technologists is one of the keys to this process. I feel licensure will be one of the tools necessary to ensure this pathway be followed properly.

As a Fellow Trained Joint Surgeon I recognize the importance for my surgical team to be highly skilled and anticipatory to my and the patient's needs leading me to the realization that all participants having licensure would create the high level of care I expect. I conclude that licensure of surgical technologists would be a means to achieve this goal.

Sincerely,



Erik T. Otterberg, MD

ETO/jmn

LINCOLN OB-GYN, P.C.

PRACTICE LIMITED TO
OBSTETRICS AND GYNECOLOGY

PARK PLAZA
301 SOUTH 70TH STREET
SUITE 200
LINCOLN, NEBRASKA 68510
TELEPHONE 483-7641

DENNIS L. HODGE, M.D., F.A.C.O.G.
GREGORY W. HEIDRICK, M.D., F.A.C.O.G.
YVONNE K. DAVENPORT, M.D., F.A.C.O.G.
CHANDRA K. LJUNGGREN, M.D., F.A.C.O.G.
JILL E. DOLBERG, C.N.M.
DANA R. RHODES, C.N.M.

December 29, 2015

To Whom It May Concern,

It has come to my attention that there is a discrepancy between how the current law in the state of Nebraska defines how the practice of the surgical technologist is delegated and what actually occurs in the operating room on a daily basis throughout the state. Currently, the practice of the surgical technologist is delegated by the nurse and the surgeon is not allowed by law to delegate any medical task or function to the surgical technologist as they are presently unlicensed personnel. The state of Nebraska also does not currently recognize or credential surgical technologists and does not have a clear definition of the role they are allowed to practice in nor the tasks and functions they are allowed to perform.

I practice alongside surgical technologists on a daily basis in the operating room. These allied health professionals most commonly function in the sterile role as a member of the surgical team that is scrubbed in at the sterile field created around the surgical patient. In this sterile role these professionals perform a broad range of tasks and functions that assist in expediting the surgical procedure as I direct them to perform. At this level of care, it is extremely imperative that all members of the surgical team are certified and have completed acceptable training establishing their competence. It is also necessary to establish a license for surgical technologists so that I am able to delegate medical tasks and functions to them with the 1898 ruling in State of Nebraska vs. Howard Paul which prohibits delegation of the practice of medicine to unlicensed personnel.

I would urge the Nebraska Medical Association to support moving forward with establishing a license for surgical technologists in the state of Nebraska, as well as clearly defining the qualifications that are required by professionals to practice in these roles and establishing a scope of practice defining the tasks and functions the surgical technologist is allowed to perform.

Patients assume that all personnel caring for them are properly educated and have appropriate clinical experience; however, surgical technologists remain the only members of the surgical team who is not required to meet threshold educational and certification criteria to practice in their areas of expertise. Regulation of this professional will eliminate this disparity and ensure that all personnel caring for patients undergoing surgery are appropriately educated and meet minimum continuing education standards. It will also legally allow the delegation of medical tasks and functions to surgical technologists which are already occurring daily in operating rooms across the state.

Thank you for your consideration to support creation of a license for surgical technologists which will in turn continue to support quality care for the surgical patients of Nebraska.

Sincerely,



Gregory W. Heidrick, M.D.

Casey J Glassburner

From: Tesmer, Timothy A <TTesmer@stez.org>
Sent: Monday, January 04, 2016 8:58 AM
To: Casey J Glassburner
Subject: RE: Support of Surgical Technologist Licensure

Casey: I am just getting around to looking at my recent e-mails from last week, and have read your letter. It has been a very busy time for us in the office as last week closed out the calendar year. Dr. Rapp has been on vacation for the past several days and will be out most of this week. My schedule, unfortunately, will not permit me to attend tomorrow's public hearing. I wholeheartedly agree with your thoughts on establishing a licensing avenue for surgical technologists, to ensure core competency and skill sets in the OR. This would augment the surgical team approach in delivering proper and exemplary care. Please include my name in support of your efforts. Time constraints do not allow me to get a formal letter off by tomorrow's meeting. Sincerely, Timothy A. Tesmer, M.D.

From: Casey J Glassburner [mailto:CGlassburner@southeast.edu]
Sent: Monday, December 28, 2015 11:35 AM
To: Tesmer, Timothy A
Subject: Support of Surgical Technologist Licensure

Dr. Tesmer,

As you may have heard through the grapevine, the Nebraska State Assembly of the Association of Surgical Technologists has submitted an application to the credentialing review process for the state of Nebraska seeking to license surgical technologists in the state.

Currently there are no regulations governing the education or competency of surgical technologists in the state. Personnel can be hired with no more than a high school diploma and trained completely on the job to fill the position of a surgical technologist. We are seeking to establish a license for surgical technologists that would set forth a minimum standard of formal education and require passage of the national surgical technologist certifying exam to establish minimum competence of individuals seeking employment as a surgical technologist in the state. The focus of this proposal is to protect the public from the potential harm that exists from untrained personnel functioning as surgical technologists in their operating rooms. Surgical patients do not have a choice in deciding who is part of their surgical team. They are trusting that every member is competent and fully trained. The establishment of the surgical technologist license will ensure this as the surgical technologist is currently the only member of the surgical team that does not have minimum education or competency standards in place.

Also, there is currently a ruling from an 1898 case called Howard Paul vs. State of Nebraska that states that physicians cannot delegate to unlicensed personnel which the surgical technologist is currently considered. Surgeons delegate and direct the practice of the surgical technologist intraoperatively on a daily basis in operating room across the state. There is currently inconsistency in various opinions from DHHS about whether this delegation is contrary to this ruling meaning that it has the potential to be seen as unauthorized. To prevent this potential from being present and to allow the delegation by the surgeon to the surgical technologist as it occurs daily throughout the state to continue, the creation of a license for surgical technologists is necessary.

A grandfather clause would be implemented so that no one that is currently working as a surgical technologist would lose their job if this license is instated.

We are seeking your support in this licensure effort.

If you could share this information with Dr. Rapp I would appreciate it as well. He did send a letter in support on March 6th, 2015.

The public hearing for this process occurs on Tuesday January 5th at 9:00am. We would love to have one or both of you testify in support of this effort and expand on the interactions that occur in the operating room between the surgeon

and the surgical technologist. If you are not able to attend, we would ask that you send a letter of support that could be read during the proponent testimony.

If you have any questions please call me at (402)580-0057.

Thank you for considering this opportunity to offer your support of improving surgical patient care in the state.

Casey Glassburner, CST, F.A.S.T.

President

Nebraska State Assembly of the Association of Surgical Technologists

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From: Rapp, Michael F
Sent: Friday, March 06, 2015 12:55 PM
To: Briel, Ron
Subject: licensure of CSFA and registry of CST

Dear Mr. Briel,

I am fully in support of licensing scrub techs so they can return to doing the jobs they are trained to do in the OR. The ones I work with are well trained, reliable and make a difficult operative case much easier.

I have been told however that the present law as written would make the scrub tech "personally supervised" by an OR nurse.

I do not understand why this is necessary. Their jobs are different. OR nurses are rarely good at being scrub techs, and there are numerous cases where the scrub tech understands what is done intraoperatively better than a nurse. A scrub tech is actively participating in a case every second while the OR nurse often has her back turned working on the computer or simply sitting waiting to see if she will be needed.

In other words, the OR nurse understands the OR as a whole but the scrub tech understands the operative case.

I have no problem with supervision. I just feel it should not be as limited as "personal". "responsible" or even "direct" supervision may be more appropriate.

Sincerely,

Michael F. Rapp, M.D., FACS



Surgical Associates, PC

575 South 70th Street, Suite 310
Lincoln, Nebraska 68510
Phone 402-441-4760
Fax 402-441-4764

General and Laparoscopic Surgery

R. Michael Norris, M.D.
Benjamin J. Hung, M.D.
Greg A. Fitzke, M.D.
Raymond J. Taddeucci, M.D.
Sarah M. Stobbe, A.P.R.N.

Bariatric Division

Benjamin J. Hung, M.D.
Raymond J. Taddeucci, M.D.

Medical Genetics

Michael A. Schmidt, M.D., Ph.D.

Colon and Rectal Surgery

Michael A. Jobst, M.D., F.A.S.C.R.S.
Kelly J. Krier, M.D.
Kendra R. Piening, A.P.R.N.
Sherri L. Selvage, A.P.R.N.

March 6, 201

Mr. Ron Briel
Program Manager-Cred. Review Comm.
Licensure Unit-Div. of Pub. Health
Dept. of Health and Human Services
P.O. Box 95026
Lincoln, NE 68509-5026

Dear Mr. Briel:

We would like to submit this letter as a letter of support for the licensure of Surgical Assistants and Surgical Technologists here in the State of Nebraska. It is our understanding that a review is currently being conducted to achieve this objective.

Surgical Assistants and Surgical Technologists provide a very valuable function in all components of the surgical case and the overall patients care. They help with the efficiencies in the operating suite, help to insure a sterile environment, and assist the surgeon with the technical and professional components of surgery. Our hope is that whatever transpires Surgical Assistants and Surgical Technologists can practice in the manner for which they are trained and in the fashion that they had before this issue arose.

As a very active group of General, Bariatric and Colorectal surgeons here in Lincoln, Nebraska that relies on having outstanding technical and professional support in our facilities, we hope that you will call on us if we can provide of any further assistance in this matter.

Sincerely,

R. Michael Norris, M.D.

Benjamin J. Hung, M.D.

Greg A. Fitzke, M.D.

Raymond J. Taddeucci, M.D.

Michael A. Jobst, M.D.

Kelly J. Krier, M.D.

Public Testimony for Surgical Tech 407 Process Public Hearing

By: **Benjamin Greenfield, MPS, CCP, LP**
Perfusionist, Director of Operations (HEME Perfusion)

Associate Professor/Clinical Coordinator
Universtiy of Nebraska Medical Center

Committee Member of 407 Process for Surgical First Assistants

Thank you for giving me the chance to speak. I would like to first and foremost say I have no stake in this process. Whether or not this progresses will NOT affect me professionally in any way. I am here simply as a public member who understands the process (from serving on several 407 committees and as an applicant group), who works daily in the operating room with interested parties including the surgical technologists, and someone who teaches students of various medical professions. I come as someone whose only stake is as a patient, both former and potential of surgical technologists in Nebraska.

First Point: Nurses (Roles and Relationship) I respect and admire them. They often run the operating room and manage most hospitals. I in NO WAY would say anything that should diminish the importance of the utmost nursing care. Discuss how the law that makes nurses the only ones who can direct others to perform medical tasks makes it hard in the operating room. But we are left with it and can respond appropriately.

Second Point: There are different levels of credentialing- I believe licensing is the best way to deal with the situation we find ourselves in. And this is why I voted as I did on the SFA committee (And agreement and assurance that this would be supported by NHA). Why was that proposal brought by the NHA and this one is being opposed?

Third Point: I have yet to hear, and have been following this process (and that of the SFA's) for nearly ten years, in multiple states, any valid reason why licensure of ST's would not make surgery safer for the public.

Fourth Point: There is a precedence for the State of Nebraska to come into Hospitals and evaluate what unlicensed individuals are performing (If they have no scope of practice). There is absolutely nothing to prevent them from doing this with ST's. This would affect surgery at EVERY hospital in Nebraska performing complicated surgery and employing ST's.

Last Point: Please don't make this a political issue. This issue is not about money or finance, politics or positioning. It is a safety issue. The Surgical Tech is a crucial member of the surgery team who has direct patient contact, performs medical tasks including manipulating tissue. And often they are the ones solely responsible for sterile set up of the surgical suite.

January 4, 2016

407 Technical Review Committee
Office Building 14 and M Street
Lincoln, Nebraska

Dear Chair Vander Broek and Members:

The Association of Surgical Technologists, representing 37,000 members nationwide, supports the application of the Nebraska State Assembly of the Association of Surgical Technologists for licensure of surgical technologists.

Surgical patient safety requires qualified and competent surgical technologists. The surgical technologist is an integral member of the surgical team. Surgical technologists prepare the operating room by setting up surgical instruments, equipment, supplies, medications and solutions. Skillful pre-surgery technique protects patients from surgical site infections and unneeded delays during surgery. During surgeries, surgical technologists stand next to the surgeon, passing instruments and supplies to surgeons. The surgical technologist must be able to anticipate the needs of the surgeon because every moment a patient is in surgery the risks related to anesthesia and bleeding increase. The surgical technologist may also care for specimens or operate lasers, robotics, sterilizers, lights or suction apparatus during surgery. Surgeons rely on swift and effective surgical technologists to achieve optimal patient outcomes and avoid preventable adverse events. Licensure of surgical technologists in Nebraska would ensure that surgical technologists meet in minimum standard for knowledge that underlies surgical technologist practice and possesses mastery of a broad range of skills related to surgical procedures, aseptic technique and patient care.

The surgical technologist is the professional in the operating room charged with the responsibility of maintaining the integrity of the sterile field and preventing surgical site infections. The sterile field refers to surfaces that sterile objects, such as surgical instruments, may contact. Protecting the sterile field involved carrying out specific procedures using sterile technique. If a surgical technologist holds certification it means the individual has had extensive didactic education and training in sterile technique.

Surgical site infections significantly drive health care costs. A study featured in the *American Journal of Infection Control*, "A Systematic Review of Economic Analyses of Health Care-associated Infections," found the average attributable cost per surgical site infection to be \$25,546. The Centers for Disease

Control and Prevention estimates that 22% of health-care acquired infections are surgical site infections.

Facilities using certified surgical technologists have lower costs associated with surgical site infections. Empirical data and studies analyzing surgical technologists' contribution to patient outcomes are rare. Most studies involving adverse medical and surgical events are not publicly available, making analysis difficult. Nonetheless, some data are available. Data from Virginia analyzing Medicare costs of surgical site infections reveal that facilities utilizing only certified surgical technologists reduced the costs associated with surgical site infections by 11%. The Minnesota Adverse Health Events Reporting Act requires public dissemination by healthcare facilities of 28 adverse medical events. Analysis of the data from 2009-2013, by facility, reveals that reported adverse surgical events (wrong body part, wrong procedure, wrong patient, foreign retained objects) occurred 40% less often in hospitals that require education and certification for surgical technologists compared to hospitals that do not require education or certification for surgical technologists. The surgical technologist is the professional near the patient responsible for counting supplies and instruments to prevent foreign retained objects. Foreign retained objects analyzed separately occurred 55% less in hospitals that require surgical technologist education and certification compared to hospitals that do not. Data were calculated using relative increase. Because of the confidentiality of root cause analyses of these events, it is difficult to determine exact fault. Nevertheless, the data decisively show that healthcare facilities that value competency in their surgical staffs experienced better outcomes. Certified surgical technologists not only positively impact patient outcomes, but also reduce medical costs borne by patients, private insurance, Medicare, and Medicaid.

Licensure is fiscally neutral to the State and, except for surgical technologists who support this endeavor, is cost neutral or a benefit to its public and private economic interests.

Licensure of surgical technologists assures that every patient undergoing surgical procedures can count on all members of the surgical team being appropriately credentialed and objectively competent. Patients assume that all personnel caring for them are properly educated and have appropriate clinical experience. Patients undergoing surgery in Nebraska deserve no less.

Sincerely,

A handwritten signature in cursive script, reading "Catherine A.G. Sparkman". The signature is written in black ink and is positioned above the typed name.

Catherine A.G. Sparkman, JD
Director of Government and Public Affairs
Association of Surgical Technologists

CRITERIA FOR THE REVIEW PROCESS OF NEW CREDENTIALING PROPOSALS

- Criterion one: Unregulated practice can clearly harm or endanger the health, safety, or welfare of the public.
- Criterion two: Regulation of the profession does not impose significant new economic hardship on the public, significantly diminish the supply of qualified practitioners, or otherwise create barriers to service that are not consistent with the public welfare and interest.
- Criterion three: The public needs assurance from the state of initial and continuing professional ability.
- Criterion four: The public cannot be protected by a more effective alternative.

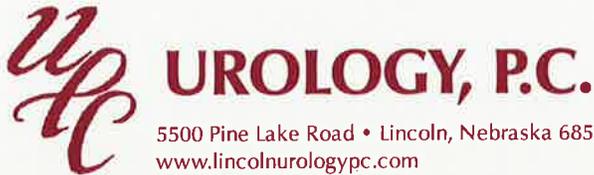
My name is Sheri Smith, I am the Administrator for Urology, PC/Urology Surgical Center. I represent the Nebraska Association of Independent Ambulatory Centers and Midwest Urology Alliance. NAIAC consists of 16 ambulatory centers ranging from endoscopy to surgical facilities and includes over 50% of independent ambulatory centers in the state. MUA consists of 28 physicians in the Lincoln and Omaha area operating in a clinically integrated network.

I will briefly comment on the criteria you are considering for the process.

1. Surgical techs have been unregulated up to this point and there has been no identified harm to the public. The applicants have failed to provide even one example of harm at the hands of a surgical technologist. Why expend time, effort and money on a non-existent problem?
2. Previous testimony has provided tuition costs in a range of \$9700 - \$35,000. This requirement of certification and licensure pushes more people into those programs. It is unrealistic to assume there would be no tuition increases over time. Increasing tuition cost could be a barrier for students wishing to enter these programs. If fewer students are entering these programs or the number of students graduating is less than the demand we have a supply and demand problem. It is not inconceivable that wages will increase as a result. While some may see this as a cost born only by the student or the facility, I would like you to consider another scenario. There is a breaking point where independent facilities will no longer be able to absorb increasing costs and decreasing reimbursement. It has been a trend from payers to decrease the reimbursement on some procedures each year and we celebrate when we have a reimbursement neutral year from Medicare. Most patients now have insurance policies that require 20% (if you are lucky) - 30% or more coinsurance and have large deductibles. An ASC is reimbursed approximately 60% of the hospital reimbursement, keeping that in mind, the corresponding 20% - 30% out of pocket expense born by the patient is significantly less than what the patient would pay if the procedure was done at the hospital. This holds true if the entire charge is applied to the deductible. Shifting cases to the hospitals that could be done in an ASC could potentially increase healthcare costs.

3. I would remind the committee there has been no need identified requiring licensure of Surgical Techs. There has not been one incident presented for your consideration. There are numerous people involved, on a daily basis, that have various responsibilities in an OR. I have a cleaning service who comes in nightly for terminal cleaning. We have trained them in the manner the ORs are to be cleaned, the products to use and they are OSHA certified. Does the need to protect the public extend to them also? I would just like you to ponder the true need to protect the public and how far it should go.

4. If the public needs to be protected from unqualified surgical technologist, a registry would be sufficient and less costly for the state to maintain.



5500 Pine Lake Road • Lincoln, Nebraska 68516 • (402) 489-8888 • Fax (402) 421-1945
www.lincolnurologypc.com

R.A. Crusinberry, M.D.
J.R. Henning, M.D.
D.L. Henslee, M.D.
P.E. Howe, M.D.
C.E. Larson, M.D.
A.J. Lepinski, M.D.
L.A. Wiebusch, M.D.
D.B. Wiltfong, M.D.

M.K. Fulton, APRN-C
S.C. Vampola, APRN-C
C.T. Bock, PA-C
K.A. Brown, PA-C
T.A. Wood, PA-C

January 4, 2016

Ron Briel, Program Manager
Division of Public Health, Licensure Unit
Nebraska Department of Health and Human Services
Lincoln, NE 68509

Dear Mr. Briel and members of the Technical Review Committee,

My name is Peter Howe and I am a practicing urologist in Lincoln, NE. I realize in-person testimony is more effective than written testimony; however my schedule usually books four to six weeks out and I am unable to attend the hearing on January 5 without undue stress for my patients.

I am the Chair of the Medical Committee for Urology Surgical Center and the President of Midwest Urology Alliance, a 28 physician clinically integrated network. We are opposed to licensure for surgical techs as we don't believe there is a need. We have three surgery techs who work for Urology Surgical Center, two since our opening in 2000 and the other for the last three years. All three were certified at one point and let their certification lapse due to cost. We hired our third tech knowing she was not certified. In my 27 years of practice, I have never had an OR incident that was precipitated by the actions of a surgical tech. During the procedure, they perform at my direction and I am responsible for all activity.

While we have been fortunate to have only had one position to fill in our 15 years in existence, we are concerned a certification and licensure process will limit the available candidates for positions in our facilities. Certification and licensure will increase the cost to facilities, anytime another entity is charged with monitoring, recording and collecting fees for others, there is a cost.

We understand your concern of an impaired tech going from facility to facility, putting the public at risk, therefore we can endorse the proposition of a registry for surgical techs.

Sincerely,

Peter E. Howe, M.D.
President, Midwest Urology Alliance
Medical Committee Chair



UROLOGY, P.C.

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R.A. Crusinberry, M.D.
J.R. Henning, M.D.
D.L. Henslee, M.D.
P.E. Howe, M.D.
C.E. Larson, M.D.
A.J. Lepinski, M.D.
L.A. Wiebusch, M.D.
D.B. Wiltfong, M.D.

M.K. Fulton, APRN-C
S.C. Vampola, APRN-C
C.T. Bock, PA-C
K.A. Brown, PA-C
T.A. Wood, PA-C

January 4, 2016

Ron Briel, Program Manager
Division of Public Health, Licensure Unit
Nebraska Department of Health and Human Services
Lincoln, NE 68509

Dear Mr. Briel and members of the Technical Review Committee,

My name is Dr. Lance Wiebusch. I practice at Urology Surgical Center in Lincoln. I am writing to express my opposition to certification and licensure for surgical techs. I understand this proposal was brought to your attention suggesting non-certified and unlicensed surgical techs are a threat to the public. I have been in private practice for over 5 years and I can assure you, the techs I have worked with at our facility, all three whom are non-certified, and those at the area hospitals have performed admirably. I was asked if our techs ever perform tissue manipulation and I can unequivocally state they do not.

We very carefully watch our overhead and constantly look for ways to lower our costs. I see this certification and licensure process as increasing our overhead. Surgical techs would be required to go to a school for training, take a test to become certified, pay for a license to work in the state and continue to pay for this license and certification. Each phase of this process requires a cash outlay. I would assume there would be an expectation of higher salary to compensate. We consider ourselves lucky if our reimbursement remains stagnant, however we have seen the reimbursement from our contracted payers to decrease over the years. Decreasing reimbursement and increasing costs does not bode well for independent facilities.

While I do not support the certification and licensure, I would be supportive of a registry.

Sincerely,

Lance A. Wiebusch, M.D.
Vice President



Harvey A. Konigsberg, M.D., F.A.C.S.
R. Michael Kroeger, M.D., F.A.C.S.
Peter M. Gordon, M.D., F.A.C.S.
Jon J. Morton, M.D., F.A.C.S.
Steven C. Koukol, M.D., F.A.C.S.
Gernon A. Longo, M.D.
Stephen S. Lim, M.D., F.A.C.S.
Patrick B. Leu, M.D.
John M. Donovan, M.D., F.A.A.P.
Brett C. Hill, M.D.
Judson D. Davies, M.D.
John H. Bishay, M.D.
Jessica E.B. Grosse, MPAS, PA-C
Cara E. Schiessler, APRN-NP, MSN

January 4, 2016

Mr. Ron Briel, Program Manager
Division of Public Health, Licensure Unit
Nebraska Department of Health and Human Services
Lincoln, NE 68509

Dear Mr. Briel and members of the Technical Review Committee:

The Urology Center, P.C. is a single specialty group of twelve physicians who have owned and operated a Medicare and AAAHC certified urology specific ASC since 1989. We are writing to express our strong opposition to the licensing of surgical technologists. Surgical Technologists do not work independently in the operating room. They work under the direct supervision of an RN or the physician. We do not feel that they have the ability to negatively impact the safety or care or in any way endanger the patient. It is our mission to provide quality care in a cost effective setting. Requiring certifications and continuing education requirements for surgical technologists will increase costs. The costs will be borne by the surgical technologist or more likely their employer in turn increasing the cost of doing business with no direct impact on patient care. We believe the overall infection control program of the healthcare facility, facility maintenance, equipment maintenance and surgeon's skills and abilities are what impact post-surgical infection rates. Our infection control rates have been well below average rates even without certified surgical technologists. We have seen no creditable evidence that requiring licensing of the surgical technologist will improve patient care.

The recent trend of various organizations (not just in healthcare) lobbying legislatures to require licensing requirements are simply filling the coffers of these organizations. The organizations require fees for testing, licensure, dues and continuing education. These are unnecessary expenses for lower wage earners and we do not believe the evidence supports improved patient care and not only that, we feel it will be quite the opposite. We will be losing high quality, engaged, and knowledgeable staff who have years of experience in their chosen field of interest.

Please take our comments into consideration when you consider moving to approve this legislation and creating another regulatory requirement that is unnecessary and for which there is no creditable, direct demonstration of a positive impact.

Sincerely,

Patrick B. Leu, M.D.
President

Jon J. Morton, M.D.
Vice-President

Laura Forehead
Administrator

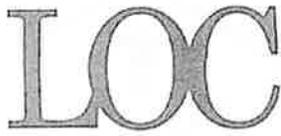
MAIN OFFICE
111 S. 90th St.
Omaha, NE 68114
(402) 397-9800
FAX (402) 397-7591
800-882-4770

**AMBULATORY
SURGERY CENTER**
111 1/2 S. 90th St.
Omaha, NE 68114
(402) 397-7178

VILLAGE POINTE
304 N. 179th St.
Suite 206
Omaha, NE 68118
(402) 397-9800
FAX (402) 397-7591

CHILDREN'S
8200 Dodge St.
Suite 220
Omaha, NE 68114
(402) 955-4002
FAX (402) 955-4004

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Suite 210
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Lincoln Orthopaedic Center
6900 A Street
Lincoln, Nebraska 68510

Mailing Address
P. O. Box 6939
Lincoln, Nebraska 68506

Phone (402) 436-2000
Fax (402) 436-2086
Work Comp Fax (402) 434-2691
Website: www.ortholine.com
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January 2, 2016

Ron Briel, Program Manager
Division of Public Health, Licensure Unit
Nebraska Department of Health and Human Services
Lincoln, NE 68509

Dear Mr. Briel and members of the Technical Review Committee:

I am writing on behalf of LOC Surgery Center, our ambulatory surgery center which provides surgical services to our patients with out-patient orthopaedic surgical procedures, and our twelve orthopaedic surgeons. We are writing to express our opposition to the licensing of surgical technologists.

Our surgery center has provided surgical care to thousands of individuals since 1999 and during this time we have employed a number of good surgical technicians, one of which has been with us since day one. Their training programs and on the job experience have provided the needed education and skill to place them in the work force as surgical technicians. Their willingness to become a good surgical technician is not from licensure but from working directly with the surgeons and learning their individual techniques. They are an assistant to the surgeon not a provider that works independently. We feel that developing a licensure creates an unnecessary barrier to this position.

It has been brought to our attention that the initial two requirements of Section 71.6221 of the Nebraska Statutes indicates that a health profession shall be regulated only when (a) the unregulated practice can clearly harm or endanger the public, (b) the regulation does not impose significant new economic hardship on the public or significantly diminish the supply of qualified practitioners, or otherwise create barriers to service that are not consistent with the public welfare and interest. Simply put there has not been enough evidence to substantiate any harm or endanger to the public by having these technicians non-licensed. Regarding item (b) in the statute we can tell you it will impact the number of good individuals that can fill these positions by creating what we feel is an unnecessary burden of entry to serve as an surgical technician.

In conclusion we believe that there has been a number of regulations imposed by the ACA that have significantly increased the cost of care to our patients. Adding what we feel is an unnecessary licensure requirement increases the cost of employing these individuals and thus impacts our overall cost in providing care to our patients. We respectfully ask that the review committee not move this licensure attempt forward to the legislature.

Sincerely,

Doug Wyatt
LOC Surgery Center - Administrator



P.O. Box 3107
Kearney, NE 68848

(888) 885-7025 • Email: Director@NebraskaNurses.org
Website: www.NebraskaNurses.org

January 3, 2016

Ron Briel, Program Manager
Division of Public Health, Licensure Unit
Nebraska Department of Health and Human Services
Lincoln, NE 68509

Dear Mr. Briel,

I am writing on behalf of the Nebraska Nurses Association (NNA). The NNA is the voice of registered nurses in the state of Nebraska. Patient safety and improved health for all is a priority for our organization. NNA seeks to support the delivery of safe, cost-effective health care for Nebraskans. For these reasons NNA opposes the licensure of surgical technologists, and continues to support the creation of a Surgical Technologist Registry supervised by the Board of Nursing.

The creation of the registry will allow for identification of those practicing in a surgical technologist role. The registry would also create a means to establish a minimum level of competency for those functioning in the role of surgical technologist. Surgical technologists function under a job description or range of functions rather than a scope of practice and therefore do not require licensing.

The licensure of surgical technologists would not achieve a more safe, or cost-effective health care environment for Nebraskans and is not supported by the Nebraska Nurses Association.

Sincerely,

Melissa Florell MSN, RN
Director of State Affairs
Nebraska Nurses Association

To: Members of the Certified Surgical Technologist 407 Committee

From: Kevin Miller
Director of the Surgical Service Line for CHI Nebraska

Date: January 5, 2016

Re: Certified Surgical Technologist 407 process requesting licensure under the Board of Medicine and Surgery

My name is Kevin Miller and I am the Director of the Surgical Service Line for CHI Health Hospitals in Nebraska. We have been informed Certified Surgical Technologists in Nebraska have requested and granted the right to the 407 process to define their scope of practice and request licensure.

First we would like to support the need for Certified Surgical Technologists (CSTs) and Certified Surgical Technologists First Assists. Both health care providers are vital staff members to the functioning team that provides surgical services and plays a vital role in caring for patients undergoing any type of surgical procedure. They along with the PeriOperative Registered Nurses and Surgeons assist in providing caring for surgical patients as well as providing quality surgical outcomes.

Members of my team monitored and supported the 407 process, introduced earlier in the year by the Certified Surgical Technologists First Assistants and the Nebraska Hospital Association. The focus and outcome was to introduce legislation in the 2016 legislature that would provide licensure for the Certified Surgical Technologists First Assist (CSTFA) under the Board of Medicine and to develop a registry for Certified Surgical Technologists (CSTs) under the Board of Nursing. These two differences was based on the fact CSTFA's scope of practice, such as wound closure, was considered to be a practice that would be delegated by an independently licensed provider. As a group we were supportive of this recommendation as well as the group's desire to seek licensure. It seemed appropriate to be under the Board of Medicine and Surgery. During the prior 407 process delegated tasks were discussed in great detail and all members in the process agreed these tasks would be performed under the direct supervision of such delegating provider. When CSTFAs are functioning in a first assist role they are working with the surgeon and not under the license and direction of the PeriOperative Registered Nurse which differs significantly from Certified Surgical Technologists.

Certified Surgical Technologists (CST's) are employed by hospitals, ambulatory outpatient centers as well as private surgeons. Typically when the CST is a physician employed provider they arrive in the surgical suite when the surgeon is working and assist until the surgeon completes the procedure. This process differs when Certified Surgical Technologists are hospital or outpatient employed. They then are tasked to assist not only with providing support during the procedure but must assist in preparation prior to and post-procedure duties. When they are completing these duties the CSTs are functioning under the direct supervision of the PeriOperative Registered Nurse therefore under his/her license and responsibility.

It is our understanding a 407 that has been submitted on behalf of Certified Surgical Technologists has requested to be licensed under the Board of Medicine and Surgery and not placed on a registry under the Board of Nursing.

We have several concerns about this request:

1. Currently there is not a danger or threat to the general welfare of the public as they are functioning in surgical suites all over Nebraska and quality surgical care is provided.
2. They do not have a validated scope of practice that would need delegation by the surgeon.
3. If the CSTs feel they have a delegated scope of practice there would need to be two scopes:
 - a. One when the surgeon is in the room
 - b. One when the surgeon is not in the room during the initial set up and completion of the surgical case when the PeriOperative Registered Nurse is in charge of the surgical suite.
4. If they would pursue licensure how will that affect the following:
 - a. How would this affect the supply and demand for the profession?
 - b. Would licensure become a barrier to practice?
 - c. How would current Surgical Technologist fit into the future of licensure?
 - d. Would licensure increase the cost of employing these individuals?

If you have any concerns or questions for me please do not hesitate to contact me at 402-618-6108. We are supportive of providing excellent surgical care to all citizens in Nebraska and look forward to monitoring the outcomes of the 407 hearings.

SIGN IN SHEET
For Public Testimony on the
Surgical Technologists' Technical Review
January 5, 2016, 9:00 a.m. to 12:00 p.m.

TESTIFIERS - Please Print or Write Legibly for the Record

OPPONENT'S NAME	REPRESENTING
✓ 1. Elisabeth Hurst	OHA
✓ 2. Karen Rustermier	AORN - Nebraska
✓ 3. Sherrill Smith	Nebraska Assoc Independent Ambulatory Care/Minimally Invasive Alliances
✓ 4. Dannelle Glover	Assoc of perioperative RN
✓ 5. Don Wesely	NNA
✓ 6. Mike Bittles	self
✓ 7. Nancy Gordiner	Surgical Services CHI
8.	
9.	
10.	
11.	
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SIGN IN SHEET
For Public Testimony on the
Surgical Technologists' Technical Review
January 5, 2016, 9:00 a.m. to 12:00 p.m.

TESTIFIERS - Please Print or Write Legibly for the Record

PROPONENT'S NAME

REPRESENTING

- | | |
|-----------------------------|---------------------------------------|
| 1. <u>Casey Glassburner</u> | <u>Nebraska State Assembly of AST</u> |
| 2. <u>Cyndi Kreps</u> | <u>Nebraska State Assembly of AST</u> |
| 3. <u>Cathy Sparkman</u> | <u>AST</u> |
| 4. <u>Carol Ringenberg</u> | <u>ADE</u> |
| 5. <u>Ben Greenfield</u> | <u>UNMC</u> |
| 6. _____ | _____ |
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