HARDIN: Wow. Am I glad that this committee doesn't have hordes of people out in the hallway like some other committees do. Welcome to the Health and Human Services Committee. I'm Senator Brian Hardin, representing Legislative District 48, and I serve as chair of the committee. The committee will take up the bills in the order posted. This public hearing today is your opportunity to be a part of the legislative process and to express your position on the proposed legislation before us. If you're planning to testify, please fill out one of the green testifier sheets that are on the table at the back of the room. Be sure to print clearly and fill it out completely. Please move to the front row to be ready to testify. When it's your turn to come forward, give the testifier sheet to the page. If you do not wish to testify, but would like to indicate your position on a bill, there are also yellow sign-in sheets back on the table for each bill. These sheets will be included as an exhibit in the official hearing record. When you come up to testify, please speak clearly into the microphone. Tell us your name, and spell your first and last name. A lot of people forget that part. Ensure we get an accurate record. We'll begin each bill hearing today with the introducer's opening statement, followed by proponents of the bill, then opponents, and finally anyone speaking in the neutral capacity. We will finish with a closing statement by the introducer, if they wish to give one. We'll be using a three-minute light system for all testifiers. When you begin your testimony, the light on the table will be green. When the yellow light comes on, you have one minute remaining, and then the red light indicates you need to wrap up your final thoughts and stop. Questions from the committee may follow, which do not count against your time. Also, committee members may come and go during the hearing. This has nothing to do with the importance of the bills being heard; just part of the process, as senators may have bills to introduce in other committees. A few final items. If you have handouts or copies of your testimony, please bringing up at least a dozen copies and give those to the page. Props, charts or other visual aids cannot be used, simply because they cannot be transcribed. Please silence or turn off your cell phones. Verbal outbursts or applause are not permitted in the hearing room; such behavior may call-- be cause for you to meet one of our fine strapping Red Coats or troopers in the room. Finally, committee procedures for all committees state that the written position comments on a bill to be included in the record have to be submitted by 8 a.m. on the day of the hearing. The only acceptable method of submission is via the Legislature's website at nebraskalegislature.gov. Written position letters will be included in

the official hearing record, but only those testifying in person before the committee will be included on the committee statement. I'll now have the committee members with us introduce themselves, starting with Senator Riepe.

RIEPE: Welcome. I'm Merv Riepe. I represent District 12, which is southwest Omaha and the fine town of Ralston.

HANSEN: Senator Ben Hansen, District 16, which is Washington, Burt, Cuming, and parts of Stanton County.

FREDRICKSON: John Fredrickson. I represent District 20, which is in central west Omaha.

QUICK: Dan Quick, District 35, Grand Island.

BALLARD: Beau Ballard, District 21 in Northwest Lincoln, northern Lancaster County.

HARDIN: And he's coming to the microphone. He's hurrying. Watch him sprint. Here he comes.

MEYER: Slow and steady wins the race. Glen Meyer, District 17, northeast Nebraska.

HARDIN: Also assisting in the committee today, to my right is our research analyst, Bryson Bartels, and to my far left is our committee clerk, Barb Dorn. Also, Sydney Cochran and Tate Smith are our pages today. Today's agenda is posted outside the hearing room. And with that, we're going to begin with LB104. Senator Raybould. Welcome.

RAYBOULD: Well, good afternoon, Chair Hardin, and good afternoon, gentlemen. My name is Senator Jane Raybould. It's spelled J-a-n-e R-a-y-b-o-u-l-d. I represent District 28 in Lincoln, Nebraska. And today, I bring you LB104, a bill to define evidence-based home visiting in the state of Nebraska, and call for a report on the program's outcomes. I'll start by speaking a little bit about this program and why I'm excited that we're bringing it before you with some of my experiences. As a young mother with our first baby, I was so very lucky to have my mom come and be my support, and coach me along with all of the things you need to know and do with a newborn. I was also very lucky that, as a young person, I had been babysitting a lot, and babysitting babies, including newborns, since I was 12 years old. When I had our daughter Clara, I was in the hospital, and I remember watching a video on how to bathe a newborn at the hospital

about five times, because I know how slippery newborns were. But I was ultimately so very lucky, because I had my own mother come and stay with me and my husband as we welcomed our daughter, and got the hang of being parents. So now, I'll fast forward to my time on the Lincoln City Council. We have had a home visiting program in Lincoln for some time, using Healthy Families America model that offers new parents an early childhood educator that will visit them in their home. But in the 2022 budget cycle, the Lincoln/Lancaster County Health Department came to us to ask for 8-- 8, 80? 8-- home visiting nurses to support new mothers, right as they come home from labor and delivery. This program is called Family Connects, and because of the support of the Lincoln City Council, every single baby born in Lancaster County is offered 3 to 4 home visits with a nurse when they go home from the hospital at no charge to the family. This has been a truly transformational program for young families in my district and beyond. So what is home visiting? Different evidence-based models. Home visiting is an evidence-based service that supports the health and well-beings of families with young children. It is voluntary, it is free for families, and it's cost effective for our community. Once again, it is voluntary and it's free. Home visiting programs pair young families with trained professionals who tailor services to meet the family's specific needs. These trained professionals can be nurses, social workers, peers and more, and they work to form trusting relationships with families to help them reach their goals in child development, family health, parent-child relationship, school readiness, and more. And outcomes matters. Here are some outcomes associated with home visiting participants, and they are: home, home visiting participants are more likely to be enrolled in school and more likely to be employed; they're more likely to access prenatal care; they're more likely to have fewer CPS reports called to the hotline-- Child Protective Services reports or calls to the hotline-- and are less likely to need emergency medical care. They are more likely to start breastfeeding, and to breastfeed longer. They're more likely to engage in a positive parenting technique, such as more reading time between parents and children compared with families not enrolled in home visiting. Outcomes associated with children enrolled in home visiting programs include that they have improved early language and cognitive development; have greater math and reading achievement in elementary school; have reduced absentee rates and suspensions compared with children not enrolled in home visiting. So, here's what can be confusing about home visiting. There are 26 different evidence-based models of home visiting in use across the United States, with only a handful of them being implemented in

Nebraska. Each model varies in professional requirements of the home visitor, the length of service, the type of curriculum utilized, and eligibility requirements. The goal is to connect a family with the best and most appropriate model to meet their needs. For example, if you are a new mother coming home from the-- or a new father-- if you are a new mother or father coming home from the hospital with your baby, the Durham Family Connects model may fit your needs best because it connects you with a nurse who conducts home visits with you, focused on the health of you and your baby. And I know you've heard about Family Connects model with Senator Dungan's bill, LB22, a couple of weeks ago. Or, if you are a family who might be at risk for involvement in the child welfare system, the health-- Healthy Families America program might be a better fit because it is more intensive, with weekly visits. Here's the history of home visiting in Nebraska. Home visiting has had a long history in Nebraska. In fact, if you speak with our public health departments, they were conducting home visits for new mothers decades ago, a practice that, sadly, was lost in an era of budget cuts. The first legislative effort in the Unicameral was in 2007, when then-Senator Gwen Howard was able to include an allocation of $600,000 for nurse home visiting services to the budget. I have asked Sara Howard, her daughter, a policy adviser at First Five Nebraska, to come and update you on the statutory history of home visiting and how important it is, more now than ever before, for families who may not have any local support. Here's what LB104 does. LB104 creates the Family Home Visitation Act, and places into statute two important pieces of the home visiting puzzle. First, LB104 creates a definition in statute for what a voluntary-- and I must say that again, voluntary-- evidence-based home visitation program is, defining it as one with clear guidelines, national certification, and high-quality service delivery. This is to ensure that state funds utilized for this programming are exclusively used for programs with clear success for families. Second, LB104 asks DHHS to submit an annual report to the Legislature on home visiting in Nebraska, to peel back the curtain on the successes of these programs and the efficacy of our state investment in home visiting. At the request of the department, we have only asked for this report for three years-- from 2026 to 2028-- to align with the federal authorization of the Maternal and Infant Early Childhood Home Visiting-- in short, it's MIECHV program-- the main source of federal funding for home visiting in Nebraska. In closing, home visiting programs in the state of Nebraska are doing incredibly significant work for our youngest children and families. Often called the silver bullet for child abuse prevention, a robust and coordinated home

visiting network in Nebraska can not only improve outcomes overall for children, but particularly for those who are at risk of court involvement, and LB104 is the first step in creating a statutory framework to support this important work. Behind me, you will hear from home visiting agencies, parents, and home visitors who do this important work across the state, as well as First Five Nebraska to offer statutory history and context. I certainly appreciate your time and consideration and attention to this very important issue, and I will be happy to try to answer any questions you may have, and will be staying to close. And hopefully, if I fail to answer your questions, please don't hesitate to ask them of the amazing people sitting behind me.

HARDIN: Thank you. Questions? Senator Hansen?

HANSEN: Thank you. So, we currently have-- we, we pay for home visiting in Nebraska, correct?

RAYBOULD: That is correct.

HANSEN: And it sounds like it's working really well?

RAYBOULD: It has evidence to prove that it is a success in the families they help.

HANSEN: So, is your bill trying to limit it? Or limit the people who can do it?

RAYBOULD: Well, we want to include language in statute that acknowledges this. Yes.

HANSEN: Why?

RAYBOULD: Well, I think it, it allows us to continue to seek out federal funding, for one, which has been significant. The match for federal funding is 90% to the state's contribution of 10%. And so, in order to, to qualify for these programs, they have to be certified programs for, you know, mothers, infant children, early childhood, so on. So, most importantly, it-- they're effective and they, they help the, the young families who, who want that type of help.

HANSEN: OK. All right. Thanks.

HARDIN: Senator Meyer.

MEYER: Thank you, Mr. Chairman. Thank you for coming today, Senator.

RAYBOULD: You bet.

MEYER: You said 10% state obligation, but there's no fiscal note on this?

RAYBOULD: There's no fiscal note on this. This is the statutory language that codifies what they have been doing for, for years. And so, that was in Senator Dungan's bill, I believe it was LB20-- LB22-- LB22. That makes that official ask and request. But we have been funding it--.

MEYER: Thank you.

RAYBOULD: --since 2007.

MEYER: If I may, Mr. Chairman.

HARDIN: Sure.

RAYBOULD: Yeah.

MEYER: Is it a regular visitation schedule? Is it, you know, like, a week after the baby's born and then a month later, and three months later? Is it--

RAYBOULD: Well, it's a voluntary program. And so, typically, a, a new mother is notified either in the hospital or with her first post-partum visit with her physician, and they offer that opportunity. And then, it's up to her and the-- and her physician to determine the frequency, or-- and it's also up to her family to decide when they would like. Typically, there are three to four visits for the baby's first year, and then, if they would like a, a, a different type of model that would help their family needs better, if their, if their newborn is a special needs baby, or if the family is at risk and has been identified at risk, then there would be a greater frequency. But it's all at the request of the family working with the visiting-- home visiting services.

MEYER: Thank you. And then just, just one little--

HARDIN: Sure.

MEYER: Just, just to-- for my own curiosity. Do, do new mothers or, or, or mothers, do they ever refuse visits? Is there-- is there a basis for refusal? Is there-- occasionally, there, there are?

RAYBOULD: I--

MEYER: Sara does--

SARA HOWARD: I'm nodding, yes, yes, yes.

MEYER: Yes. [INAUDIBLE].

RAYBOULD: And, and then, I-- I'm certainly going to allow Sara Howard to, to fill in on those details. But it-- because it's a voluntary service, I would assume that, you know, after one or two visits, you know, parents could say, hey, I think I got-- I got this. I think you gave me the confidence I need to, to be able to care for this crying, screaming, wiggly thing. So, yeah.

MEYER: OK. Thank, thank you very much.

RAYBOULD: You bet.

HARDIN: Other questions? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. I guess my initial question gets to be-- is-- are mothers or mother-in-laws no longer qualified or eligible for doing this task?

RAYBOULD: They are-- in my personal opinion as a grandmother, I'm-- I think I am totally qualified to be able to offer the same type of services if so requested by my daughter and my son. But they seem fully capable of doing it. But yeah, so-- yes, of course, mothers and mother-in-laws serve, like, a vital role in the whole process of becoming an effective, confident parent. So, yeah. I'm grateful to my, my parents who coached me. I think-- well, my kids survived.

RIEPE: I'm just interested how you would keep a mother or a mother in law away.

RAYBOULD: Well, I, I, I agree with you. I know my son said, "Hey, mom, don't come and visit," and I was there within a few hours, so.

RIEPE: The other-- kind of a follow-up. May be more of a comment. In the 1980s, the, the first process on this thing, I think was-- and

there's probably no one else in the room that's of that age-- that they used to have the Penguin newsletters, and they sent out these newsletters on a regular basis and said, at this age, your child should be doing this, and at this age, your child-- and it's very helpful. Particularly for-- all parents, but particularly for new parents. But I suppose postage going up has made that unaffordable. So I, I don't know. Is there-- in, in fact, I tried to look at the notes that I have, too-- is there a fiscal note on this?

RAYBOULD: There's not a fiscal note on LB104; it's on Senator Dungan's bill, which is LB22. And that is requesting the continuation of the funding that the federal government matches 90% to the state of Nebraska's contribution of 10%. And I know-- I think Sara Howard and someone else might be able to tell you where those funds come from.

RIEPE: You've mentioned Senator Duncan's [SIC] bill a couple of times.

RAYBOULD: Yeah.

RIEPE: Can you share with me, or us, how that-- how the two kind of complement one another?

RAYBOULD: Well, they, they both complement each other. The-- this bill codifies the language of the visiting-- nurses visiting program, and the funding request from Senator Dungan continues and matches this language in statute that we're putting it forward.

RIEPE: Is there an opportunity then to merge those two bills, prior to hitting the floor?

RAYBOULD: I, I would--

RIEPE: Or are they significantly different?

RAYBOULD: I would say they are significantly complementary to one another. One is fiscal and the other is statutory with language. So, I see no-- I mean, they do complement each other and the great work that these visiting programs offer.

RIEPE: OK. Well, thank you for being here.

RAYBOULD: You bet. Thank you.

RIEPE: Thank you, Chairman.

HARDIN: Thank you. I know that Senator Dungan's bill, I think, is perhaps first up tomorrow if we keep the same schedule that we had this morning, so.

RIEPE: When is it coming up?

HARDIN: Tomorrow morning. I'm sorry. Monday morning.

RIEPE: I was going to say--

HARDIN: We're going to be here, Merv, whether you are or not.

RIEPE: I didn't get the invite. OK, thank you.

HARDIN: Well. Any other-- any other questions?

RAYBOULD: OK. Thank you. I'll stay.

HARDIN: Thank you. You said you would be here for the end. Proponents for LB104. Welcome.

LANA TEMPLE-PLOTZ: Thank you. Some familiar faces and some new faces. I think I have nine copies, so, sorry about the-- good afternoon, Chairman Hardin, and members of the Health and Human Services Committee. My name is Lana Temple-Plotz, L-a-n-a T-e-m-p-l-e-P-l-o-t-z, and I'm the CEO of Nebraska Children's Home Society, also known as NCHS. I'm here today in support of LB104. NCHS is a statewide, accredited nonprofit with offices in North Platte, Grand Island, Kearney, Lincoln and Omaha. NCHS utilizes its 132 years of experience to put children's needs first through an array of services designed to build strong, supportive families and nurture children. We work towards a better Nebraska for all by providing compassionate support, enduring connections, and innovative solutions that help families thrive. Our core services include adoption and post-adoption, family support, and early childhood education. A major component of our family support services includes home visiting. NCHS offers two models: Parents as Teachers, and Healthy Families America. And our specialists serve families in Keith, Red Willow, Lincoln, Douglas, Sarpy, and Saunders Counties. NCHS is part of a statewide partnership of home visitation providers who work together with a common goal: ensuring every family in Nebraska has access to quality services delivered in their homes, designed to build on their strengths as parents and help ensure their children grow up healthy and safe. Together, we support this bill because it further outlines the important components of effective home visitation, and helps

ensure we are holding ourselves accountable to positive outcomes. Home visitation is a voluntary program provided primarily in the home with families whose children are five years old or younger, or who are pregnant. Why is evidence-based home visiting so important? Because this ensures the models used with parents are tested and proven to be effective, and are associated with a national organization that's had-- that has outlined standards and practices to ensure effective implementation. Why did we support increased access to home visiting, regardless of which model the family chooses? Because we understand one size does not fit all, and we want families to have the opportunity to choose the program that's right for them, whether they need a stronger focus on development and health, their visiting nurses, or a focus on attachment and bonding through Healthy Families America. We understand that having a variety of models ensures we can meet families where they are. Nebraska has been investing in home visiting since 2007, and, to date, there has not yet been a comprehensive report on the impact on children and families. This bill requires the department to provide such a report to the Legislature. And my time is up. I want to express my appreciation to all of you, and I'll take any questions that you have.

HARDIN: Thank you. Questions? Senator Quick.

QUICK: Thank you, Chairman Hardin--

LANA TEMPLE-PLOTZ: Hi, Senator Quick.

QUICK: And thank you for being here. So, like, do you work directly with-- do you have a-- like, neck-- network of nurses that you work with, or that you can-- they know what's-- where-- what homes to go to, and that-- right?

LANA TEMPLE-PLOTZ: Absolutely. So, our organization works in the counties that I mentioned, and we have specialists that are our employees that work directly with families, and we connect with community resources, hospitals, clinics to get referrals from those individuals and serve those families. We call those families and offer them our services, we meet with them. And, as we mentioned before, it's all voluntary, so just a, a support to families to help them be the best parents they could be.

QUICK: OK. And just one other question [INAUDIBLE] all right. So, do you build those relationships-- [INAUDIBLE] I'm sure some come after

delivery, but are a lot of those built-- the relationships built before they deliver?

LANA TEMPLE-PLOTZ: Yes. Yes. So, our organization in particular-- we've been around for 132 years, so we have a lot of experience with working directly with hospitals and, and families. So, yes, we try to work with pregnant and parenting individuals, and so we serve both.

QUICK: OK. Thank you.

HARDIN: Other questions? Senator Hansen.

HANSEN: Thank you.

LANA TEMPLE-PLOTZ: Hello.

HANSEN: Thanks for coming.

LANA TEMPLE-PLOTZ: Yeah, absolutely.

HANSEN: Can you expound a little bit more on the accessing prenatal care part of what you guys do?

LANA TEMPLE-PLOTZ: Sure. So, for that component, we just help families find resources. So, if you're experiencing an unplanned pregnancy or not sure how to, how to get prenatal care, where are the best places to go? We provide you those resources, we help you make those appointments, things like that.

HANSEN: Now, when you say unplanned pregnancy, what would you refer them to?

LANA TEMPLE-PLOTZ: So, we would refer them to a medical professional.

HANSEN: For what?

LANA TEMPLE-PLOTZ: For prenatal care.

HANSEN: OK. Abortion at all?

LANA TEMPLE-PLOTZ: Prenatal care. So, no. Prenatal care.

HANSEN: OK. Thank you. Just making sure.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. I did look here in your notations that you do do home visiting. How do you make-- how do you get referrals?

LANA TEMPLE-PLOTZ: So, we get referrals from community partners, from hospitals, from clinics, from pediatricians and OB-GYNs, from schools. If folks go and get-- and access community resources through, you know, some of our community collaboratives, we get referrals there. We do a lot of outreach and networking with folks across the state.

RIEPE: Who's your primary competitor?

LANA TEMPLE-PLOTZ: We don't have competitors, we have partners.

RIEPE: Well, OK.

LANA TEMPLE-PLOTZ: So--

RIEPE: How do you--

LANA TEMPLE-PLOTZ: There's no way that--

RIEPE: Let me reframe that, then. Who is, is it that might be going after the same home visit that you're going after?

LANA TEMPLE-PLOTZ: No, because we all offer different--

RIEPE: So, you have a monopoly?

LANA TEMPLE-PLOTZ: I didn't say that.

RIEPE: It sounds like--

LANA TEMPLE-PLOTZ: We offer a variety--

RIEPE: If it is one, it is one, you know.

LANA TEMPLE-PLOTZ: We offer a variety of different services. Everyone has a different focus that they have. So, for us, it's Parents as Teachers and Healthy Families America are the two models that we use, and there's other models available. So, it's voluntary and it's the parents choice, so there's no way that my organization could serve every pregnant or parenting individual in the state, nor should we, because one size doesn't fit all. So, we want you, as a parent, to go to the place that you're most comfortable.

RIEPE: I'm just thinking-- parents-- we-- you know, we talk a lot about choice. And I think that parents would need to have some idea of what your ideology is in relationship-- because it might be a matter of religion, or--

LANA TEMPLE-PLOTZ: Sure.

RIEPE: --other options that might say I'm more comfortable.

LANA TEMPLE-PLOTZ: Absolutely.

RIEPE: Not that you're-- they're going to do any better, but they might be just more comfortable. And that's quite frankly one of the things that I would have an interest in is that right to pick and choose.

LANA TEMPLE-PLOTZ: Absolutely. Absolutely.

RIEPE: But I don't know how you do that in this model.

LANA TEMPLE-PLOTZ: Sure. So, within the context of this model, if we have families who are interested in home visitation, we ask them a series of questions about what is their best fit in terms of which model would be better for them, and depending upon where they are out in the state and what their needs are, that-- if they, for example, have a child who has some special developmental things happening with them, or some special needs, perhaps our agency isn't the best served, because we don't have nurses. Right? So, maybe that mom would feel-- or that parent would feel more comfortable having a trained nurse come and visit them every time they have a home visit, so we would refer them over to Visiting Nurses Association because they have trained nurses. If that mom wants to make sure that she has a strong attachment to her baby because perhaps she experienced not a strong attachment with her parents, we-- and that's something that's important to her, then Healthy Families America focuses on attachment and bonding.

RIEPE: So do you look at the acuity, maybe, of the infant, coming out-- if they've been in the ICU for a number of days, they might have a different acuity level than the, quote-unquote, general public of babies.

LANA TEMPLE-PLOTZ: Right. So, yes, absolutely. So, with our referral sources, we try to educate them on the, on the types of models that we use so they have a better understanding. So, example, if you're a

pediatrician or an OB-GYN, we try to educate you on what the kind of models are that we use, so you have a better understanding of that. And if there's a family that's referred to us that we feel isn't a good fit for the models we have-- the example that you gave is an excellent one-- we would then do a, a warm handoff over to Visiting Nurses, which means we would help that mom get connected to Visiting Nurses.

RIEPE: So, do you have the size within your organization to accommodate several different situations?

LANA TEMPLE-PLOTZ: Yes. So, every one of our models has certain parameters around how many individuals we can serve on our cases, and all those kinds of things.

RIEPE: So, you're trying to match--

LANA TEMPLE-PLOTZ: Yes.

RIEPE: OK.

LANA TEMPLE-PLOTZ: And so we do a matching-- also, to your point with-- as new referrals come in, we do-- we match them to our specialists, because--

RIEPE: Fair enough.

LANA TEMPLE-PLOTZ: --there's different levels.

RIEPE: OK. That answers my question. Thank you, Chairman.

HARDIN: Other questions? Seeing none. Thank you.

LANA TEMPLE-PLOTZ: Yes. Thank you.

HARDIN: Proponents, LB104. Welcome.

HAILEY CRUMLEY: Thank you. Good afternoon, Chairperson Hardin, and members of the committee. My name is Hailey Crumley, spelled H-a-i-l-e-y C-r-u-m-l-e-y. I am here today from the Columbus area in support of LB104. I will be sharing my personal experience receiving home visitation services, and explaining why it's essential for Nebraska to remain proactive in early childhood by investing in evidence-based home visitation programs. I'm a child care director, and I worked in the early childhood care field for more than 12 years.

And I am also a mother of four children and a previous foster parent. In early 2022, my husband and I found out we were expecting twins. That was a lot. That was a-- double the diapers, double the sleepless nights, and I was really worried about how I was going to handle that. A teacher at my center recommended the Healthy Families home visitation program through Columbus Hospital, and I am so grateful that I, I sought them out and was able to join the program. Our home visitor, Karla Rosendahl, quickly became an invaluable support system for our family. She provided not only resources, but also expert guidance on maternal and infant health, parenting strategies, and emotional well-being, all key goals of evidence-based home visiting. She worked around our schedule, met us where we were, and helped navigate challenges from nursing struggles to my son's medical concerns. When my husband, a farmhand, returned to work just after that weekend and after our twins were born, Karla was there for me. She offered practical support and emotional reassurance. She would bring a hospital grade scale to ease my concerns; my twins were little and we wanted to make sure they were gaining enough weight. And she also encouraged me to seek postpartum mental health support when I needed it most. Beyond infancy, home visiting continued to impact our family in ways I never expected. In 2023, we became foster parents to a toddler with special needs. The guidance, connection-- the guidance and connections that Karla provided helped us navigate the complexities of the child welfare system. She connected us with child development specialists, attended team meetings, and even helped us access diapers when our budget was stretched thin. This is exactly why LB104 is so critical: it ensures that Nebraska's home visitation programs meet a high standard of quality and accountability, improving outcomes for families might-- like mine. Additionally, requiring DHHS to submit an annual, annual report is also essential for the high quality. As you take on the difficult task of which programs to invest in, too, for our state, I'll hope you-- you will consider advancing LB104 so more families across our state can receive access to their own Karla. Thank you for allowing me to testify today.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. I'm trying to educate myself here. What, what are the credentials, the training, if you will, of these people that are visiting? Because I notice in your testimony, or in your written piece here, it says-- I, I caught one of these things says "my son's medical concerns." So, it sounds like one of the twins had-- your son, or I don't know, maybe it's two boys. I don't know, but one of them had some-- they were different, as you would expect. But what

kind of a person did they send out? Was it an RN? Was it a nurse anesthetist? Was it-- what [INAUDIBLE] they send?

HAILEY CRUMLEY: So, Karla was from Healthy Families, and I think her degree is actually in social work, maybe.

RIEPE: Social work?

HAILEY CRUMLEY: Yes. So--

RIEPE: [INAUDIBLE] OK.

HAILEY CRUMLEY: She was our-- she was our, our Healthy Families home visitor. So, what she did is when I had-- when I had concerns about my infant son-- I have a daughter; I have a boy and girl twins-- my son got the-- he got all the problems, and the girl is very perky and very outgoing. So, my son had a lot of airway issues. So, she recommended specific-- because she works in the hospital-- specific referrals or doctors that I could see and go to, an EMT, those sorts of things. And then, she also helped me apply for-- maybe you've heard about the monitors that they put on their feet. I'm trying to think of what they're called. They're, like, owlet socks that monitor airway, heart rate, those sorts of things. She helped me apply for one of those as well. So, just broadened my horizons on, on that. I know-- I have tons of early childhood education as far as development, but the health stuff is way out of my realm.

RIEPE: It sounds like maybe she was focused mostly on the babies. But my other-- next questions-- because you [INAUDIBLE] in here ease my concerns, so did she have any knowledge or background on the postmortem [SIC] "dispression?"

HAILEY CRUMLEY: Yeah. So, as a social worker, I think she had a lot of experience and a lot of knowledge on that.

RIEPE: She was a social worker.

HAILEY CRUMLEY: Yes.

RIEPE: OK.

HAILEY CRUMLEY: Yes. And I will say, she's actually still our home visitor currently, because my twins are two. So she, she is with our family for five years. Now, we do--

RIEPE: She-- does she now have a room? [LAUGHTER]

HAILEY CRUMLEY: I would love to give her, her room. She comes to our birthday parties. It's lovely, actually. We only see her on a monthly basis now. In the beginning-- I think someone asked about how often. She came over weekly, in the beginning, when I went home with my twins, because my husband didn't really get leave. And so, she came over weekly. Now, she visits us monthly, or even every other month. So.

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

HARDIN: Senator Ballard.

BALLARD: Thank you, Chair. Thank you for being here. It's good to see you. Do, do-- did you get to choose your home visitor, or was Karla assigned to you?

HAILEY CRUMLEY: So, I met with the-- so, from my understanding, the Columbus Hospital's program only has two home visitors; it's not super large. And she drives all over. So, she drives through the surrounding towns. They cover more than just Platte County; they do Butler County-- I'm not sure if they do Colfax, but I do know they do Butler and Platte. And so, I didn't get to choose, but I did fill out a questionnaire that asked about my family. I work at Christ Lutheran north of Columbus as a child care director, and so obviously, "Lutheran" was one of the things I wrote down, and then she attends a Lutheran church, also. I don't know if that's in relation or not.

BALLARD: OK. Thank you.

HARDIN: Any other questions? Seeing none. Thank you.

HAILEY CRUMLEY: Mm-hmm.

HARDIN: Proponents, LB104. Welcome.

DEZARAE BRANDT: Hello, Senator Hardin. It's nice to see you again, and I appreciate the opportunity to visit with you and other members of the Health and Human Services Committee today regarding my support for LB104. I'm Dezarae Brandt, spelled D-e-z-a-r-a-e B-r-a-n-d-t, and I'm a program manager of a home visitation program utilizing the evidence-based model of Healthy Families America at Panhandle Public Health District. I would like to extend my gratitude to Senator Raybould for introducing this very important bill to give definition,

credibility and accountability to what I know is incredible-- incredibly impactful for families here in Nebraska. I'm honored to be testifying here today for the very first time to share my passion and dedication to serving families through home visitation. The way home visitation found me is a story I enjoy telling; it's truly a leap of faith that has turned out to be the best one I've ever taken. Before stepping into this work, I spent nearly a decade as a probation officer in the Panhandle of Nebraska. In that role, I witnessed women and children struggling with overwhelming barriers. To name a few, addiction, mental health challenges, housing, food insecurity, abusive relationships, unmet medical needs, and lack of support. Too often, I saw parents bring children into the same cycles of instability they were trying to escape, and while I worked hard to help, I often felt helpless, stretched between my duty to the court system and my desire to do more for these families. I watched too many women and children slip through the cracks simply because the right support wasn't reaching them in time. My empathy extends, as I'm also a mother of three young children myself. Since transitioning to this vital work of home visiting in 2020, I have witnessed firsthand its life-changing impact on families. Home visitation is more than a program; it's a lifeline. It's trained professionals stepping into the homes of expecting and new parents, not to judge or instruct, but to walk alongside them. It's about building trust, offering guidance, and ensuring that every child gets the strongest start possible. It's important to know, as you've heard many times today, home visitation is voluntary. Families choose to participate because they see the value in having a trusted partner on their parenting journey. Home visitation is particularly valuable in rural communities due to the unique challenges and strengths these areas present. Rural areas often has vast differences between homes, and limited access to essential services. Home visitation brings support directly to families, eliminating transportation barriers. Rural communities often experience higher levels of social isolation, especially for families with young children or those facing challenges. Home visitors connect families with local "resourches"-- resources such as health care providers, child care, community organizations, and opportunities to meet other parents, fostering a sense of belonging and integration within their communities. Our, our rural site is currently serving 100 families. This spring, we're expanding into it four additional counties, and will be serving families across the rural Panhandle. This is our chance to reinforce the power of prevention and early intervention by strengthening the standards that guide these essential programs. By establishing a clear statutory definition and ensuring

accountability, we are making a long-term commitment to Nebraska families. Thank you for your time, and I'm happy to answer any questions.

HARDIN: Thank you. Questions? Seeing none. Thank you.

DEZARAE BRANDT: Thank you.

HARDIN: Proponents, LB104. Welcome.

ANAHÍ SALAZAR: Hi. Thank you, Chairperson Hardin, and members of the Health and Human Services Committee. My name is Anahí Salazar, A-n-a-h-í S-a-l-a-z-a-r, and I am a policy coordinator for Voices for Children in Nebraska, here in support of LB104. Family home visiting is well-established and widely recognized as a prevention strategy aimed at improving the health and well-being of pregnant individuals and parents with infants and young children. These programs provide a valuable opportunity for continuous parental education, social support, and connections to community services. Voices for Children in Nebraska supports LB104 because it will outline family home visiting services for families with young children in statute, and require a report to the Legislature, helping access-- assess if the program is working or not in the state. This investment is crucial for strengthening families throughout Nebraska, and plays a key role in preventing child welfare issues. Providing visits by nurses, social workers, and other early childhood and health professionals helps sets parents and children up for success. Data from Family Connects, a model used in family home visitation, shows that Family Connects model has been acknowledged as a health equity approach because of its use as a-- use of a comprehensive family risk assessment to assess acute health needs as well as family needs related to health care access, parenting, household safety, and parent-- parental well-being, the use of family needs data to improve community systems of care, and effectively connecting family-- families to community resources to address their needs. Healthy Families America home visiting, which works in Nebraska, has had a success in helping families avoid the child welfare system and stay together. According to the 2024 Public Health Solutions and Healthy Families Alliance-- which is one of the programs that helps families in the child welfare system-- prevention track outcome report in Nebraska, 11% of cases were opened with a child welfare traditional response, while 8% of those cases were both alternative response and initial response. But, within six months from discharge, 100% of the cases remained safely at home. Investing in home visitation supports Nebraska's commitment to fostering healthy

and thriving communities. Nebraska can continue to lead in creating supportive environments for all families. Thank you, Senator Raybould, for introducing this important legislation, and the committee for listening and your consideration. I'm available for any questions. Thanks.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. Is your son named Jim?

ANAHÍ SALAZAR: Oliver.

RIEPE: Oliver?

ANAHÍ SALAZAR: Yeah.

RIEPE: OK. Sorry. I have a stick in my head, here.

ANAHÍ SALAZAR: Yeah.

RIEPE: My question is this. I'm trying to figure out how this all fits together. I'll give this, and then you react to me if I'm way off-base, but it sounds to me like it's the second phase to a doula service. You know, that-- is, is that fair to say? Kind of a continuation of that?

ANAHÍ SALAZAR: Yeah. I believe doulas provide support to moms or parents-- or mothers who are birthing while in the hospital, or wherever they-- they're giving birth. So, that support, throughout that-- and the prenatal support are-- yeah. Prenatal support? But then, can help with post-natal support. It-- for the families, I've heard doulas being specifically more geared towards the mother, to the birthing person, whereas I think family home visiting is tailored to help both mom and child, creating that safety once baby goes home.

RIEPE: OK. OK. I'm just trying to get the continuum in, in my head. Thank you, Chairman.

HARDIN: Other questions? Seeing none. Thank you. Proponents, LB104.

SARA HOWARD: OK, I'm your last person.

HARDIN: Welcome.

SARA HOWARD: Thank you for-- OK. Chairman Hardin and members of the Health and Human Services Committee, thank you for allowing me to

testify today. My name is Sara Howard, spelled S-a-r H-o-w-- S-a-r-a H-o-w-a-r-d, and I'm a policy advisor at First Five Nebraska. First Five Nebraska is a statewide public policy organization focused on promoting quality early care and learning opportunities for Nebraska's youngest children, and my position at first five Nebraska is focused on the area of maternal and infant health policy, because we know that healthy moms and babies are critical to ensuring the long-term success of children in our state. I'm here to testify in support of LB104. So, you've heard a little bit of this history before. This is-- home visiting in Nebraska is a bit of a labor of love for my mother and I. So, my mother passed the first home visiting bill in 2007, and it was a line item in the budget for evidence-based nursing home visiting. So, my mother was a social worker for the state of Nebraska, a frontline worker for 34 years. And she realized that people won't come to the door for a social worker, but they will come to the door for a nurse. And so, that was why she was able to get this funding in the budget. And it started out very small; it was $300,000, and then it was $600,000, and then I was elected in 2012, right after the Maternal and Infant Early Childhood Home Visiting [SIC] bill had passed on the federal level, which was our federal funding source for home visiting. It's sometimes pronounced "Mick-Vee" [PHONETIC]. And so in 2013, I opened up the line item that she had put in place previously for evidence-based home visiting overall. So, not just nurse home visiting, but evidence-based home visiting. That meant that it could be a social worker, an early childhood educator or a nurse helping families when they bring a baby home. So, last year, under a new reauthorization of the MIECHV program-- so MIECHV, on the federal level, has to be reauthorized every five years-- last year, Representative Adrian Smith was one of the sponsors of the federal MIECHV reauthorization, and that, that group really worked to get-- in addition to your base allocation as a state for home visiting, you got an additional match. So, last year with Senator Vargas and Senator Wishart, we got additional funds so that we could draw down the maximum of the match. The dream is that every family in Nebraska is offered some type of home visiting when they bring a baby home, or during those early years. Offered; it's completely voluntary, you can say no at any time. But the real purpose of LB104 as we're building the house of home visiting is that it is really odd for something to exist exclusively in our budget and not have a statutory definition. And so, it has lived in our budget since 2007; we have never defined what evidence-based home visiting is. And so, that's what this bill is asking you to contemplate. The second piece of it is obviously the report, because we've been investing for almost two decades in home

visiting and we've never said, "Hey, is it working?" I'm a fan. I know it's working, but it's really hard for me to prove to you that it's working without a report. I think the reason why you don't have a fiscal note on this is because the federal government requires annual reporting every October, and so what will most likely happen is that they'll give you the October report every February. So, that's why there isn't an additional cost, because they already have the report. Thank you for your time. I'm happy to try to answer any questions you may have.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. And thank you, Senator Howard, for, for being here and for your testimony. So there's been a lot of, I think, great questions to kind of put a finer point on home visits and what that looks like. But I just kind of want to put a finer point here. My-- so, my understanding of this bill-- and please tell me if this is incorrect-- is that, essentially, this just looks to officially define and provide a little bit of oversight to something we, as a state, have been doing in funding for nearly 20, 20 years or so?

SARA HOWARD: Yeah.

FREDRICKSON: Is that-- that's the whole shebang?

SARA HOWARD: That's it. That's the whole thing.

FREDRICKSON: Got it.

SARA HOWARD: This is a very easy bill in my mind, but I can imagine it would be challenging in other ways. I might just clarify the 90/10 match for LB22 versus LB104. So, LB104 is just about evidence-based home visiting definitions overall. It aligns with our budget, it reflects the definitions of our budget, and it calls for that annual report. LB22 is asking you to contemplate allowing a specific type of nurse home visiting to be able to bill Medicaid. When you think about Medicaid, that's a matching program, and that's a 90/10 match to the postpartum mother. Did that make sense? Oh, good. Oh, that's so great. OK.

HARDIN: Any other questions? Senator Hansen?

SARA HOWARD: Yes, sir. Yes.

HANSEN: I'm going to go back to what I asked before. Why, why do we have to define it now?

SARA HOWARD: You know-- OK, so, there is so much that we can do statutorily around home visiting to expand access, but the very first step has to be defining it in statute. Everything will go back to those original-- to these original definitions that you're putting in place.

HANSEN: Will there be people who will be left out now?

SARA HOWARD: I don't think so, because the goal is, is for pretty much every-- all of the 26 evidence-based models are included inside of this definition. I think the only thing that you might run into are "emerging models." I put it in quotation marks, for the transcribers. "Emerging models." Those are models that have not had a rigorous academic study yet, but are emerging.

HANSEN: So how do they become evidence-based, then?

SARA HOWARD: They go through a rigorous academic study. So, they'll follow the children and the mothers to see if the outcomes that we're saying are, are the outcomes for the model are we doing what we want them to do.

HANSEN: Then will the federal-- would the-- would a-- would they be defined federally?

SARA HOWARD: They're defined federally. So, this mirrors the, the federal definition of home visit right now.

HANSEN: OK. So, emerging--

SARA HOWARD: Clear as mud, huh?

HANSEN: --emerging models will not be included in this?

SARA HOWARD: No, no.

HANSEN: So we, we have some of those in Nebraska-- I'm always just kind of [INAUDIBLE] just curious, like--

SARA HOWARD: So we, we-- yeah.

HANSEN: --before I get an email, before somebody--

SARA HOWARD: Right, right, right.

HANSEN: --blows up my phone or something like that, saying--

SARA HOWARD: [INAUDIBLE]

HANSEN: --we lost our funding, or whatever. I don't know.

SARA HOWARD: Yes. Yes. We actually don't have any emerging models at this time that I know of. We have five models operating in the state of Nebraska. So, you heard about Healthy Families; that's what's happening in the panhandle. Very popular. It's what's-- our main source of funding is MIECHV. You've heard about Family Connects, which is our nurse home visiting only available in Lincoln-Lancaster County. The other one is Parents as Teachers, which-- Elana [SIC] Temple-Plotz talked a little bit about Parents as Teachers, that's a lot more, I'm going to teach a parent how to really bond with their child. And then, there are a few smaller models that are sort of like one-offs in the state as well. And then, I, I would be murdered if I forgot Early Head Start. So, you-- you're familiar with Head Start; that's center-based care. There is also a home visiting model for Head Start called Early Head Start. And so, Head Start workers are, are visiting with families as well.

HANSEN: OK. All right. Thanks.

SARA HOWARD: Thank, thank you.

HARDIN: So, I would be remiss if I didn't point out to all of you that when I sit in this seat, I have three previous chairs of this committee sitting here right now: Senator Riepe, Senator Hansen, and now, Senator Howard. So, I would be remiss if I didn't ask a difficult "how" question.

SARA HOWARD: I'm, I'm ready.

HARDIN: Are you ready?

SARA HOWARD: Born ready.

HARDIN: How are we not planting seeds for a future entitlement when we do this?

SARA HOWARD: Oh, so that's a good question as well. And I've seen a lot of statutory structures. The future entitlement would be if I came

to you and I said, "We need to move the money out of the budget. We're going to put it in this bill." I wouldn't ask for that, though. We've had great success leaving it in the budget. I think the only challenge is that you want to make sure that the budget is just, like, four lines. So, it just says evidence-based home visiting. So, if we don't have a statute that, that defines it, then really, you can kind of go in a new direction. But I, I will not at this time be asking you to move all that money over into the statutes.

HARDIN: Prepositions matter at this time.

SARA HOWARD: Well--

HARDIN: Yes.

SARA HOWARD: I mean, who can see-- who can read--

HARDIN: Hold that thought for six years.

SARA HOWARD: --who can see the future?

HARDIN: We'll see.

SARA HOWARD: I mean, my mom's watching right now. I don't want to-- her be disappointed.

HARDIN: And she's cheering. She's cheering. So. Thank-- yes, Senator Ballard.

BALLARD: Thank you, Chair. Good to see you, Sara.

SARA HOWARD: Nice to see you as well.

BALLARD: So just so I'm clear-- I think you answered my question with your exchange with Senator Hansen, but all the definitions-- some of these are little broad. They're all defined under federal guidelines?

SARA HOWARD: Yes, they are all defined under the federal MIECHV, or the Maternal and Infant Early Childhood Home Visiting [SIC] law.

BALLARD: OK. Thank you.

SARA HOWARD: Yay.

HARDIN: Any other questions? Thank you.

SARA HOWARD: Thank you. I had a lovely time. Thank you.

HARDIN: Proponents, LB104. How about opponents, LB104?

KEESHA McQUAY: Proponent.

HARDIN: Oh, you're a proponent? OK. Don't be shy. Come on up. You'll miss your chance. Elbow your way to the front. Welcome.

KEESHA McQUAY: Hello. Chairman Hardin and members of the Health and Human Services community-- Committee. Sorry. Thank you for the opportunity to submit testimony and support of LB104, the Family Home Visitation Act. My name is Keesha McQuay, K-e-e-s-h-a M-c-Q-u-a-y, and I'm a provisionally-licensed mental health practitioner and provisionally-certified master of social work. I practice at Compass, and have worked in the human services field for almost eight years. I'm representing the Nebraska Association of Behavioral Health Organization(s)-- NABHO-- and we represent 62 member organizations, including community health, mental health, substance abuse disorder providers, regional behavioral health authorities, hospitals and consumers, operating across the state of Nebraska. Thank you for the opportunity to submit testimony in support of LB104, and we thank Senator Raybould for her leadership on the issue. We strongly believe that this bill represents a crucial step forward in supporting Nebraska families and ensuring the healthy development of our children, and will effectively intervene with children and families early on, which can help address mental health issues and reduce costly and intensive services down the line. Home visitation programs, as authorized in this act, offer invaluable support to families, particularly those who are facing challenges such as poverty, lack of access to resources, or stress of parenting young children. These programs provide a range of services, including parent education, developmental screenings and referrals, support and connection to resources, strengthening parenting bond-- parent-child bonding. Evidence-based home visitation programs have been shown consistently to produce significant positive outcomes, including improved child health and development, stronger parent-child relationships, reduced child abuse/neglect, and increased family self-sufficiency. Research also shows that home visitation is cost-effective, saving money that would otherwise be spent later on on more costly programs and services such as child welfare services, K-12 special education, health care and the criminal justice system. LB104 will enable Nebraska to expand access to these vital services, ensuring that more families across the state benefit from the proven effectiveness of home visitation.

Investing in our families and children is an investment in the future of the state. By supporting LB104, the Nebraska Legislature can make a real difference in the lives of countless children and families. We urge the committee to give LB104 a favorable recommendation. Thank you for your time and consideration. I've included some research studies, in case any of you guys are interested in it.

HARDIN: Thank you.

KEESHA McQUAY: Mm-hmm. Do you have any--

HARDIN: Questions? Seeing none. Thank you.

KEESHA McQUAY: Awesome. Thank you, guys.

HARDIN: Proponents, LB104. Going once. Going twice. Two and a half. OK. Opponents, LB104. Opponents? Those in the neutral, LB104. Senator Raybould.

RAYBOULD: Yes. Well, I want to thank the committee. Thank you for your attention on this. I want to thank First Five Nebraska and Voices for Children, and nav-- NABHO, and for the folks that traveled from Columbus and Scottsbluff so that you could hear their passion about the work that they do for helping children and Nebraska families, and the home visiting program. You know, it's, it's really about helping families stay together, helping parents become confident and capable with their healthy, happy kids as proof. And so, I ask for your support and your vote to move this forward to General File. So, I want to thank you all again, and thank you all for testifying.

HARDIN: We had-- for the record-- and we may have questions. Any other questions for Senator Raybould? We, online, had 18 proponents, 5 opponents, 2 in the neutral. So, thank you.

RAYBOULD: OK.

HARDIN: This concludes--

RAYBOULD: All right. Thank you.

HARDIN: --our hearing for LB104. We'll be moving on to LB203. We'll start just as soon as the spawning of the salmon comes to an end out the doorway, here. On-- oh, I'm sorry. We're going out of-- LB312. OK. LB312, sorry. LB312 will be next.

STROMMEN: Good afternoon. Ready?

HARDIN: Ready.

STROMMEN: Chairman Hardin, members of the Health and Human Services. My name is Paul Strommen, P-a-u-l S-t-r-o-m-m-e-n. I represent District 47, which is the Panhandle. Today, we'll be discussing LB312. So, let's dive right in. LB312 would add the profession of nurse anesthetists to the Rural Health Systems and Professional Incentive Act. The Rural Health Systems and Professional Incentive Act was created in 1991 by this Legislature, and is administered by the Rural Health Advisory Commission. The act was put in place to incentivize health professionals, upon graduation from their respective degree programs, to go work in designated health profession shortage areas, which is basically every county in Nebraska outside of the metro area. LB312 would provide the opportunity for a nurse anesthetist to take advantage of this incentive and potentially make the choice to work in Sidney, Scottsbluff, Alliance, Pender, Aurora, or any of our critical access hospitals that might otherwise be struggling. The act currently recognizes several eligible recipients, to include pharmacists, dentists, physical therapists, occupational therapists, mental health practitioners, psychologists, nurse practitioners, physician assistants, psychiatrists, physician in an approved specialty. LB312 would simply add the profession of nurse anesthetists to this list. The bill as currently structured in statute would make them eligible for up to $15,000 per year for three years for loan repayment assistance. According to the Nebraska Association of Nurse Anesthetists, several of whom are here and will be testifying, the average student debt of a graduating nurse anesthetist is around $150,000. So, this incentive obviously would not solve the total debt incurred in terms of fund eligibility, but it just might be the straw that breaks the camel's back that could make sure that we keep those rural ERs and ORs open so that access to needed health care stays an option for those rural families. In talking with hospital leaders in my district, finding providers has become a serious issue, and we need all the tools we can fit into our toolbox to make sure we are able to deliver quality health care locally. I believe this is an excellent way to attract these highly trained individuals to our small communities. And, if these individuals stay and work there for three or more years, the likelihood that they stay for the majority of their career and maybe the rest of their lives greatly increases. Thank you.

HARDIN: The word "anesthetist" is difficult to say.

STROMMEN: I was trying to get through it quick because I feel like the faster you say it,--

HARDIN: You, you did an ex-- you did a wonderful job.

STROMMEN: --the easier it is to say it. If you slow it down, it becomes--

HARDIN: It-- yes.

STROMMEN: --difficult.

HARDIN: I understand completely. Questions? Senator Frederickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Senator Strommen, for being here and for bringing this bill.

STROMMEN: Yes.

FREDRICKSON: So my question for you is, do you have something-- do you have something against the urban parts of the-- are you trying to take our people? Is that what this is coming down to? [INAUDIBLE]

STROMMEN: I am, yes. Very much so.

HARDIN: Yes. Yes, he is, and we're OK with that.

FREDRICKSON: I'm just giving you a hard time. No, I, I, I appreciate you bringing this bill. I think, I think it's-- it-- I-- it actually kind of strikes me as unusual that the nurse-- I'm going to try to say it-- anesthetists are not included in, in, in this program. You know, obviously, they provide a vital service, as well, so. Thank you.

STROMMEN: Most definitely.

FREDRICKSON: Yup.

STROMMEN: Yeah. And, and it is-- again, it's, it's difficult to attract people to our area of the state. We don't understand why that is, but it, it just-- it is what it is. And so, anything that we can do to help incentivize people to come out and work there is just a benefit for us, so. Not that we're trying to take anything away from Omaha and Lincoln.

HARDIN: Other questions? Senator Riepe.

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

STROMMEN: Yes.

RIEPE: The question that I have is do you have an idea of what the budget is, and how much is in the fund, what with all of these various professions drawing on it?

STROMMEN: As of-- I think-- and don't quote me on this, but I think there's $1.5 million in there.

RIEPE: $1.5 million?

STROMMEN: I think. But I can find--

RIEPE: And is that funded?

STROMMEN: --I can find that out for you.

RIEPE: That's a nice round number.

STROMMEN: OK.

RIEPE: Said it's-- is that funded through the General Fund?

STROMMEN: Again, I--

RIEPE: I should know this, but I don't.

STROMMEN: --I can find-- I can find that out for you.

RIEPE: OK. And also, just as a curiosity in terms of payback ability, do you have some insight in terms of what the annual income would be for a nurse anesthetist in rural Nebraska? In terms of--

STROMMEN: I don't, but I'm--

RIEPE: --what you're going to reflect on their ability to pay back the loan?

STROMMEN: I, I don't-- well, I, I know that-- I, I don't have an exact number now. I think that that would have to be from hospital to hospital, from facility to facility. Maybe some of these young folks behind me might have a better answer for that question than I do.

RIEPE: OK. Thank you. Thank you for being here.

STROMMEN: You're welcome.

HARDIN: Bryson did point out, it's from the Cash Fund. $1.5 million.

STROMMEN: It is cash fund.

RIEPE: Cash fund? OK. OK.

HARDIN: Other questions? Seeing none. Will you circle back?

STROMMEN: Yes. I'll be right here.

HARDIN: Wonderful. Thank you.

STROMMEN: Thanks.

HARDIN: Proponents for LB312. Welcome.

KRIS ROHDE: Thank you.

HARDIN: I notice your pin says "CRNA" and--

KRIS ROHDE: Yes.

HARDIN: --not "anesthetist."

KRIS ROHDE: It is much easier to say CRNA, so you may absolutely call us that. That is fine.

HARDIN: Thank you.

KRIS ROHDE: Good afternoon, Senator Hardin, and members of the Health and Human Services Committee. I-- my name is Kris Rohde, K-r-i-s R-o-h-d-e. I'm here today to support the amendment for LB312 to include certified registered nurse anesthetists-- or CRNAs-- for student loan repayment assistance. I have been practicing as a CRNA for nearly 15 years, and I currently practice at Memorial Community Hospital and Health System, which is a critical-access hospital in Blair. As a CRNA in a rural facility, I am responsible for providing anesthesia for all patients undergoing both surgical and non-surgical procedures, labor and delivery, and providing assistance throughout the hospital, including stabilizing patients in the emergency department if needed. As one of two CRNAs, the responsibility we have to provide anesthesia care as well as backup throughout the hospital can be daunting. It is very important that we have the right people in place. This is standard for CRNA-- CRNAs across the state, especially

those who practice in the rural setting. CRNAs are the only anesthesia provider in rural Nebraska, and they have been the only anesthesia provider in those areas since these facilities have opened. By allowing CRNAs to be part of this legislation, it can only help ensure there is always anesthesia available. As you all know, we are facing a shortage of health care professionals everywhere. But in the rural hospitals, the ability or inability to recruit could be the difference between keeping the doors open and closing permanently. The health care deserts are real, and they are a very frightening possibility for many hospitals across the state. Many hospitals rely on travelers or locums, which are temporary staff to keep them running. This includes CRNAs. The increased cost to our hospitals to hire temporary staff is extensive, and I worry that no health system can maintain that for long. So, I believe if we could recruit CRNAs to rural facilities, they would become invested in the community, and may end up staying for-- there for most, if not all, of their career as a nurse anesthetist. By adding us to LB312, it would help with recruitment, and eventually, retention. When I graduated in 2010, there were no hospitals offering loan repayment in Nebraska, and my decision to practice in an urban setting would have been different if I had the option to receive some financial assistance. This will be a great opportunity for our students as well as our hospitals to offer loan repayment. It will help the hospitals stay open, generate revenue from procedures, and offer anesthesia care close to home for the residents of these areas. It would also help bring new professionals and their families to these communities, and by the time their commitment to the hospital is up, they will become invested in these towns, schools and businesses. Thank you for your time, and please consider adding CRNAs to the Rural Health Systems and Professional Incentives Act in LB312.

HARDIN: Questions? Senator Quick.

QUICK: Thank you, Chairman Hardin. And thank you for being here.

KRIS ROHDE: Yes.

QUICK: So, like, I'm-- so, to become a nurse "anethetist"-- "anessis"--

KRIS ROHDE: Just say-- you can just say CRNA.

QUICK: Yeah. You first have to work as a nurse, and then you go forward to become that? Or--

KRIS ROHDE: Yes. So, to become a nurse anesthetist, you have to work in a critical care area, which is usually the ICU for at least two years. That's what we would prefer. So, most of these nurses have come from larger facilities just to get ICU experience.

QUICK: OK. Thank you.

KRIS ROHDE: So, two years there, and then they apply, and then grad school.

QUICK: All right. Thank you.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here,--

KRIS ROHDE: Yes.

FREDRICKSON: --and for your testimony. It's good to see you. One, one part of your "testimee"-- testimony that stood out-- I want to make sure I heard that correctly. So, you said oftentimes in rural parts of the state, CRNAs are the only anesthesia providers. Is that, is that correct?

KRIS ROHDE: Yes. Yes. So, the urban centers would include Omaha, Lincoln, Grand Island, Kearney, Norfolk, Hastings, Scottsbluff. That's where they do have some anesthesiologists. But any facility outside of those towns or cities, it's only nurse anesthetists.

FREDRICKSON: OK. Thank you.

KRIS ROHDE: Mm-hmm.

HARDIN: So a doctor-- a medical doctor is a medical doctor. You're an RN; you have experience as an RN. Can you differentiate the education that happens after that, between what CRNAs earn versus what a medical doctor earns, as far as the piece of anesthesiology goes?

KRIS ROHDE: Yes. So we have hands-on experience, obviously, as a nurse, practicing at the bedside in the critical care area. So, possible-- let's just say the average is two years. So, after you've practiced for two years-- sorry, let me go back. You have your BSN, so you have your bachelor's degree in nursing first; then, it's two years of critical care experience, hands-on experience; then, it's three years in grad school. And in those three years-- generally, the first

two semesters are just classroom, so just didactic. And then, you start having a few days in the OR initially, and then, by the middle of that third semester, you're full-time clinical. And so, pretty much, it's about two years of full-time clinicals; of just using what you've learned in the classroom, doing hands on anesthesia care. You're in the OR, working alongside nurse anesthetists or an anesthesiologist getting that training. Now, since I'm not a medical doctor, I can't be exact in, like, what their training is, but they have their bachelor's degree, and then they apply to med school and they go to four years of medical school. And then, they apply for their residency, and they have a three-year residency in anesthesia. So, in medical school, that's their, like, general medical knowledge, where they study all sorts of different things, and then they kind of, from that point, pick and choose what they enjoy the most. And so then, they hone in on just anesthesia and clinicals for the foll-- the last few years of their residency program. So, they are considered medical doctors because they went to med school and learned how to do anesthesia, and we are nurses that learn how to do anesthesia in grad school, and we end up being able to do the exact same thing. Now, depending on the hospital facility, you may have different roles, or-- I'm just-- sometimes, we are restricted to doing things because they have a residency program-- for example, at the med center where I've worked the last ten-and-a-half years-- we did not do open-hearts, livers and lung transplants, because we have a residency that they then go to a fellowship to get fully trained. So, those numbers are taken up by the residents and their fellows. So, the CRNAs do everything else.

HARDIN: Thank you. Senator Riepe.

RIEPE: Thank you, Chairman. And, good to see you again.

KRIS ROHDE: Good to see you.

RIEPE: Thanks for being here. I'm curious, how many designated health professional shortage areas are there in the state of Nebraska? You don't have to give me towns, I just-- is it 5, 10, 20?

KRIS ROHDE: Areas of the state?

RIEPE: Yeah. Of these designated health professional shortage areas.

KRIS ROHDE: I don't know that I have those numbers.

RIEPE: OK.

KRIS ROHDE: I mean, I believe that we are experiencing shortages across the state--

RIEPE: OK.

KRIS ROHDE: --in, in everything. It seems like-- yeah.

RIEPE: Well, yeah. We've experienced that. My second question would be-- is-- do most of these-- and I will assume the answer is yes, because you couldn't survive if you didn't practice in a regional group practice of anesthesia-- nurse anesthetist-- I mean, you can't, you can't survive solo.

KRIS ROHDE: No, you can. And we do.

RIEPE: You can?

KRIS ROHDE: Yes. We do have CRNAs who practice solo. It's a-- usually a smaller community that they provide the anesthesia care for either a specific hospital or a group of facilities that offer anesthesia services. So sometimes we do have solo providers.

RIEPE: How do you cover during mental health breaks for a vacation to go to the Caribbean or whatever?

KRIS ROHDE: So, we-- the temporary staff that I talked about, locums, usually the people who maybe live around there or they've been students there, or they just have a connection to that person, that CRNA who's already there-- they will reach out to the temporary people and ask them, "Can you cover while I go on vacation?" And there's usually a pretty good network of CRNAs within the state. We-- if we don't know them, someone-- we can find someone who does. And so, if they have an emergency or something like that, we have ways to get a hold of each other so that we can find coverage for that place.

RIEPE: So the standby ones, do they have to have a certain competency of repetitive cases? Because if they haven't done a case for six months, I would be quite concerned.

KRIS ROHDE: So, I haven't met a CRNA that hasn't done a case in a long time, unless they're retired. But in order to maintain our license, we have to have so many hours of anesthesia practiced, hands-on.

RIEPE: OK.

KRIS ROHDE: Yes.

RIEPE: My last-- final question, if I may, Chair, is are you required to have a cooperative relationship with a board-certified anesthesiologist?

KRIS ROHDE: No.

RIEPE: You are able to practice independent?

KRIS ROHDE: Correct. We opted out of physician supervision in 2002. So, we are trained to the full extent of our license. And the only thing that will restrict your practice is possibly the hospital policies and bylaws where you practice, with the group that you join, or-- you know, like I said, the med center, we don't do open-hearts, liver transplants, lung transplants. So, you're only restricted by the place where you work.

RIEPE: And by your liability premiums.

KRIS ROHDE: True. Yes. And we all do carry malpractice insurance.

RIEPE: That's comforting. For the trial attorneys. Thank you, Chairman.

HARDIN: Senator Quick.

QUICK: Thank you, Chairman Hardin. And one of my questions is-- so, my wife is a registered nurse, but she's labor and delivery, and she has to have a certification to work in that area, too. So, how does that certification work for you, then? Is it-- is it same process, or?

KRIS ROHDE: Similar, yeah. So, all nurses-- we still have to maintain our nursing license. So, you have certain criteria that you have to meet. Now, luckily for us, with our continuing education that we get every year, it doubles for our nursing license. But yes, we also have to-- we have a credentialing board, and we have to re-credential every few years to make sure that you're up to date on the current standards of practice, new research, things like that. So, yes, you do have to maintain that as well.

QUICK: OK. Thank you.

HARDIN: Senator Meyer.

MEYER: Thank you, Mr. Chairman. Probably less about a question, but, but just something to add to the conversation. I actually have a family member that's a nurse practitioner working in a rural community. And rather than regions, they kind of look-- identify as counties in general. And so, it, it doesn't have to be-- you, you can have-- as an example, you may have a county relatively close to an urban area that is considered a, a health care desert for lack of a better word. And so, my daughter does work in a-- in an area such as that. And it is advantageous. Number one, she likes the rural area, she's from a rural area, and also, it, it helps tremendously to have this opportunity to attract people to those areas. We talk a great deal about trying to provide medical services in our underserved communities, and here is a, a great opportunity to, to advance that, quite frankly. And, and something that I think we're-- it's in critical need in our rural communities especially, so. I also had a family member that was a nurse "anesthecist" and I'm not going to say it again, and, and, and-- but he worked more in urban areas, but-- so I got a good deal of familiarity in, in that part-- that part of it. And as you described, as he worked in the communities he worked in, that was exactly the position he was in, working in multiple hospitals and, and multiple communities. So, it's a very valuable service that you make.

KRIS ROHDE: Thank you.

HARDIN: Other questions? Seeing none. Thank you.

KRIS ROHDE: Thank you.

HARDIN: Proponents, LB312. Welcome.

BRIELLE STUTZMAN: Good afternoon, Chairman Hardin, and the members of the HHS Committee. My name is Brielle Stutzman, B-r-i-e-l-l-e S-t-u-t-z-m-a-n, a registered nurse and currently a student at Bryan College of Health Sciences in the Doctorate of Nurse Anesthesia program. I stand here-- sit here-- today asking for your support of LB312. And thank you, Senator Strommen, for your introduction. This bill will help improve health care for the people of Greater Nebraska. I grew up in Arapaho, out in south central Nebraska, graduated from Bryan with my bachelor's in nursing, and accepted a job at Bryan in the ICU/ER flow pool. I worked there for a couple of years before working at Phelps Memorial Health Center in Holdrege, Nebraska, to be closer to home. At this facility, I came to realize how crucial CRNAs are in the critical-access hospitals. I worked in the emergency

department alongside a physician, a physician's assistant, or an advanced practice registered nurse, and though were-- there were doctors available, this was my primary team. I was caring for a patient one evening who was quickly taking a turn for the worse and needed to be transferred. It's imperative for patients to have intravascular access, especially for a transfer, in order to give them rescue medications. And we were unable to get access. Typically, at Bryan, I'd call the intravascular access team for help. But in Holdrege, the resources and personnel are limited. I had to call in the CRNA, who placed a difficult line in the patient's neck so he could safely be transferred to a higher level of care facility. I often think about what I would have done if there was not a CRNA available. What would have happened to that patient, or patients in the future? This is one of the many examples as to why CRNAs are essential in Greater Nebraska. LB312 has the opportunity to entice CRNAs to rural settings and keep them there. My experience in Holdrege was my motivation to continue my education towards an advanced practice. However, it's relevant to note the CRNA who assisted me in Holdrege was a locum, sometimes referred to a trap-- as a traveler, or a 1099 provider. Locums come to hospitals for short periods of time to fill gaps at the core staff. Rural hospitals specifically experience "extential" financial strain to hire locums, and the sad reality is most rural hospitals rely on locums. LB312 would incentivize CRNAs to strongly consider rural health care by providing student loan repayment assistance. Rural health cares could attract more core staff, CRNAs, and reduce the need for locums. Eliminating locums would provide relief of financial burdens for critical-access hospitals. Please give your rural constituents the same opportunities for life-saving procedures as urban citizens by supporting LB312. Thank you for your time and consideration.

HARDIN: Thank you. Questions? How much does it cost to become one of these?

BRIELLE STUTZMAN: Great question.

HARDIN: Not, not including the RN degree. But you're, you're in the middle of it. So, you wake up at 2:37 in the morning and you're thinking, oh my gosh. What, what's it cost?

BRIELLE STUTZMAN: So without all of our other expenses, strictly school is roughly $90,000.

HARDIN: For the whole package?

BRIELLE STUTZMAN: Correct.

HARDIN: OK. So, $15,000 a year helps?

BRIELLE STUTZMAN: I would say so.

HARDIN: OK. All right. Just trying to get a scope of, of what this--

BRIELLE STUTZMAN: Sure. Many of us have house payments, and a lot of them have children and other expenses, too, so.

HARDIN: I've heard this described as the best kept medical secret for a profession out there. And-- would you agree?

BRIELLE STUTZMAN: I would agree. But it's a running joke now that it's been kept secret too long, that there's a shortage. So.

HARDIN: Ah. OK. Scarcity.

BRIELLE STUTZMAN: Sure. Yes.

HARDIN: OK. Very good. Senator Meyer.

MEYER: If I may. Thank you. Just a question. Are you aware of any federal program that's matching, similar to the state program?

BRIELLE STUTZMAN: I am not, however--

MEYER: It might be something to investigate.

BRIELLE STUTZMAN: OK.

MEYER: Just, just a suggestion.

BRIELLE STUTZMAN: Sure. Thank you.

HARDIN: Senator Quick.

QUICK: Thank you, Chairman Hardin. And-- I just wanted to ask. You know, so, you have to work as a nurse first. Do you think that that training and education to be a nurse was vital to becoming a CRNA? [INAUDIBLE]

BRIELLE STUTZMAN: I do. The-- there is a requirement to working in the ICUs for-- they prefer two years, but some have less. And that experience there is probably as close as you can get to the CRNA

experience. It is much different, I will say. And if you ask any nurse, they will say you could work ten years in the ICU and you still may not be prepared for work as a CRNA, just because the scope is so much broader.

QUICK: Thank you.

BRIELLE STUTZMAN: It's very-- it was very helpful for me, as of now, I will say.

QUICK: Yeah. Thank you.

BRIELLE STUTZMAN: Yeah. Thank you.

HARDIN: Other questions? Seeing none. Thank you.

BRIELLE STUTZMAN: Thank you.

HARDIN: Proponent to LB312.

SHAYLA STEENSON: Hi.

HARDIN: Welcome.

SHAYLA STEENSON: Good afternoon, Chairman Hardin, and members of the Health and Human Services Committee. My name is Shayla Steenson, S-h-a-y-l-a S-t-e-e-n-s-o-n. I'm here today to speak in support of LB312, and to advocate for CRNAs dedicated to serving Greater Nebraska. Before I continue, I just want to thank Senator Strommen for introducing this bill. I'm a registered nurse currently enrolled in the Doctor of Nurse Anesthesia Practice Program at Bryan Health College. To help illustrate the significance of this bill and its potential to impact rural health care, I'd like to share why I'm personally invested in this cause. I come from a large family with rural roots in Greeley and Wolbach. Everyone I care about lives in rural Nebraska. Having a family in these communities-- including my father, who's a volunteer first responder-- I've witnessed firsthand how vital small town health care teams are. The first stop for a patient experiencing a medical emergency in rural areas is often a critical-access center, and can be the key to saving lives before they reach larger hospitals. So, not only is it imperative to have those volunteers to get them there, but having an adequate team wait-- waiting for them when they arrive can make all the difference. In Lexington and Holdrege in particular, during the pandemic, I witnessed CRNAs stepping up to fill critical gaps, ensuring that patients

received the care they needed despite limited resources. Larger hospitals were to-- forced to divert patients due to no open beds during that time, making rural health care provider-- providers even more essential. And although there were no elective surgeries for a time, the CRNAs in small communities did not slow down. This versatility and dedication is exactly why being a CRNA serving rural Nebraska is so attractive to me. All of that paints a wonderful picture of how I see my career progressing. However, at the end of the day, when I graduate, I know the amount of debt I will have to face, and I know I'm going to have to take my finances into consideration when I choose where to land a job. While CRNAs earn competitive salaries, the burden of student loan debt due to the advanced degrees required are often in the six-figure range, accompanied by interest rates continuing to climb as I continue to study. Thinking about this can be overwhelming, especially for those of us wanting to work in rural communities where the health care systems can't always compete with urban areas in terms of salary and resources. In Greater Nebraska, there aren't large teams of CRNAs; in many places, there are just a few, if that, who give 110%, often choosing to work in these smaller towns rather than moving to Omaha or Lincoln, where they could have better hours and benefits. Despite the challenges, these providers continue to serve their communities with everything they have. When I graduate, I want to be able to serve these communities, ensuring that they have access to the care they deserve, and I know I'm not alone in this. Therefore, I urge you to support this bill, to support those of us who want to make our hometowns a safer place for people to stay and come back to. Thank you for your time.

HARDIN: Questions?

BALLARD: I do.

HARDIN: Senator Ballard.

BALLARD: Thank you, Chair. Thank you for being here. Thank you for your testimony. Among your colleagues at Bryan Health College, are, are-- most of them that would enter this program, are-- do they come from rural communities? Or, is it possible to get-- that want to go back to rural, from rural communities-- is it possible to get some folks from either Lincoln or Omaha to, to work their way out to rural Nebraska?

SHAYLA STEENSON: I think it would be, especially-- I know there's a couple that have lived in urban areas all their life, but whoever they

have married now is from a rural area, so they're looking into it. The things that they're looking at, though, is the difference in incentives. Like, right now, it's just not-- I mean, we get presentations from all the hospitals around, telling, telling us their packages and things like that. One thing, the rural communities only have, like, two CRNAs sometimes, and they can't make that trip out to come try to get us to come there. And then, second of all, their packages, when we do find them out, aren't as good. So it's just-- I think that if you had more incentive, people would make that decision.

BALLARD: OK. Thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you. My question would be this-- and thank you for being here. Would-- are most of the new nurses just looking to be employees of the hospital, or, or to be independent contractors?

SHAYLA STEENSON: I think now, since we've all experienced the discrepancy between a traveler and a core staff member in nursing, we experienced this-- like, the same thing, the pay difference; I think now, we see it as more-- it's going to become an issue. Like, the hospitals can't sustain that forever. So, we do want to be core staff. But the discrepancy is so big that if you're looking at this pile of loan debt, that's pretty attractive.

RIEPE: So, you'd rather be an independent contractor.

SHAYLA STEENSON: It's also a lot of paperwork, and I don't know if I want to do that, but--

RIEPE: OK. OK. Fair. Thank you.

HARDIN: Other questions? Thank you. LB312, proponents. Welcome.

LAUREN STAUFFER: Hello. Good afternoon. Thank you, Senator Strommen, Chairman Harman [SIC] and members of the HHS. My name is Lauren Stauffer, L-a-u-r-e-n S-t-a-u-f-f-e-r. I'm a registered nurse currently at the new Bryan College of Health Sciences CRNA program. I sit before you today to highlight the critical need of supporting LB312 and CRNAs that dedicate themselves to providing care to Greater Nebraska. To demonstrate the urgency of this cause, I want to share the foundation of my beliefs. As a new nurse, I began my career in a high-risk labor and delivery unit in a large city. I was amazed at the level of care that we could provide with the abundance of resources

and the specialists that we had available. However, I just had this undeniable aspiration to serve the smaller communities where I came from. There, I experienced something truly special: a sense of unity. One conversation in particular that solidified my path-- after an incredibly tragic patient event that turned successful, a physician told me: People think that it's so high-risk to work in these big facilities that have things, but it's high-risk to work in these small communities where you don't have things, and you have to use your brain, and you have to think about what you're going to do next. What-- how many, how many packs of red blood cells do I have? Do I have anything that can support me in these times? Or do I not? And what decisions do I make, because I don't have anything? That's high-risk. It's not as high-risk to have everything that you need when you need it. And I just thought that that was so important, because it was a-- it just opened my eyes to see that the high-risk and the acuity that is needed out in these critical-access hospitals is so important. That statement resonated deeply with me, fueling my desire to serve rural communities. The further I moved from high-resource hospitals, the more I realized the central role that smaller facilities play, and how imperative it is to keep them open. More importantly, I recognized the need to invest in these hospitals and the people who provide care there. We ensure that intelligent, driven providers choose to serve in these areas. Without them, lives would be lost before patients could even reach a larger facility. Imagine a mom in labor, unable to reach the hospital in time. A child choking, needing immediate intervention. A trauma patient requiring stabilization before transport. These facilities are not just important, they're life-saving. That is why we must actively support initiatives like LB312 and help these CRNAs come to critical locations like this. This is not just about career opportunities; it's about commitment. Commitment to the mom in labor, the child struggling to breathe, and the accident victim who needs immediate care. Commitment to ensuring that every Nebraskan, no matter where they live, has access to safe, high-quality medical care. Help us get there, and help us keep you safe. Thank you.

HARDIN: Thank you. So you're saying that rural CRNAs need to be MacGyver?

LAUREN STAUFFER: Yeah.

HARDIN: OK.

LAUREN STAUFFER: They have to be prepared, because--

HARDIN: They have to be prepared.

LAUREN STAUFFER: --anything can come in.

HARDIN: You may have to do more with less.

LAUREN STAUFFER: Yeah, exactly.

HARDIN: OK. Questions? Senator Riepe.

RIEPE: Thank you. I think you told me earlier today you're here from Kansas.

LAUREN STAUFFER: I am, yes.

RIEPE: Goody for you. What made you come to Nebraska? Was it another reason, or did you come here specifically for this particular training program?

LAUREN STAUFFER: So, I had the choice to go to KU and Bryan, thankfully, because I got into both programs. And I went to KU, and I just was not impressed with their program, and I really enjoyed Bryan and how they invested in rural communities, because I've been a rural nurse and I wanted to have experience in rural facilities like Bryan provides, and this gave me the opportunity to feel like if I did start out in a rural facility as a new graduate CRNA, I would be comfortable. And that's what secured my decision for going to Bryan.

RIEPE: So, were you from rural Kansas?

LAUREN STAUFFER: Yeah.

RIEPE: OK.

LAUREN STAUFFER: Are you familiar with Wichita area?

RIEPE: Yes.

LAUREN STAUFFER: So--

RIEPE: Relatives are--

LAUREN STAUFFER: --far-- a little bit further from Wichita, out in those smaller communities surrounding.

RIEPE: Came here. Very good. Thank you, Chairman.

HARDIN: This is by far the best testifier. This is just proof that Nebraska is getting it done.

RIEPE: One by one.

HARDIN: One by one. Thank you. Appreciate it. Thanks. Proponents, LB312. Welcome.

CALEB RICE: Thank you. Good afternoon, Chairman Hardin, and members of the DHHS [SIC]. My name is Caleb Rice, C-a-l-e-b R-i-c-e, and I'd like to thank Senator Strommen for introducing this bill. I'm a registered nurse, currently enrolled in Bryan College of Health Sciences, to pursue my education to become a certified registered nurse anesthetist. I'm honored to speak to you today as I urge you to support the amended LB312 to include CRNAs among the professionals who can benefit from this vital bill. I was born and raised in rural Nebraska; it's a place I'm plowed to-- proud to call home, and it's here that my journey towards becoming a CRNA began, and my experiences with CRNAs are what inspired me to pursue this career in health care and give back to the communities that shaped me. I strongly believe that adding CRNAs to LB312 would improve the health care system in rural Nebraska in two significant ways. First, through my own personal experiences as a patient in rural Nebraska, they highlighted the critical role that CRNAs play in providing high-quality care in emergency situations. When I was 16 years old, I was involved in a serious car accident north of Cozad, Nebraska during the late winter. I was transported to Cozad Community Hospital, where I was in hypothermia shock and in urgent need of medical attention. It was the combined efforts of the emergency room staff, physicians, and the CRNA on duty that saved my life. The CRNA used an ultrasound-guided I.V. to stabilize me when my veins were difficult to access due to my dangerously low blood pressure. Without their expertise, I can only imagine how different the outcome would have been. This experience, along with other hospitalizations in rural areas, showed me the vital role that CRNAs play in ensuring the health and safety of Nebraskans in less populated areas. CRNAs are essential for trauma care, routine surgeries, and maternal care in rural Nebraska. This is something that LB312 already aims to strengthen for the critical persons receiving pregnancy- and emergency-related care. By amending this bill, the CRNA inclusion will ensure that these communities continue to have access to life-saving care and potentially preventing hundreds of deaths annually. Second, the inclusion of CRNAs in LB312 will spur more providers into rural Nebraska, addressing the shortage of health care professionals in these communities. CRNAs often go unnoticed in their

expertise until their need is exposed during life-threatening situations. Witnessing their work is what inspired me to pursue a career and give back to underserved areas. The funding provided by LB312 would serve as a powerful incentive for CRNAs-- many of whom have never considered working in rural Nebraska-- to relocate to these communities. Larger urban hospitals have-- can offer bonuses and loan forgiveness due to their revenue, but LB312 can surprise-- provide a similar extrinsic motivator for CRNAs to contribute to the health care needs of rural Nebraskans. As we pursue our education, CRNAs take on a significant student loan debt, and the support of LB312 would alleviate some of that financial burden. As we all know, rural Nebraskans face a shortage of health care providers. And with your help in LB312, we have the opportunity to bring CRNAs into these communities. Thank you for your time. Any questions?

HARDIN: Thank you. Questions? You have a unique perspective on how you decided to make this career choice.

CALEB RICE: It worked its way to me.

HARDIN: Nice. It found you.

CALEB RICE: Mm-hmm. A good kept secret found me, so.

HARDIN: Thank you so much for that perspective. We appreciate it.

CALEB RICE: Thanks.

HARDIN: Proponents, LB312. Welcome.

SHARON HADENFELDT: Hello, Chair Hardin. My name is Sharon Hadenfeldt, S-h-a-r-o-n H-a-d-e-n-f-e-l-d-t. I'm a certified registered nurse anesthetist, and I'm here on behalf of the Nebraska Association of Nurse Anesthetists, of which I am the Vice President, in support of LB312. CRNAs are vital to rural hospitals and the communities they serve, and this bill will encourage CRNA graduates to seek employment in these hospitals. I'm the program director for the Bryan College of Health Sciences Doctor of Nurse Anesthesia Practice Program, though I am not here on behalf of Bryan today. I'm going to briefly describe the path an individual must take to become a CRNA. The first step is earning a bachelor's degree and becoming a registered nurse. ICU experience as an RN is required in order to apply to the CRNA program, with most applicants having two to five years of ICU experience. The CRNA program is three years of full-time doctoral study. The program requirements are heavy, with students required to commit more than 40

hours a week to classroom and clinical study. This does not permit students to work. The average cost of attendance is $70,000 a year; this includes the cost of tuition, living expenses, or other expenses such as travel to clinical sites for clinical rotations. Our program has 34 clinical sites throughout the state, including 13 Nebraska critical-access hospitals. Every student is required to complete at least one critical-access rotation, with some completing several rural rotations. In the past three years, 15 of our graduates have taken rural positions, and we feel this is partly due to the exposure during their education. While becoming a CRNA requires a strong commitment from all students, students from rural Nebraska may have extra expenses. A rural student's family may remain in their home community while the student completes the program. Housing while attending class, extra travel time, and additional child care expenses are a few examples. These students are committed to rural Nebraska, and will greatly benefit from LB312. The typical graduate has greater than $200,000 in student loans at graduation. I often speak with applicants about the reality of this debt. I share that CRNAs are in high demand, with plentiful job opportunities. Our students are recruited by employers from their rural-- from the first year in the program. When considering their employment opportunities, the ability to repay their student loan is top-of-mind. LB312 will assist Nebraska critical-access hospitals in attracting these graduates in a competitive CRNA job market. Thank you.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you. I'm taking [INAUDIBLE]-- I want to make sure I heard this right. You said the, the costs, fundamentally-- not living costs, but $70,000 a year?

SHARON HADENFELDT: So, cost of attendance is figured by our financial aid office, and that does include living expenses. It, it is a formula for living expenses, and it does take in account whether the student has a family or not.

RIEPE: But it-- I'm going to put him in an embarrassing situation, but one of our committee members, Senator Fredrickson, is a Colombia graduate, which is an elite East Coast school, and tuition was probably about $70,000. Is that right? I'm embarrassing you, but--

FREDRICKSON: Is, is he allowed to ask, Chair? Can I answer the fellow committee member? Yeah, but I would-- graduate school is probably around $65,000.

RIEPE: 55?

FREDRICKSON: 65.

RIEPE: 65.

FREDRICKSON: Something like that. Paid the loan.

RIEPE: I would say this tuition is, is not on the light side. So, I would scold my friend Russ Gronewold for charging so much.

SHARON HADENFELDT: Well, the tuition isn't $70,000.

RIEPE: Oh, OK.

SHARON HADENFELDT: So the tuition is-- for the three years is about $90,000.

RIEPE: That's still a high price.

SHARON HADENFELDT: It's, it's a intensive program, and it cause-- it caught-- includes a lot of resources.

RIEPE: No comment.

HARDIN: Miss Hadenfeldt, recruit me now.

SHARON HADENFELDT: OK.

HARDIN: I would like to be a CRNA. What might I make, as a seasoned CRNA? I get it, I've got to become an RN, and I have to be a good RN for some period of time. But once I get out into the field, how much, how much money can I make?

SHARON HADENFELDT: Well, I'd first ask you, ask you what your GPA is. That's--

HARDIN: It's astonishing high.

SHARON HADENFELDT: All right. Well, in, in Nebraska, it's probably somewhere between $200,000 and $250,000, depending on how many weekends, holidays, nights, how much overtime.

HARDIN: OK. Gotcha. And I would imagine that you have the gold standard program in the state of Nebraska. So much so that it's magnetic for people from places like Kansas. OK. Thank you. Any other

questions? OK. Thank you. Proponents, LB312. Proponents? Opponents, LB312. Those in the neutral? Senator Strommen. We had, online, 68 proponents, 0 opponents, 0 in the neutral.

STROMMEN: Who, who would oppose this? I mean--

HARDIN: Who would oppose this? My goodness.

STROMMEN: --after speaking with these folks behind me, who--

HARDIN: That's right.

STROMMEN: --who would dare oppose? So I just wanted to touch on-- Senator Riepe had a question earlier. Primary care, at least 91 of Nebraska's 93 counties have a primary care shortage in at least one specialty. So, I just wanted to answer that question.

RIEPE: But do nurse anesthetists qualify as primary care?

STROMMEN: I guess you would have to figure that out.

RIEPE: Did you ask Dr. Ken [PHONETIC] back there?

STROMMEN: Yeah. So, I think, I think that we can all recognize how important this is for rural health care, and just how significant it would be for the folks that are trying to train themselves up, to help our rural communities out. I don't really have much else on this. If you guys have any other further questions, feel-- please feel free to ask. If not, just have a great afternoon.

HARDIN: A correction of mine, Senator Riepe. It's a combination of General, Cash and federal. Bryson has done a wonderful job of circling that in. So, it's a combination of those three sources.

RIEPE: What were the three sources again?

HARDIN: General, Cash, and federal.

RIEPE: OK.

HARDIN: So. Senator Hansen.

HANSEN: Thank you. And if you can't answer this, maybe someone behind you can. How do we know the Rural Health Systems and Professional Incentive Act is working?

STROMMEN: Say, say again?

HANSEN: How do we know the Rural Health Systems and Professional Incentive Act is even working? Like, how do we know the money we're, we're investing is working, and people are staying? Like, longer than three years, or longer than five years? Like, do we have any data on that?

STROMMEN: Oh, [INAUDIBLE] I guess would be the-- what's-- how do we know that they're staying in those communities?

HANSEN: Yeah. So, we give somebody $15,000 to come here for three years, and after three years they leave. After they got the money. Or are they staying for, like, 15 years? Do we have any data on that at all? Or maybe the students--

STROMMEN: I, I don't, I don't have any data on that. I, I could-- I can speak to the fact that having them just for three years is unbelievably helpful.

HANSEN: Yes. And I agree with you on that.

STROMMEN: So, so, so the fact that they're there for that short period of time-- and for some people, three years might be a long period of time. But if they're there for that period of time, it does help, help those rural communities out. And the hope, obviously, is that they're going to stay longer. I don't have the data on that, but I'm sure that I could find it.

HANSEN: Yeah, just curious.

STROMMEN: Or at least try and find it.

HANSEN: It makes sense to me, [INAUDIBLE] that we have it. And I like your bill. I'm just trying to figure out--

STROMMEN: Yeah.

HANSEN: --for the taxpayer, is it doing what it's intended to do? Keeping them longer.

HARDIN: Senator Riepe?

RIEPE: Senator, would you pledge that if any were not married, that you would help them to find a local boyfriend or a girlfriend?

STROMMEN: Yes.

RIEPE: You would pledge to that?

STROMMEN: I-- there's plenty of folks in western Nebraska that would be more than happy to step up to that.

RIEPE: OK, we're going to hold you to it. Thank you, Chair.

HARDIN: Thank you. Senator Meyer?

MEYER: Thank you, Mr. Chairman. You know, it's a difficult question Senator Hansen asked, whether there had been continuity after someone had spent three years in rural communities. But part of it is they're getting involved in a rural community, perhaps their life starts in a rural community. Once again, having a, having a family member that is in a rural community and, and having the benefit of this particular program. One thing it will do, if you draw people to a rural community in a health, health situation, you draw other people in with similar skills, and pretty soon you may have what would be an underserved community a much better-served community, and you help much, much broader surroundings. So, I would rather see the opportunity to have someone come to a rural community even for three years and provide those services than not have them at all, quite frankly.

STROMMEN: Yes.

MEYER: Once again, I don't mean to testify, but, but the personal experience and, and having seen that in Iowa and in Nebraska-- Iowa has a similar program-- I have seen the benefit of it, and actually the attraction of people to communities that make a greater, a greater footprint-- medical footprint in those communities, quite frankly. And-- so. Don't mean to testify, but, but I, I think it's, it's something well worth trying.

HARDIN: Well, thank you.

STROMMEN: Thank you.

HARDIN: Appreciate you being here.

STROMMEN: Appreciate it.

HARDIN: This would conclude LB312 for the day.

STROMMEN: Have a great day.

MEYER: You can get me my $20 later, Paul. OK, thanks.

HARDIN: Next up, LB257. We'll wait a moment for the room to transition over, and then Senator Quick. We all have to stop having fun now. We all have to get very serious. Senator Quick, LB257.

QUICK: Thank you, Chairman Hardin, and members of the Health and Human Services Committee. I am Dan Quick, D-a-n Q-u-i-c-k, and I represent District 35 in Grand Island. And I'm here today to introduce LB257. The purpose of LB257 is to adopt a way for marriage and family therapists who have a valid and unrestricted license in another state to become licensed as an MFT in Nebraska. This legislation improves licensure portability for MFTs by removing unnecessary requirements that hinder the ability of MFTs licensed in other states from obtaining, obtaining a license in Nebraska. The amendment I passed out adds language to further clarify the Americas-- American Association for Marriage and Family Therapy's-- AAMFT's-- goal to encourage license portability. Currently, the licensure process for MFTs is disjointed among states. For context, if a licensed marriage and family therapist moves to another state, they will likely have to take the same classes they already took, or complete additional hours of supervision in order to be licensed in their state. The AAMFT has developed a model for license portability that promotes more objective, objective dealing and standardized between states. This policy and bill propose that a full and unrestricted license shall be issued to an applicant to practice in Nebraska as an MFT if they have a valid and unrestricted license to practice as an MFT in another state, have completed an application for licensure and paid any required fees, and has passed the Nebraska jurisprudence examination. In 2023 and 2024, 13 states adopted the model portability law or modified their portability/reciprocity laws to match AAMFT's model policy, including border states of Iowa and Kansas. Ten other states are looking to introduce legislation to encourage MFT portability. If you are a licensed, licensed MFT in another state and in a good standing, then you should be able to move to Nebraska without taking extra steps to get licensed. LB257 would attract additional therapeutic talent to Nebraska and address the mental health professional shortage in our state. Thank you, and I would appreciate the committee's vote to advance the bill to General File. There are testifiers with personal experience who are coming after me, who will be better equipped to answer how impactful adopting this policy would

be. But I'm happy to answer any questions that you may have at this time.

HARDIN: Thank you. Questions? Do you have a sense, Senator Quick, what the-- some of the other ten states are? I think you mentioned Kansas and Iowa. Is that right? In terms of where some of that reciprocity already--

QUICK: Yeah, some of the states-- you want to know what are some of the other states that are--

HARDIN: Curious.

QUICK: Yes. So, we have Alaska, Delaware, Idaho, Indiana, Kansas, Utah, Illinois, Georgia, Arizona, Iowa, Tennessee, Maryland and Virginia.

HARDIN: OK.

QUICK: Yeah. And then there's-- the other-- oh, you want the-- you want to know the ten states that are looking at it.

HARDIN: Curious.

QUICK: I'm sorry. Yeah, the ten states are Arkansas, Michigan, Kentucky, Pennsylvania, Connecticut, Nevada, North Carolina, Texas, and Washington, Washington, Washington, D.C., and Nebraska.

HARDIN: OK. Thank you. Appreciate that.

QUICK: Yeah.

HARDIN: You'll stick around?

QUICK: I will.

HARDIN: All right. Thank you. Proponents, LB257. Welcome.

ANNE BUETTNER: Thank you. OK. Good afternoon, Chair Hardin, Vice Chair Fredrickson, and committee members. I am Anne Buettner, A-n-n-e B-u-e-t-t-n-e-r. I'm the legislative chair of Nebraska Association for Marriage and Family Therapy. Marriage and family therapists are mental health clinicians who specialize in marriage and family therapy, and a majority of us in Nebraska are licensed independent mental health practitioners. Licensure portability is the ability to take an individual's qualification for licensure in one state and apply them

to another state. So, for our discipline, the process has been disjointed and inconsistent across the states, mainly due to a widespread policy started in older days that-- of only approving applicants who prove their qualifications to be substantially equivalent, substantially equivalent to the requirements of the state they are applying. So, in theory, the substantially equivalent model seems logical, but in practice, it is very inconsistent and creates barriers, simply because it is subjective. So, consequently, there are many licensed marriage and family therapists in good standing for many years have to take same classes over again, or even have more supervision-- supervised hours. Now, our national association created a model who has objectivity and standardization, and it is called a full endorsement model, just like what Senator Quick had said. You know, I won't repeat. 15 states have already embraced it, and now 10 states are looking into it. And that colorful map at your handout is self-explanatory. OK? Now, in Nebraska, we do have a provider shortage. And 2-- 2024 Mental Health (in) America Report is a national study-- ranked Nebraska as 24th in the country for provider coverage, meaning that 330 residents-- the ratio, 330 versus one mental health provider. Now this can be any discipline, you know. So, we are living in an increasingly mobile and global world, needless to say. A therapist needs to be-- needs to abide by the laws where the client, the patient, resides. So, simple as following the client-- I mean, we have widespread use of telehealth, you know, be it taking vacation from Nebraska to Florida, and so on. So, the final message is, is that licensure-- streamline-- streamlining the licensure processes is necessary for marriage and family therapists. Any questions?

HARDIN: Thank you.

ANNE BUETTNER: OK.

HARDIN: It's interesting to me, because we use the word compact a lot--

ANNE BUETTNER: Yes.

HARDIN: --in this world; we use reciprocity at times, we use the word portability at times, and so this sounds like it would make--

ANNE BUETTNER: Let me explain the differences. Will you, sir?

HARDIN: Please, take it away.

ANNE BUETTNER: OK. Reciprocity is a subset of portability. Portability is up here, overarching.

HARDIN: OK.

ANNE BUETTNER: OK? It's just, like, how I defined it. Taking an individual's qualification for licensure in one state and apply them to another state. That's the simple definition of portability. Interstate compact, like the professional counselors and the social workers that have passed there successfully--

HARDIN: Which almost no one fits. But keep going.

ANNE BUETTNER: OK. They-- that is a form of portability.

HARDIN: Yes.

ANNE BUETTNER: And when there is a compact, there is an agreement among those states. OK? We do not have agreement. We just-- each of us would try to-- would try to follow the full endorsement model so that we can transfer to each other. You do understand, when it comes to portability-- is, is a universal movement. Has to be. Intrinsically. Nature of the beast. Has to be a universal movement. Otherwise, what's the sound when one hand clapping? So, therefore, all of us are trying to achieve, you know, this full endorsement model. You can never get 50 states to do it, of course-- being realistic, of course. Actually, the nurses-- its considered in this nation as the most successful interstate compact because, because they have 34 states participating.

HARDIN: OK. Thank you. Questions? Seeing none. Thank you.

ANNE BUETTNER: OK. Thank you.

HARDIN: Proponents, LB257. Welcome.

ADRIAN MARTIN: Thank you. Good afternoon, Chairman Hardin, and members of the committee. My name is Adrian Martin, A-d-r-i-a-n M-a-r-t-i-n. I'm a licensed independent marriage and family therapist, an MFT. I graduated from the UNL MFT master's program some 20 years ago. I'm in private practice in Omaha, the past president of NAMFT, an approved supervisor with AAMFT, and I also sit on the state Board of Mental Health Practice. The purpose of this bill, LB257, is to streamline the process for marriage and family therapists licensed in other states to become licensed here in Nebraska. Whilst there is an existing provision in our regulations for licensing by reciprocity, it is

reliant on the applicant having credentials that are proven to be substantially equivalent to the Nebraska licensing requirements during the application process. This bill serves to simplify that process through license portability. MFTs undergo a robust training and professional development. We are unique in the mental health field, and the treatment is provided from a systemic perspective, working with the dynamics and influences of the couple, the family, the wider community, and society. Nebraska will benefit from having more MFTs to provide more systemic treatment. Taking a systemic perspective and zooming out, there is also a wider benefit to the portability initiative. AAMFT is spearheading the adoption of this MFT license portability model across the nation. As you heard from Anne, and from Senator Quick, so far, 13 other states have already modified their regulations, including two of our closer neighbors, Iowa and Kansas. Ten other states are in the process of doing so this year. This initiative will allow Nebraska licensed MFTs to more easily apply for licensure in those states that accept this model, removing the need to prove their education standards, possibly requiring additional coursework, or having to show equivalency in their post-graduation supervised practice. License portability increases the likelihood that when individuals and families currently in treatment move to another state, they can continue to work with their current marriage and family therapist remotely, without having to start over with a new provider. Personally, I have a highly specialized training in couples therapy, and I provide an unique, intensive approach that accelerates the repair of relationships. I have become licensed in several states outside of Nebraska because of the demand of that work, and I can say the ease in which becoming licensed by reciprocity varies greatly, and there is certainly room for improvement. The license portability model will ease that process. If the applicant's license is in good standing, the process should cut through all current layering and micro-checking for equivalency, which can be somewhat subjective and inconsistent. This bill would give us a standardized and objective process. Nebraska state legislators have already shown that they believe in mental health providers practicing across state lines by passing the interstate compact bills for the professional counselors and the social workers. I thank you for your time, and trust that you can see that this is a bill that benefits both Nebraska licensed marriage and family therapists, and also the citizens of Nebraska.

HARDIN: Thank you. Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for your testimony and being here. One question I had for you, sir. You had mentioned one of

the potential benefits of this is this-- there was a couple that was engaged with a provider that might move, for whatever reason, to a different state. So when, when you said it-- would that mean if they were seeing a provider here in Nebraska and they moved to another state, that state would all-- would have to be a part of the reciprocity agreement for them to have that continuity of care? Is that correct?

ADRIAN MARTIN: Yeah. So, the provider here would have to then apply by reciprocity for a license in the state where the client moves to.

FREDRICKSON: OK.

ADRIAN MARTIN: Yeah.

FREDRICKSON: OK.

ADRIAN MARTIN: And the hope is, by-- the more states that take on this initiative, the easier that process is going to be.

FREDRICKSON: OK. And so, how, how is that different today than it would be under this bill? So, if we were to pass this bill, how would that look versus-- like, what does it look like today? Can you help me understand the difference, there?

ADRIAN MARTIN: I mean, it's a bit of a, a lottery depending on which state they move to.

FREDRICKSON: OK.

ADRIAN MARTIN: In terms of-- you know, you could apply to a state, and they could have all sorts of requirements and certainly want to see kind of your licensure, what your education is, whether it meets, you know, their expectations and their own licensing standards. So, sometimes it can take quite a long time to, to be able to do that. And sometimes, it involves additional coursework and so on. The purpose of this is to make it much more seamless.

FREDRICKSON: Thank you.

HARDIN: How does this work? And so, I am a licensed marriage and family therapist in Iowa.

ADRIAN MARTIN: Uh-huh.

HARDIN: I come to my senses, and I move to Nebraska. Can I simply apply for my new resident license immediately and, and go to work? Or, do I need to essentially go through more training certifications? How does it function?

ADRIAN MARTIN: If we can pass this portability bill, then in essence, someone from Iowa can come in, submit their application, pay their money, pass the Nebraska jurisprudence exam, and then pretty seamlessly gain a Nebraska license.

HARDIN: OK.

ADRIAN MARTIN: That's the hope.

HARDIN: I see. Very well. Other questions? Seeing none. Thank you.

ADRIAN MARTIN: Thank you very much.

HARDIN: Proponents, LB257. Welcome.

HEIDI APPLEGARTH: Thank you. Chairman Hardin and members of the Health and Human Services Committee, thank you for having me today. My name is Heidi Applegarth; that's H-e-i-d-i A-p-p-l-e-g-a-r-t-h. I'm a provisionally licensed mental health practitioner in the field of marriage and family therapy. I graduated from UNL, and I'm a member of the state board here in Nebraska, but my credentials are far less important to me than my role as a wife and a mother of five children. Because I value family relationships so deeply, I've centered my career around strengthening other family relationships. Strong families are the core of strong communities. So, although I know a little of politics and law, I'm here today to advocate for the brave people who step into my office each day to better their lives and families. To give you a picture of what it's like for me and for my clients in therapy, I'll use a typical example of Mary and John. When Mary and John come to my office, it's not immediately clear what their struggle is. They tell me they're having difficulties, communication, but it's up to me to ask the right questions to determine what the real problem is. It's a bit like being a detective. I look for clues in their behavior, observe how they talk to one another, and ask a tremendous amount of personal questions. Eventually, with Mary and John, it surfaces that John has difficulty maintaining an erection during sex and it has become a point of contention between the couple. Mary feels that something must be wrong with her; John feels something may be wrong with him, and both feel inadequate. John and Mary have

never disclosed such struggles to anyone, and now they can open up to me, a perfect stranger. And while erectile dysfunction is a common problem, it is a symptom rather than the cause, so then the work of discovery begins, and I pry into the most sacred and personal parts of their lives to uncover answers. And right when the truth begins to surface, John and Mary maybe move somewhere, or go to a summer home for a period of time in a neighboring state, and they want to know if I can continue treatment via telehealth. But I have to tell them no, because if I want to get licensed in the state there and I have to take extra coursework, which I don't have time for. And so, I can give them referrals, but then they're starting that detective process all over again and opening up about very personal matters. So often, they'll just decide they're good enough, they're not going to do further work, and that always makes me really sad because that work really serves as a force for their children, their children's children, when they better their relationship, and it is definitely not about just their sexual relationship or their interpersonal relationship, the suffering. So this-- that's why this bill matters to me. It ensures that licensed, experienced therapists can continue treating clients when they relocate to another state with similar portability laws, and it allows for continuity of care and prevents termination prematurely. And, as mentioned previously, it doesn't help just the clients; it helps Nebraska, because it allows therapists moving here to quickly begin working instead of facing unnecessary licensing delays. And so, I hope you will consider LB257.

HARDIN: Thank you. Questions? What's the potential downside of all of this?

HEIDI APPLEGARTH: I have a hard time seeing any, but I don't know if I'm blind to that. I'll be honest.

HARDIN: We'll have opponents who may toss some out, but I just wondered, from your perspective, if--

HEIDI APPLEGARTH: Yeah. I mean, I think it would be a huge service to people who have built a relationship with a therapist, either in another state and coming here or vice versa. And-- it's a hard process to start over again, for sure.

HARDIN: OK. Thank you. Appreciate that. Proponents, LB257. Proponents. Going once, going twice. Opponents, LB257. Anyone in the neutral, LB257? Seeing none. Senator Quick, will you come back? And we have, online, 12 proponents, 0 opponents, 2 in the neutral.

QUICK: Thank you, Chairman Hardin, and, and members of the committee. And I want to thank the testifiers, too. And I think you heard, especially with the last story, about how it's not just about the, the therapist that maybe would move to another state or come to our state, but also the patients or the clients that they serve, and how important that would be. I know in Grand Island, we used to-- you-- I-- we at least used to call them "snowbirds," and so they would leave for the winter, and they would go down to Arizona and stay, and I'm sure that-- that's still happening in our community. And for them, if they're seeing a therapist-- to move down there, I think this would be important for them to have that accessibility to, to, to their therapist that they've, that they've been working with for, for maybe years, so. I think-- also, if there is a therapist that comes here, or-- you know, they have to meet the qualifications and, and our standards-- at least to our standards; maybe they have higher standards, you know. But to have them actually go through a whole process of education and, and more training just because-- and, and they've already had it in another state, but now they'll have to do that again, and it just take that, that, that much more time for them to, to get that. So, I would ask you to please vote this out of committee and see if we can get LB257 to the floor. Thank you.

HARDIN: Thank you. Any questions? Seeing none. Thank you. This concludes LB257. We will transition over to LB203. Senator Kauth. We'll take a moment or two, as--

Speaker 8: As a little.

HEIDI APPLEGARTH: Situation room.

Speaker 8: You can't see it, can't you?

HEIDI APPLEGARTH: I didn't reach out.

HARDIN: Welcome.

KAUTH: Thank you. All right. You ready?

HARDIN: Take it away when you're ready.

KAUTH: Good afternoon, Chairman Hardin, and members of the Health and Human Services Committee. My name is Kathleen Kauth, spelled K-a-t-h-l-e-e-n K-a-u-t-h, and I represent District 31 in Millard and southwest Omaha. Thank you for hearing LB203. This bill addresses the responsibility of a public health director to issue directed health

measures. The COVID-19 pandemic brought to light certain flaws in our system. One such flaw is the issue of who gets to restrict freedoms, under what circumstances, and to what degree. Public health directors hold enormous power over individual liberties during the pandemic, such as the ability to force mask-wearing, restrict business operations, in-person gatherings, school attendance, even how far apart we were supposed to stand from each other. Public health directors acted in what they considered the best interests of the public, but as unelected bureaucrats, they should not have been allowed to issue directed health measures restricting personal liberties. LB203 changes the role of public health directors with regard to directed health measures from one of authority to one of advisement. It maintains the importance of the education and experience brought by public health directors, but redirects the responsibility of restricting personal liberties. This should serve to redirect the ire of the public from the public health directors to the elected officials, where it belongs. This does not mean there will never be another situation where liberties are infringed upon. It means that only elected officials should have the ability to restrict those liberties. They are directly responsible to the citizens who elected them. Should those citizens feel a decision is not in their best interests, the elected officials will face an accounting at the ballot-- at the ballot box. This is a core tenet of our constitution. Our liberties do not cease to exist because there may be an emergency. In fact, it is even more important to safeguard them in a time of crisis. Under LB203, public health directors will serve as advisers to the elected officials who oversee their department. The public health officials will present their case regarding the need for a directed health measure, their rationale and evidence, and recommended guidelines for implementation. Their contribution stops there. The elected officials' job is to assess the information provided, make and implement a decision. It is critically important, especially in what may be an emergency, to maintain our rights. Elections have consequences, and the responsibility for decisions regarding citizen freedoms must lie with those elected officials. Thank you for hearing LB203, and I'm open to questions. That's just-- greatest sound in the world, isn't it? I love the background.

HARDIN: Yes, indeed. She's our cheerleader in here.

KAUTH: Absolutely. See, she likes the bill.

HARDIN: That's right. That's right. Questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Senator Kauth, for being here. So, I think-- I, I think you make some compelling points, I think-- especially when it comes to kind of accountability and the public having a direct say with, with that. The one question I have that kind of comes up around this is sort of around timing. And so,--

KAUTH: Mm-hmm.

FREDRICKSON: You know, obviously there's-- it's one thing to look at a measure that's related to maybe a communicable disease, for example, but I'm kind of--

KAUTH: A flood, or-- I mean, something huge and fast moving.

FREDRICKSON: Right. I'm-- yeah. I'm thinking of, you know-- yeah, a flood, or if there's something like-- even, like, a-- in, in a restaurant, right? If there's maybe, like, a rodent outbreak or, you know, where there might need to be sort of swift action. Can you walk me through that [INAUDIBLE]?

KAUTH: Absolutely. So-- and, and for the, for the restaurant, for the small-- this does not apply to that. We still want the public health directors to have-- in the case of those smaller things. This is about a community-wide "we're going to lock everything down." Community-- again, with the COVID as the background for this. When it's that big of a deal, we've got to have our elected officials being the ones responsible for making that decision. But the timing is very, very important. So, in the bill-- and I worked with the public health group, and they'll, they'll-- I believe they're here to testify, too. You know, we talked about how do we make that happen, and-- without hindering response time. And so, part of that is, can it be in writing? Can they do a Zoom? Can they do-- you know, can it be text and then follow up with an in-person meeting to make sure that we are keeping everything in the public and accountable? So that's-- they'll, they'll be able to discuss that a little bit more. But that was very much a part of the consideration. And the, the bill originally-- and I brought this in '23, and originally it was, it was a little bit more stringent, I'm guessing. And I worked with the public health directors, and we figured out the best way to make this work.

FREDRICKSON: OK.

KAUTH: So, thank you. I appreciate the question.

FREDRICKSON: Yes. So, so, so just so I'm clear. So--

KAUTH: Yeah.

FREDRICKSON: --like, something that would be more targeted. So, say--

KAUTH: Yeah, and so if, if--

FREDRICKSON: --the McDonald's on 23rd Street,--

KAUTH: Yeah. Or--

FREDRICKSON: --they could shut that down, quick--

KAUTH: Right.

FREDRICKSON: --if there was a--

KAUTH: Right. Or if the--

FREDRICKSON: --safety or [INAUDIBLE] concern, or--

KAUTH: --the, the swimming pool at wherever has E. coli.

FREDRICKSON: Right.

KAUTH: Like, yes, absolutely.

FREDRICKSON: OK.

KAUTH: And-- because that's-- that is not necessarily restricted an entire community's--

FREDRICKSON: Community. Right.

KAUTH: --freedoms; that's saying, OK, in this spot--

FREDRICKSON: Yup.

KAUTH: --we got problems.

FREDRICKSON: Yup.

KAUTH: And so, we want to make sure that we protect that.

FREDRICKSON: OK. All right. Thank you.

KAUTH: Thank you.

HARDIN: Other questions? Is there a sense-- I don't think the bill says anything about this, and I get it. Judgment, individual consideration, all that kind of thing. Is there a sense of time on this? In, in terms of, well, this situation is only community-wide, but is lingering. COVID lingered,--

KAUTH: Yes.

HARDIN: --shall we say. And so, is there a time part of this consideration, if you will?

KAUTH: Like, did we put time limits in the bill specifically?

HARDIN: Well, it's like-- not really time lim-- well, maybe. I guess I'm just wondering--

KAUTH: It's more of who it applies to. So again, if it applies--

HARDIN: OK.

KAUTH: --to everyone. So-- and the-- a great example. In February 2022, our public health director did a commun-- and you remember Senator Fredrickson-- did a community-wide mask mandate again, over the objections of virtually every elected official, every-- you know, and a doctor, she felt that it, it needed to happen. So, the entire county of Douglas County was forced back into a mask mandate for a full month. So, that's-- that was one of those things where I think most people would have said, listen, we, we need-- if you advise this, that's great, but let's actually take a vote and let's make sure that we are going through that process. So, I don't know if there's a--

HARDIN: I see.

KAUTH: --time limit on it.

HARDIN: OK. Senator Meyer.

MEYER: Thank you, Mr. Chairman. You mentioned the county you were in, and they went to a month-long wearing a mask, essentially mandated that you do that. I was on the county board during COVID, and was quite involved with vaccination protocols and things of that nature, and, and quite involved in all that. Our public health director, and kind of each of the county boards-- it was provided for at the state level that each county or each public health director would have the

authority with the-- without the approval of the county representatives to enforce a directed health measure.

KAUTH: Mm-hmm.

MEYER: And it could be you, you might be-- you might think guns are a health measure, and you could, you could take that. For us, it was COVID. Three-- there were four counties in our, in our group to rubber stamp what you wanted to do, wanted to put a sunset clause on it. We didn't even bring it to a vote, because essentially it was taking the rights of our citizens away from us without due process.

KAUTH: Correct.

MEYER: And they could pick you off the street if they suspected you had COVID, put you in a secure facility. They could take my house, they could take your house and use that for that secure facility, and this is what it said, and this is what the resolution said, and, and there was no provision to restore it to its original condition when they were done. We rejected it out of hand, quite frankly.

KAUTH: Thank you.

MEYER: And, and didn't even consider it. And so, this is what happens when you have these types of-- the ability for the state to come in and force something on you, as we all experienced. And once again, I'm not trying to testify here, but we went through this, and we, we rejected it out of hand simply because, in my opinion, it was unconstitutional. Now, had we agreed to submit to something like this, if we had voted as a county board and said, you know, absolutely, we're going to go along with you, and then later, we tried to pull out of it-- if we took it to court, the judge would say, well, you, you agreed to do this. If somebody takes my rights, I'll fight to get them back. I'm not going to vote them away. And so I, I-- I've-- I've have seen this in action. I have lived this. And the heavy hand of the government all too often is, is pushing down on us, quite frankly. So, once again, I'm not-- I don't want to testify. It seem like that's all I get done today.

KAUTH: I'd kind of like you on this side.

MEYER: It's not my intent. But having been down this road, I know exactly where this ends up, quite frankly, so. No question, just-- I appreciate your experience.

KAUTH: And thank you for your stance.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman Hansen [SIC]. Thank you for-- Harding [SIC]. Why'd I call you Hansen?

HARDIN: [INAUDIBLE].

RIEPE: Handsome or Hansen?

HARDIN: Ben was sitting here longer than me.

KAUTH: [INAUDIBLE] he's right there.

RIEPE: Maybe I called you handsome.

HARDIN: Well, that's very, very kind, but--

RIEPE: Let's, let's not have that. We have had this discussion before. My first question would be, is-- there is-- I don't know whether every county has it, but I'm talking primarily my district, Douglas County. There is a board of health.

KAUTH: Mm-hmm.

RIEPE: Are they elected or appointed?

KAUTH: I believe part of the board is elected. So, there are some elected officials who sit on it. So, we went through, and-- again, the, the public health department helped me go through-- every single public health director, and I think that they can respond to that better. But it's, it's listed out who it is, or which board it is, and what percentage they have that are elected officials.

RIEPE: The other question that I have is-- and one of the-- excuse me. One of the statements says the-- a major [SIC] of elected county and city representatives. And all I could see there is that could be a very difficult process of those two. And quite frankly, I think if they're up to it, they're probably going to turn to the Board of Health, because they won't have that expertise about whether to call a crisis.

KAUTH: The, the city officials won't?

RIEPE: Yeah. Although--

KAUTH: Well, but, but--

RIEPE: --they are elected.

KAUTH: -- and that's-- that is-- but that is why the public health director's role is still critically important for advice, to say here's what, here's what I'm seeing, here-- and here's what I would advise you to do and why.

RIEPE: Well, that's why I asked if the Board of Health had-- was elected, but if they have some elected, which I think was one of your campaign--

KAUTH: That was one of the--

RIEPE: --[INAUDIBLE] to-- for some time.

KAUTH: Yeah.

RIEPE: And I, I, I still think that was valid. But my question is, if the Board of Health-- if that who the-- who the county and the city council are going to turn to anyway, why wouldn't we go to that board and require that board to then make a-- as an elected-- well, even if they have one or two elected on it--

KAUTH: As long as--

RIEPE: --to be final authority?

KAUTH: As long as they're-- as long as the elected officials are the ones making the decisions. So, yes. And I'll, I'll--

RIEPE: OK.

KAUTH: --have to double check and get back to you on that.

RIEPE: It doesn't necessarily have to be the county board,--

KAUTH: Right.

RIEPE: --who are more probably familiar with bridges and highways.

KAUTH: Right. Right.

RIEPE: City council's more involved with-- I don't know what.

KAUTH: Beer.

RIEPE: Beer?

KAUTH: Liquor, liquor licenses.

RIEPE: Yeah.

KAUTH: So, yes. And that, that point is well-made.

RIEPE: Gets into a crisis, things happen really, really fast.

KAUTH: And so, let me, let me look into that and make sure-- and you and I can visit with that, make sure that it's correct in the bill.

RIEPE: I appreciate it. I'm just-- we're trying to get--

KAUTH: Yep.

RIEPE: I know last time it was a big controversy.

KAUTH: Mm-hmm.

RIEPE: A big one.

KAUTH: Yep.

RIEPE: So, thank you for taking [INAUDIBLE].

KAUTH: Oh, of course.

HARDIN: Other questions? Senator Meyer.

MEYER: Just another observation once again, and I should be sitting over there rather than over here. In our, in our public health district, there was one representative from each county that belonged to the, to the public health board. And then, there were doctors, dentists, hospital administrators, school board administrators, those types of things that were appointed by the county, essentially, request people to apply for the job. And so, there was a-- there was a medical component, a professional medical component as part of the advisory group dealing with the public health district. If I understood that-- if that-- if I understood your question right, at least that was my experience in the public health board I was on. So, there was, there was a professional health component to that.

RIEPE: If I may ask a question across. Did they have an executive board then, that-- many times, it-- because it's--

MEYER: There was no--

RIEPE: [INAUDIBLE] everybody on there, it sound like it was a-- I don't like boards of more than 5 or 7 people to get things done. But if you have an executive board of maybe the three officers, or something like that. They-- hopefully elected-- could rapidly respond to what we need. Trying to get 17-- everybody-- somebody's out to dinner, somebody on vaca-- you know. In a crisis, it's a nightmare.

MEYER: There was no executive board.

RIEPE: There was no executive?

MEYER: But the director-- the director has-- she's been a little bigger vote than everybody else, but quite frankly, the medical professionals would weigh in. I-- I'm going to guess-- once again, this is a poor thing to do, but from my experience, I believe each public health board may be made up slightly different. There is no cookie-cutter, this is the public health board. So, there may have been-- in other, in other public health boards, there may have been an executive board that made final decisions. But in the, in the proposal that our, our director came to us with regard for making unilateral directive health measures, she had represented in a conference call that she would certainly consult the entire board prior to making those types of, of calls, and, and, and get a consensus of the board. And yet, when I read the resolution, there-- none of that was in there. Actually, she had sole-- or he, if, if you have a male director-- had sole authority to declare a directed health measure. And, and essentially, I felt-- from the county's standpoint, I do not have, as a county elected representative, the authority to vote or give away my residents' rights. They have their own rights. I can't give them away, nor can I take their rights. And therefore, that's why we did not even consider participating in any type of directed health measure, signing a new resolution in that regard, so. But I think there's, there's probably a difference in structure between different public health boards. I don't think there was one cookie-cutter type of, of, of scenario. And, and--

KAUTH: I think you're right.

MEYER: --if, if that's different than what my understanding is, certainly, I would stand corrected. But I believe that's the case.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. So, so just one more question of clar-- so, my understanding, based on your testimony, was that it-- it's the written communication, but part of what you changed from last time was in the interest of expediting, like, if there's something urgent, got-- like, a meteor hits. I don't know. Like, I mean-- but I, I-- but you think about it, it seems like--

KAUTH: Right.

FREDRICKSON: It's not a matter of, like, when there's going to be--

KAUTH: You can never be prepared enough.

FREDRICKSON: --a crisis, it-- if there's-- if it is-- [INAUDIBLE] a crisis, but-- so, the-- they could-- they're-- like, this could be, like, a text message thing that sent--

KAUTH: Yes. We, we--

FREDRICKSON: --a directive could-- and then you meet later, or whatever it might be.

KAUTH: So, basically, we want to make sure that we understand we are in the 21st century, and--

FREDRICKSON: Yup.

KAUTH: --everyone has one of these, usually.

FREDRICKSON: Yup.

KAUTH: If, if a meteor hits, it's probably going to affect service a little bit. But, but-- so that we can make those decisions quickly, but then the follow-up has to be that, that open public hearing. Once things have calmed down, said, here's what happened, here's what we did, here's the decision we made. Here are, you know, a, a record, because your texts would be a record of how we voted and how we communicated.

FREDRICKSON: Got it.

KAUTH: Again, to give that flexibility to make sure that we can respond should, heaven forbid, we have-- I mean, we live near Offutt, too; it could be a nuclear weapon.

FREDRICKSON: Right, so-- God forbid. And, and it, and is it-- is there-- and maybe I'm getting in the weeds here, but is there-- is it just sort of a-- you know, I'm assuming it's a majority of the elected board,--

KAUTH: A majority. Yes.

FREDRICKSON: --or whatever that might be. In the event that not everyone on the board is reachable for whatever reason, if it is some type of catastrophe, do you have any thoughts on--

KAUTH: I believe Mr. Gerrard is going to be testifying,--

FREDRICKSON: OK.

KAUTH: --and, and we worked through that quite a bit.

FREDRICKSON: Good to know. OK, great. Thank you.

HARDIN: Senator Quick.

QUICK: Thank you, Chairman Hardin. And so I, I apologize,--

KAUTH: Oh, no.

QUICK: --I wasn't here for your, for your opening. Just one question on-- do you know, are-- can a, a public health director be held liable if-- just, let's say something happens in your community, and someone feels like they weren't provided--

KAUTH: Adequate info?

QUICK: Adequate.

KAUTH: We didn't touch liability at all. But again, putting it-- making it clear that, in that situation, they're an advisor to the elected board, I would think any liability would switch to that elected board. So, as long as they're providing, you know, their expert opinion on something, they would have-- I don't think the liability would change at all from their regular job. So-- and that's a good question. I haven't asked about their liability for the regular job, so I'm not sure where that lies.

QUICK: OK. All right. Thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. Is it your intent to see that there's some kind of a documented plan, because when I mentally go through this, any kind of serious process is going to include the government. Because martial law could be a possibility. And so--

KAUTH: If there's-- yeah. An asteroid. Yep.

RIEPE: Some-- and, and I think at times, too, on something of this significance, and I'm assuming the highest level of crisis that we could imagine, you probably want to have two people pushing the, the nuclear button and, and not just one. At least two. Which you, you know, to try to get together--

KAUTH: As--

RIEPE: --ten or twelve people is just--

KAUTH: It-- that-- exactly.

RIEPE: It won't happen.

KAUTH: Exactly.

RIEPE: It won't happen. The things are moving too quickly. So, if you can find the-- talk two responsible people. And one of those might be a public health person, the other one might be a physician. I don't know. I-- that's just--

KAUTH: Well, does-- so, is, is your question that, that we-- I mean-- and we can certainly amend this to say each health board puts together their action plan if something happens? I mean, that's certainly something-- I'm sure they have something, don't they?

RIEPE: I would think so. And there's probably a requirement to update it, as boring as it might seem at the time. When the crisis hits, it's not so boring.

KAUTH: Right. Right. Let me, let me double-check on that.

RIEPE: I don't know that I had a question, or just kind of a foggy thought.

KAUTH: It's a good observation.

RIEPE: But thank you. Thank you, Chairman.

HARDIN: Other questions? Will you stick around?

KAUTH: Sure.

HARDIN: Wonderful. We're looking for o-- we're pro-- proponents of LB203. Welcome.

ALLIE BUSH: Thank you. I lost my baby. All right. My name is Allie Bush, A-l-l-i-e B-u-s-h. I am representing the grassroots group Nebraskans Against Government Overreach. And it's kind of funny because, you know, as Senator Riepe had brought up, it kind of was a fiasco when, when this was the highlight four years ago. And I started scrolling through my phone, and all the speeches that I put together during that time. We were the start of the frustration. And I can tell you there were thousands, thousands and thousands of people who showed up who are opposed to directed health measures that didn't-- that were done without a vote by an elected body. And while we as Nebraskans Against Government Overreach would like to see an elimination outright of all medical mandates, people should have the right to make those health dish-- decisions for themselves. Of course, we absolutely supported the Boards of Health making any and all recommendations they want. Recommend, recommend, recommend. Recommend all you want. I would-- from all of your expertise, please tell us what you think. But as free Americans, we should be able to make those decisions for ourselves. Obviously, LB203 does not quite go that far, but we respect beyond measure that Senator Kauth has stayed committed to finding a solution that the Legislature can accept that puts accountability with the appropriate boards that make these decisions. So, I could sit here and read to you guys how we went on about mask mandates being a constitutional violation, and how people gave no consideration to those with religious refusals and exemptions. But today, we're just going to ask you guys to please push LB203 out of committee. Let this come to a more open conversation, and let's find a solution that truly ensures that any directed measures are put forth by an elected body. That's the important part, is that the people that are making these decisions and putting forth a mandate that we feel is wrong is at least done by those who were elected to be in those positions and make those decisions for the residents that are affected by that mandate. So, thank you very much.

HARDIN: Thank you. Senator Riepe.

RIEPE: My only comment is just-- you talked about the elected-- in an ideal world, you would possibly have a vote. But in a crisis-- and emergency health care is where I come from-- the first thing you have to do is stop the hemorrhaging. Nothing else matters if you don't stop the hemorrhaging.

ALLIE BUSH: The-- yes.

RIEPE: And so, you have to have split-second decision to, to-- for someone to take some action,--

ALLIE BUSH: Mm-hmm.

RIEPE: --and it's definitely never going to be a totally popular decision. You know, I was never big into the mask piece.

ALLIE BUSH: Right.

RIEPE: But--

ALLIE BUSH: If you don't--

RIEPE: That, that was me, and that was personal.

ALLIE BUSH: If you don't mind, let me add that in the case of these health directives-- and, and let's say we were talking about emergency of COVID-19, right? That was an emergency, we needed immediate action. They took that immediate action, and it still took them over 48 hours to get together with the people that made those decisions. Even then, no health director was able to put out a directed measure within 24 hours. It did not happen. So, with that in mind, this legislation would still allow the process to take place that they currently operate under. It just ensures that it goes to a vote by the elected body first. Nobody's putting out a directed health measure in 20 minutes. It's not happening. I don't care what the emergency is. It's not going to happen. There's too many mech-- moving mechanisms to even get a notice out to people. You can't do it in 20 minutes. There's always, always time to take a vote by the members who are elected to make those decisions for the residents, wherever they may be. Respectfully.

HARDIN: Other questions? Seeing none. Thank you.

ALLIE BUSH: Thank you very much, guys.

HARDIN: Proponents, LB203. Welcome.

JEANNE GREISEN: Hi there. My name is Jeanne Greisen, J-e-a-n-n-e G-r-e-i-s-e-n-- it's actually Dr. Jeanne Greisen-- and I'm here representing Nebraskans for Founders Values. And I'm going to add on to a little bit what Allie said before me, that this is a good step in the right direction. I'm not sure that this bill would do everything we need. Obviously, we need "framerook"-- framework at the state level, but it may have to be at the county level, and it does have to come from people that are elected by the people so they have good representation on what gets implemented. And I'm going to also comment to what Senator Riepe was saying, that you have to do things in an emergency. And I'm going to say, well, maybe our emergency actions didn't really work very well with COVID. I'm not sure any of you have seen the committee-- the Congressional [SIC] Committee on Oversight and Government Reform. They did a report, a two-year investigation, over 500 pages of the final report on lessons learned from COVID and the path forward. And it debunks everything that we did with COVID. So, it actually come out, and the social "distings"-- distancing, the six-feet-apart social distancing recommended was arbitrary and not based on science. The mask mandate, there was no conclusive evidence that they effectively protected Americans from COVID-19. The lockdowns. They prolonged the lockdown, caused measurable harm not only to American economy, but also to the mental health and wellness of Americans, with a particular negative effect on young citizens. The COVID-19 misinformation-- and this was huge, and this came from the health directors. Public health officials spread misinformation through conflicting messages and a knee-jerk reaction with a lack of transparency, and the "pervases"-- it-- pervasive information campaigns, and then they demonized people that went against the narrative. And so, this is a government report that came out that is actually factual on what happened. So, to say that we need something so emergency with a knee-jerk reaction is completely false. And I go with-- you know what? People need to learn how to care for themselves. And we don't need the government taking away our rights, even if it is an emergency. Any questions?

HARDIN: Questions? Seeing none. Thank you. Proponents, LB203. Proponents. Welcome.

ROY ZACH: Thank you, Chairman. My name is Roy Zach, R-o-y Z-a-c-h. Dear Senators, I rise in support of L203 for the reason that it adds a

degree of public oversight to certain health directives. We all remember the tyrannical measures put in place, or the infamous COVID-19 lockdowns. My father was in a nursing home with two cracked neck vertebrae for two weeks during the lockdowns. No family members could go into the building to meet with him. We could only stand outside in the frigid winter weather, look into his window and talk to him on a cell phone. During that time, the nurses said he wouldn't eat much. I later reviewed 471 pages of his medical records from those two weeks in the nursing home. My father lost 20 pounds in those two weeks. How does that happen? He was virtually immobile. This gives one pause, and makes one critically question the entire medical establishment. I respectfully asked you to consider the following news articles I've brought for you. Also, please go online and read the abstract and details in Microsoft's patent W02020060606. Cryptocurrency system using body activity data. Essentially, you would be reward with electronic currency for, for performing desired behaviors or tasks. What do you suppose the flip side is? What do you suppose happens if you do something undesirable? Did you note the last six digits of the patent number, 060606? I call this the "666 patent." Please consider this carefully, along with the articles I'm giving you. I sincerely hope you ask the question, what is really going on in our health care industry and its collusion with big tech, international pharmaceutical companies, the legacy mass media, big finance and government agencies. The people who are right wisely heeding President Eisenhower's warning about the rise of the military industrial complex understand what's coming, coming. What we have now is sinister rise of a technocracy via government directives, and intent-- and attempted worldwide control system. At the core of the egregious desires are two main objectives: population control and control of the population. These articles, among many others, may well lead us to that conclusion. This is why we need more legislation like LB203. Thank you.

HARDIN: Thank you. Questions? Seeing none. Thank you, Mr. Zach. Proponents, LB203. Welcome.

DIANNE PLOCK: Good afternoon. Thank you for letting me testify today, Senator Hardin, and the rest of the committee. My name is Dianne Plock, D-i-a-n-n-e, Plock, P-l-o-c-k, and I'm here in support of this bill. I think we can all remember COVID-19 and our own Lancaster County Health Director directed items or events to occur that had-- in my mind, absolutely made no sense. It took away my right to choose, my right to-- well, basically, informed consent. My right to a lot of things. If this ever happens again, I would hope that someone would

have the common sense to put the kibosh on it. I'm sorry. I'm not-- don't necessarily like all the language in this bill as it's proposed, but it's better-- it's a, it's a good start. I'll put it that way. And if I were to revise the bill a little bit, I'd probably take out any reference to a dentist, because I don't really know how a dentist other than-- has anything to do with public health, other than the teeth-- having to do with teeth, which is probably going to get us on a fluoride issue, which we'll be discussing later. But, in any event that's where I stand.

HARDIN: Thank you.

DIANNE PLOCK: Welcome.

HARDIN: Questions? Seeing none. Thank you.

DIANNE PLOCK: Thank you.

HARDIN: Proponents, LB203. Proponents. Opponents, LB203. Welcome.

KERRY KERNEN: Thank you. Good afternoon, Senator Hardin, members of the Health and Human Services Subcommittee [SIC]. My name is Kerry Kernen, K-e-r-r-y K-e-r-n-e-n, and I'm the health director for the Lincoln-Lancaster County Health Department. I'm here to testify in opposition of LB203. On a daily basis, my staff is monitoring and responding to infectious diseases in our community. Routine surveillance and public health responses in place for infectious diseases, such as respiratory illnesses like influenza, COVID-19, pneumonia, pertussis, as examples. My staff also monitor and respond to infectious diseases such as tuberculosis, sexually transmitted infections, measles, mumps, hepatitis, just to name a few. In addition to daily surveillance of public health actions, my staff and I are continuously monitoring the potential for new or novel infectious disease threats. These might include infectious diseases that are less common but very serious, such as monkeypox, any of the class of the viral hemorrhagic fevers, H5N1, H5Na, avian influenza and others, to name a few. In my 25 years working in public health, we've seen the need to develop appropriate and timely public health interventions to control the spread of infectious diseases and save lives. A few examples is-- when we saw anthrax in 2001, Ebola in 2014, H1N1 in 2008, measles in 2015, hepatitis A in 2019, and monkeypox just as recently as 2023, to name a few. According to the Center for Disease Control and Prevention, over the previous three decades, the incidence of infectious disease outbreaks has increased considerably, and the

trend is expected to increase further. Public health measures are essential for controlling and preventing emerging outbreaks of infections and illnesses. With the continued trend of increased incidence of emerging infectious disease outbreaks, I need the authority to quickly respond to protect the health and safety of my community. There is no one-size-fits-all directed health measure; there is a toolbox of many options, and the tools for consideration and implementation are really infectious disease-specific. DHMs for respiratory infections may include, but not be limited to restrictions on gatherings, business operations and/or mask mandates; DHMs for non-respiratory infections-- as I mentioned, the viral hemorrhagic fevers-- may include public health orders for isolation and a quarantine. These directed health measures are meant to reduce disease transmission. The timing for the consideration and implementation of public health action is critical, especially for infectious diseases that are not prevalent here in the United States, or even Nebraska. Based on the review and analysis of comprehensive data from health system partners such as emergency departments, inpatient admissions, health care providers, labs, academic institutions, child care centers, long-term care facilities, pharmacies, contiguous counties and the state Department of Health are a few examples that I would-- be connected with, so that I can determine action to take, and which may include a directed health measure. It's important to recognize that these decisions are not made in isolation. Actions in Lincoln and Lancaster County during COVID-19 were informed by consultation with our department's infectious disease consultant, local health care providers, health systems, elected officials, [INAUDIBLE] businesses and other experts. At the time-- as, as recently we-- sadly, we had 473 individuals from Lancaster County that died due to, due to COVID. If we had had the same deaths rate as Nebraska, 342 more people would have died. Johns Hopkins University analyzed over 700 counties with similar demographics, and found that Lancaster County was in the lowest 10% for COVID death rates in the nation. Such data is strong evidence of the positive impact of the authority of the local health director, and the development and implementation of directed health measures. Maintaining the authority to take quick action during an infectious disease threat will be vital to protecting the health of my community, especially those most vulnerable.

HARDIN: Thank you.

KERRY KERNEN: Happy to answer any questions.

HARDIN: Questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here, and for your testimony. Question for you. So, I, I don't remember if you were here for Senator Kauth's opening or not, but she spoke a little bit about her original bill a couple of years ago versus some revisions or changes that she's made in the interest of expediting. I don't know if you had any thoughts on those change--

KERRY KERNEN: So I'm a, I'm a, I'm a new health director, and so I--

FREDRICKSON: OK.

KERRY KERNEN: --was not involved, and I'm not familiar with the previous language of the bills. I'm just familiar with this one here, so--

FREDRICKSON: OK.

KERRY KERNEN: I, I would have a hard time answering that, yeah.

FREDRICKSON: OK. OK. I guess-- so, for-- the question I have might be, so-- that-- my, my understanding is-- I don't want to speak for the introducer. My understanding is kind of the spirit of this bill is to have decisions ultimately lay on the responsibility of, of, of elected members, per se. But there is this indication that it seems like there can be quick communication from a public health director, whether that's through texts, et cetera, to sort of expedite those decisions. Just kind of curious to get your thoughts on, on that concept, or--

KERRY KERNEN: I mean, if, if, if-- if and when I would, would ever made a decision-- again, I would not-- I would not make that decision in isolation. I would be having lots of conversations, especially those directly impacted, especially on the health system side, health care provider side. And I would be in communication with my elected officials to let them know, here's the situation, give them situational awareness, and then provide my recommendation. And then, if, if I have that authority, I'm going to implement that, unless there's, you know, very strong concern from them, and then we have to talk that through. I do get very concerned when it comes to the timeliness of, of this decision, because these emerging infectious disease threats are out there now. We're watching very closely what's happening in Uganda, Tanzania; we had Lassa fever in Iowa just last year. So, I need that ability to make that decision quickly, but I'm still going to be in constant communication with my elected officials and my Board of Health.

FREDRICKSON: Great. Thank you. That's helpful. Thank you.

HARDIN: Senator Hansen.

HANSEN: Thank you. I, I-- you kind of brought this up. Your-- these decisions are not made in isolation. You work with department's infectious disease consultant, local health care providers, hospital systems, elected officials, businesses, and other experts. And you also say then, based on review and analysis of comprehensive data from multiple sources, then you're able to make a determination what you need to do. So, why are you against having elected officials vote on a directed health measure that would possibly lead to isolation or quarantine, which would take away some of these rights or liberties? Because it doesn't seem like-- if you're able to do that much in that much time, review comprehensive data analysis, you know, consult with all these other people-- we're dealing with counties and cities, and it shouldn't take that long for them to kind of get together, if it's a crisis that's that bad. At least a majority would have to have a quorum to make a decision on a directed health measure. We're not talking it's going to take them a week; I'm assuming maybe hours to kind of get together. Why, why, why is that a problem?

KERRY KERNEN: I think-- it-- I think we just have to keep things in perspective. So, all my staff would be-- I'm not the one person doing all of this. I have a lot of staff that will be feeding me information that's coming from our community partners on the health system side, all, all of the ones that I listed. And it's not all these partners that are going to be reaching out, it's going to be infectious disease-specific. And quite honestly, it's going to be our health care providers and our labs that we get that first acknowledgment that we have an issue in the community that we have to address. Then, I reaching out to my health system partners to say, "What do you see? What are you hearing?" And I'm-- that's not to say that I'm not having those conversations with elected officials, but as I'm gathering that information, I'm going to be able to quickly come to a decision, because there's protocols that are out there for every infectious disease threat. It's not that I have to come up with something; I'm going to be following that guidance, most likely from the state and CDC, because we have that already in our communicable disease manuals and our infectious control manuals as a-- our response plan.

HANSEN: Which is great. And I think your, your opinion and your expertise is vital. And I think the work that you do is vital. The rub I have-- and I think the purpose of this bill-- is the decisions that

you make or recommend that could lead to the taking away of somebody's personal liberties or freedoms, constitutional rights or constitutional freedoms-- that's a problem that I have, and I think that's where the elected officials come into play. I mean, those are the people they elected to represent themselves, to make those kind of decisions. And I think your expertise they should listen to, but ultimately, I think it should be up to an elected official to make those determinations on whether they should, you know, refuse certain rights that they should have, I think. And I think that's the rub that I have, and maybe kind of where this bill is-- kind of the genesis of where it's coming from. I'm assuming, so. That's just my two cents.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. I'm looking at your letter. I'm looking at the very back, and it talks about this health-- directed health measures. Is that synonymous with the local health board?

KERRY KERNEN: So, our local health--

RIEPE: Is that, is that the health board that's making those directed health measures?

KERRY KERNEN: No, they're coming from the health-- they're coming from the health director.

RIEPE: OK. My question would be this, is-- and I know we talk in here, and you say-- the one line says local DHMs, which are directed health measures. At that time, and I-- since that's going back to COVID-- had a clear and measurable impact on slowing, slowing the spread of virus. My piece would be this, is-- I think the policy we're trying to put together has it to do-- has not to do with just viruses, but it has to do with the overarching-- no matter what the crisis is, that we would have a vehicle to respond to that in a very timely manner. And so, none, none of this, I don't believe-- I'm quite confident it's not intended to be criticism. I've always said no one intentionally makes a mistake. I don't think you guys made a mistake; at the time, it was the right decision. And these things were happening so quickly, whether it was Omaha or Lincoln, or-- you know, out in Glen's neighborhood. They were all happening really fast. But [INAUDIBLE] I think if something doesn't happen right away, you have to have a elected group within X hours that does respond to it to get the credibility, and quite frankly, take the accountability for it. They

mess it up, they're elected; they'll pay the price. But thank you. Thank you for being here.

KERRY KERNEN: You're welcome.

HARDIN: Senator Quick.

QUICK: Thank you, Chair-- Chairman Hardin. So, my last year in the Legislature before was in 2020, so I was here during COVID. One of the things that happened in our community was, we have a large employer, a packing plant. And so, I was getting calls from family members, employees at the packing plant, that they were maybe being-- I want to say, not "forced" to come to work, but told to come to work even if they were sick, and it wasn't helping our situation. So, I reached out to our mayor, I reached out to our public health director, and, and no criticism of our elected officials, but I want to say, at some points, they were more interested in serving the need of the employer than they were to-- of the, the employees. So, we-- you know, we're want to be careful we're not crossing that line, so. I know what-- with our public health director, we worked directly together with the mayor, and we-- I actually went out and met with our employer-- or, packing plant, and some other employers, and then we had weekly COVID meetings, Zoom meetings with local leaders, with, with them. I, I know the packing plant was part of those meetings, too. I went out and toured the plant to see what things they'd put in to try to help with that situation. So, I think-- I commend, like, our, our public health district for everything that they did to help our community and help everyone in our community. And they worked directly with our local elected officials; they worked together with doctors, with our religious community, and we all make these decisions together, and she, she was heading it, so she was in charge of all of that. But she was really doing a great job. And I don't know if you've-- I know there's some large employers in, in Lincoln or Lancaster County, and so I don't know if you witnessed any of that, or can attest to any of that.

KERRY KERNEN: So, I was actually up at Douglas County Health Department during co--

QUICK: In Douglas County? Sorry.

KERRY KERNEN: --most of COVID, and I've-- yeah, I've been down here in Lincoln for about the last three years, so. But yeah, large employers,

we worked with them a lot just to navigate just their challenges, and how could they keep business open, and-- yeah.

QUICK: OK. All right. Thank you.

HARDIN: Senator Meyer.

MEYER: Thank you, Mr. Chairman. In reference to Senator Quick's analogy with the packing plants and that. There were a number of businesses that were considered essential, and that's why they stayed open. Would you say that's accurate?

KERRY KERNEN: The--

MEYER: Packing plants, food production,--

KERRY KERNEN: Mm-hmm.

MEYER: Those things, regardless of the situation and the possibility of infection, real or imagined. They stayed open because they were essential--

KERRY KERNEN: Correct.

MEYER: --for providing for the community, so. The reference, perhaps, was to-- for the benefit of the business, but really was for the benefit of the community, that those types of businesses stayed open. Would that be a fair analysis?

KERRY KERNEN: Yes. And I think the majority of businesses did stay open. There were some directed health measures that came from the governor at the time during a-- there was a period of time, the barbershops, the beauty shops, and massage locations were closed for a period of time, but for the most part, the majority of the businesses were kept open. And health department-- local health departments worked with those business owners to figure out how they could keep their-- not just their staff, but their-- the consumers, or the constituents that were coming in for services.

MEYER: And if I may, Mr. Chairman. My understanding-- and, and-- from my time on the public health board is essentially what the public health boards did was directed by the governor and the state, actually; you followed their directives with regard to what actually happened in your public health district. At least that's how it was represented to me at the time. And so, rather than unilaterally making

decisions in a particular health district, actually, the directorates [SIC] were coming from the governor and from the state as to what those directed health measures were, is that correct?

KERRY KERNEN: So, that was probably not correct for Lancaster County and Douglas. Those health directors were making those DHMs independent-- some were in, in coordination with the governor's DHMs, and there were some that they got added to. And it all depends on the timeline, because those DHMs fluctuated and changed based on the information that we were getting as far as the spread of COVID.

MEYER: Thank you.

HARDIN: Additional questions? Thank you.

KERRY KERNEN: Thank you.

HARDIN: Opponents, LB203. Welcome.

TRACY AKSAMIT: Thank you. Good afternoon, Chairman Hardin, and committee members. My name is Tracy Aksamit, T-r-a-c-y A-k-s-a-m-i-t. I'm representing myself, and oppose this bill which proposes to increase Nebraska's public health governance. While I genuinely value many public health measures. I am requesting that we consider simply allowing a holistic model to complement our public health approach, recognizing that many scientists do not fully agree with all aspects of communicable disease theory, with many questioning disease transmission as the primary cause of illness. I've provided you with a resolution to shift the direction of public health in Nebraska, and additional information expanding on holistic healing and the impact of electricity and radiation on health. Your packet includes a graphic of our invisible electromagnetic world, a list of electrical effects, both positive and negative, documented by 18th century doctors compared to a 2023 Scientific American article on COVID and long COVID symptoms. And finally, a three year RF monitoring report I produced for my neighborhood. And-- I'm sorry, another flier covering the benefits of nutrient-dense foods on health, pregnancy and dental care. So, I'll conclude here by reading as much of the resolution as time permits: A resolution to shift the direction of public health in Nebraska. Whereas, the current health model in Nebraska has not produced the desired long-term health outcomes, and recognizing the need for systematic change to improve the overall well-being of our population, it is proposed that the direction of the health-- public health in Nebraska be shifted toward a more holistic, preventative and

self-care oriented model, incorporating current evidence-based science and revising outdated and industry-centric environmental regulations, and-- looks like I'm going to miss out on most of this, so I'm going to shift to the back regarding the 1996 Telecommunication Act, which basically exempts state and local governments. There's a lot of important things in here that explain how I got to radiation, but radiation is important. My three visits to the virology symposium, the university's virology symposium; you'll, you'll note some information about virologists and, and viruses. And so, shifting-- I'm going to just go to the end here, and say thank you.

HARDIN: Thank you. Questions? Seeing none. Thank you. Opposition to LB203.

JULIA KEOWN: My name is Julia Keown, J-u-l-i-a K-e-o-w-n. I'm a critical care and forensic nurse in Nebraska. Born and raised in Grand Island, and then been in Lincoln for the last 20-plus years or so. I actually also worked on the COVID ICU at Bryan West for the entirety of its duration in 2020, so this-- I am no stranger to this. I am here on behalf of the Nebraska Nurses Association, the NNA, which represents the more than 30,000 nurses in Nebraska. We are here in opposition to this bill, LB203. The following statements represent the Nebraska Nurses Association position on LB203: We are proud and fortunate in the great state of Nebraska to have nurses leading our most populous public health departments. They are highly educated in population health and epidemiology, and are experts in public health practice. Health directors are uniquely qualified to follow the public health ethical standards that guide evidence-based public health practice, including the balance of optimum targets for health and well-being, and, in cases, balancing the autonomy, freedom, privacy and other legal interests of individuals and populations for the common good. Requiring approval of the city council and/or county board to issue directed health measures creates bureaucratic red tape that will delay implementation of emergency public health services. Further, the legislative intent behind this law undermines the education, experience and skill set of the public health director, who is uniquely qualified to implement evidence-based practice. This law interferes with trust and confidentiality between patients and clinicians in the delivery of timely, evidence-based care by politicizing public health. In the cases of individual DHMs, a patient's right to privacy may be violated by requiring an individual's personal health information be shared publicly before an elected board and community members. This is obviously a clear HIPAA violation, so, it's a violation of federal law, right? Further, nurses

across the state work closely with health departments and, at times, need emergency guidance, including directed health measures in settings including, but not limited to schools, nursing homes, occupational health, et cetera. As nurses in Nebraska and the United States, we are bound by our professional duty to our patients and our code of ethics as delineated by our overarching parent organization, the Nebra-- the American Nurses Association, excuse me, the ANA. This bill creates the very real possibility of a quickly-spreading deadly pathogens circulating and wasting precious time, potentially up to almost a month, waiting for the next Board of Health meeting to ratify a directed health measure prior to its implementation. For these reasons, the NNA opposes LB203, and we respectfully ask the committee to stop advancement of this bill. So, that is my first part. And then, the second part is my own personal analysis of issues that I'm finding in LB203, and I'm very happy to answer any questions you have about that. But as I touched in my previous testimony, the thing that really concerns me is the ratification that is required by boards of health.

HARDIN: Thank you. Questions? Senator Hansen.

HANSEN: If it was such a dire circumstance, wouldn't the board of health have an emergency meeting, like, within hours?

JULIA KEOWN: Nope. Nope. So, the boards of health-- so, if you look at-- and obviously, our district, the two most populous counties in Nebraska, right? Because those are, those are where the spread's likely going to start, and since the population is more dense, it's going to spread faster, right? Exponential growth law. So, the Lincoln-Lancaster board-- Lincoln-Lancaster County Board of Health has nine members. They meet on the second Tuesday of every month at 5 p.m., so they only have meetings every 28 days. But also the law as written here, it requires for Lincoln-Lancaster County Health Department to get not only a majority of the board of health permission, but a majority of the city council permission. So that's what, like nine people? And then, you have to wait. It actually says-- the bill actually says you have to wait to have the DHM ratified at their next scheduled meeting. So, like I said, that's every 28 days for Lincoln- Lancaster County. And actually, it's the same with Douglas County Board of Health. I wrote--

HANSEN: Where is the scheduled meeting part? I just want to make sure I write that down.

JULIA KEOWN: You just have to look it up. But I, I did write them down on the issues--

HANSEN: Oh, OK, gotcha.

JULIA KEOWN: --with LB203. So yeah, Lincoln-Lancaster County, second Tuesday of every month at 5 p.m., and then I also wrote down the Lincoln City Council. Those guys are week-- weekly meeting, and then--

HANSEN: But they can have an emergency meeting, can't they? They don't have to, like, wait 20 days--

JULIA KEOWN: I don't know. That's a great question for someone who's above my pay.

HANSEN: [INAUDIBLE] because I'm actually curious, because then, if some language does need to be cleaned up, I think there's some things that I might-- might be-- [INAUDIBLE]

JULIA KEOWN: It very clearly would. As, as is-- this is not a good bill.

HANSEN: OK.

JULIA KEOWN: And it will actually threaten the health of the public, because it, it actually says the, the DHMs have to be ratified at the next scheduled meeting.

HANSEN: That's the part I'm kind of curious-- concerned, because then, there-- you know, should be something that says--

JULIA KEOWN: Quite concerning.

HANSEN: --"or when they meet next time," you know, kind of--

JULIA KEOWN: Right.

HANSEN: --some, some [INAUDIBLE] information about that.

JULIA KEOWN: Right.

HANSEN: And then, you also mention in here, on one of your bullet points here on your other testimony, the, the first one you handed out, the case of individual DHMs, "a patient's right to privacy may be violated by requiring an individual's personal health information be

shared publicly before an elected board." Can you an example when that would happen? Because I can't imagine that would ever happen.

JULIA KEOWN: Absolutely. Tuberculosis is a great example. Right now-- you guys might not know this, but as an epidemiology geek, I do. Right now, in the Kansas City area, we have the--

HANSEN: Largest outbreak.

JULIA KEOWN: Largest outbreak in recorded U.S. history of tuberculosis, right? So, that's a big deal, if we have someone running around with-- say they, they are mentally not competent, but they also have active tuberculosis, so, they're not able to really comply with a, an isolation order to please stay at home to protect other people, right? So, then you would have to-- in order to implement that DHM, you would have to-- according to this, you would have to contact all of these city council members and board of health members, which is sharing that patient's private information; you'd have to get permission from all of those people; and then, according to this law, you'd have to go to that public board of health meeting and share that, that public-- or, that private information on that patient, get that DHM ratified, and then you can come back and implement it. And if that DHM happens, like, the day after a board meeting, you're potentially waiting, like, 27 days to get this patient isolated.

HANSEN: You probably wouldn't have to share his public information, though-- these private information. You can say "Patient A" without giving birthday, without giving social security number, [INAUDIBLE] names. You can still give an incidence of what's happening without giving his-- a person's name.

JULIA KEOWN: That's a great question. That would be a question for the experts behind me who are actually in the public health direction. But honestly, I don't know why you wouldn't have to give information on that patient, and especially if you are in a small-- if you're in a small rural place in Nebraska, and you say, well, Patient A has, you know, mental health issues and they also have tuberculosis, a lot of people at that public health meeting-- or, that-- at that board of health meeting are actually, without even having the patient name, going to know exactly who that patient is, right?

HANSEN: But you're still not-- you're still not breaking HIPAA violation. Or, HIPAA law.

JULIA KEOWN: Actually, I-- double-check me on this, but I think if it can easily be traced back to that patient, I, I believe that may still be a violation of HIPAA law.

HANSEN: OK. All right.

JULIA KEOWN: But there's people smarter than me on that one.

HANSEN: OK. All right. Thank you.

JULIA KEOWN: Yeah.

HARDIN: Senator Meyer.

MEYER: Thank you, Mr. Chair. I'm not familiar with county and city like Lancaster, Douglas County. The county handbook has a, a section in it directing the counties that we do have an emergency meetings; we don't have to wait for our next regular, regular scheduled meeting. During the COVID crisis, we actually had emergency meetings of the public health district. So, those provisions are there. With regard to what the city would require-- and certainly, the health director from Lancaster County could, could address that. But the idea of waiting 28 days to address an emergency is ridiculous on its face--

JULIA KEOWN: Agreed.

MEYER: --and, and--

JULIA KEOWN: Absolutely.

MEYER: --would not happen, quite frankly. So, your fears in that regard are probably unfounded.

JULIA KEOWN: Not according to the way this bill is written, however. The bill is--

MEYER: In, in practic-- in practical application, I believe your fears are unfounded.

JULIA KEOWN: I believe the bill says at the next scheduled meeting. Regular-- regularly scheduled meeting, even.

MEYER: I appreciate your time.

JULIA KEOWN: Absolutely.

HARDIN: Senator Quick.

QUICK: Thank you, Chairman Hardin. I just want to thank the nurses, because-- my wife is a nurse, and she took care of-- even though she worked in labor and delivery, they did have COVID, COVID patients--

JULIA KEOWN: Absolutely, they did.

QUICK: --come in, who were having babies, and they would--

JULIA KEOWN: Yup.

QUICK: --have to wear that full gear all day long. And she would have marks on her face from those-- from the masks. So, I know what, what a lot of you went through, and--

JULIA KEOWN: Yeah.

QUICK: We live close to the hospital and it was like a-- it was like, what, you know-- it was like a MASH unit, so the helicopters were flying in and out because we didn't have room for all the COVID patients. So, I really appreciate all the-- all of your care that you-- for the patients that you--

JULIA KEOWN: Yeah, it was carnage unlike anything we've ever seen.

QUICK: Thank you.

HARDIN: Additional questions? Seeing none. Thank you.

JULIA KEOWN: Thank you.

HARDIN: Opponents, LB203. Welcome.

DANIEL SMITH: Good afternoon, Senator Hardin, and members of the Health and Human Services Committee. My name is Dr. Daniel Smith, it's D-a-n-i-e-l S-m-i-t-h, and I'm in a-- I'm a physician specializing in infectious disease, and I'm part of consultants for infectious disease practice here in Lincoln, Nebraska. I'm speaking to you in opposition to LB203 that would change the powers and duties of health directors and certain local public health departments. While the physicians in my group work locally and frequently with our health department, they are always monitoring infectious diseases globally. And as you know, Nebraska is only an airplane ride away from an outbreak. And so, infectious diseases in returning travelers is not uncommon. As an

example, just today I saw a patient in the hospital this morning with malaria who returned from travel to Nigeria. And so, there's a few other examples that's kind of already talked about earlier. So, just in October, at the-- in Iowa, there was a conf-- confirmed the death of an Iowa resident from Lassa fever, and that individual had recently returned from travel to West Africa, where it's believed that he contracted the virus. On January 30, Uganda declared an outbreak of Ebola virus with the Sudan virus disease in Kampala. And so, the Sudan virus disease is in the same family as Ebola, and I'll bring attention to the case of Ebola that was treated at UNMC in 2015. And then just today, our Nebraska Department of Health and Human Services issued a health action network about the outbreak of Ebola in Sudan. And then, on January 20, Tanzania confirmed a positive case of Marburg virus in the Kagera region, and that's the same area that experienced an outbreak in 2023. And more cases have been confirmed with dozens of suspected cases, ten deaths, and 281 contacts. I bring up the number of contacts to give you a sense of the speed in which one case can turn into many simply by day-to-day contact with the infected individual, and the outbreak can quickly become regional and beyond if rapid and aggressive action by the appropriate health official is not taken to contain the outbreak. And so, you can imagine that our practice, as well as public health officials will be-- do ongoing monitoring of these outbreaks. And so, I wanted to consider an analogy: so, if there's a flood that washed out a bridge on a rural road, and the sheriff's department, you know, learning of this event immediately places a blockade on either side of the washed out bridge with a sign saying "road closed," what if the sheriff instead had to leave the road open and contact the county transportation board, which meets every month, to first discuss and get permission to close the road. Of course, that would be inappropriate and put lives at risk.

HARDIN: Your red light is on, but, continue, sir.

DANIEL SMITH: So I was-- so why should public health emergencies be treated any different than in that, you know, road emergency? And so, I won't go through these examples here. But, you know, we talked about tuberculosis and how, just in Kansas City, you know, the largest U.S. outbreak is ongoing right now. And so, you know, just having the local health departments have the ability to implement directed health measures where there are significant and immediate threats to public health, you know, just-- with LB203, having to wait, you know, would cripple the ability of local health departments to do their job to protect the public.

HARDIN: Yes. Thank you. Dr. Smith, we appreciate what you and your colleagues sacrificed and have done. We really do. Can we, can we have a genuine conversation just over the fence real quick, here?

DANIEL SMITH: Sure.

HARDIN: The only currency we have, as politicians-- and if you ask anyone in the public, "Who would you rather live next to: an internationally-known terrorist or a politician?" Most of them would choose the terrorist, I'm afraid. Politicians aren't known for having a deep bank of trust built up, if you will. I think the medical community took a hit during COVID. That's probably why we're looking at this bill now, right? If we don't all have 20/20-- there will be a question at the end of this, I promise-- if we don't all have 20/20 hindsight, we have better, better vision looking backwards. Right? This committee actually invested an entire session dedicated to just that topic of what did we learn following COVID, and, and that situation? What I would like to talk with you about is kind of a trust question. How does the medical community-- and that's bigger than you; that's bigger than Lincoln; that's bigger than Nebraska. So, it's kind of million feet up in the air kind of question. How do we begin to rebuild this trust? Because an awful lot of Americans and Nebraskans feel that that was badly damaged in terms of how things were handled during COVID. I do appreciate your examples of Ebola and, and these other kinds of things that have I've peeked through here. Oh my. But how do we begin to rebuild that lost trust? And again, I'm not suggesting that it was lost on 100% of everybody, but enough folks that it certainly created a public ire. And you're an expert. What, in your opinion, as you look backwards, do you look at and say, you know what, this is how we go about restoring trust in all of this? Can I get that sense from you?

DANIEL SMITH: Yeah. I mean, it's, it's a hard question to answer.

HARDIN: Sure.

DANIEL SMITH: You know, there's a lot of misinformation out there on, you know, various websites and stuff. And so, it's hard to, you know [INAUDIBLE]--

HARDIN: It is. And then, yet-- just-- what was it last week, the CIA finally came around and said, well, there's a possibility this could have not come from a wet market in, in Wuhan. And so, you know, people

are saying welcome to the party in 2025. But, can I have, have you struggle with that some more, in terms of that difficult thing?

DANIEL SMITH: Yeah. I mean, you know, you-- you know, you see patients in the hospital and they'd rather get their information from, you know, the internet and request certain things that, you know, there's no-- you know, so-- there's no evidence that that helps. And so, sometimes it's hard, you know, when you're seeing patients, you know, if they would trust something else than trust you. And it-- I mean, I don't have a great answer of how to restore people's trust, unfortunately.

HARDIN: It's something we'll have to work on together. Is it possible that if it's not this bill, is there a law that could be passed that would help restore that trust?

DANIEL SMITH: Probably not.

HARDIN: You don't think so? Whether it's a damaged marriage or a damaged corporation, or whatever it might be. It does take t-i-m-e, doesn't it?

DANIEL SMITH: Definitely.

HARDIN: Yes. Thank you, sir. We appreciate it. Ah, Senator Quick has a question.

QUICK: Yeah. Thank you, Chairman Hardin. So-- and I wanted to thank you also for all the work that-- and I'm sure you've put a lot of time into-- with COVID patients. But one of the things within our community was education from our public health district, with all the-- our local officials, and-- whether they were elected or physicians, the medical community, you know, we had a great collaboration. I think education is one of the ways that we can really change that perspective. And I don't know, is that-- that's something you could address? Or--

DANIEL SMITH: Yeah, no, I, I agree. I think educating the public as best as possible from trusted, reliable sources, I think could help restore, you know, trust in the medical community for sure.

QUICK: Thank you.

HARDIN: Other questions? Thanks for being here.

DANIEL SMITH: OK. Thank you.

HARDIN: Opposition, LB203. No other opposition? Neutral. Welcome.

BETH BAZYN FERRELL: Thank you. Good afternoon, Chairman Hardin, members of the Committee. For the record, my name is Beth, B-e-t-h, Bazyn, B-a-z-y-n, Ferrell, F-e-r-r-e-l-l. I'm with the Nebraska Association of County Officials, I'm appearing neutral in LB203. When this issue was introduced two years ago, we didn't have a position on the public policy aspects of it, and we still don't today. We've stayed out of the discussion of whether, you know, DHMs are constitutional, or mask mandates, all of those things. That's not our, our issue. We've looked at it strictly from the mechanics of it. How do you get from point A to point B? And that was our conversation. We worked with Senator Kauth on that two years ago, and this bill reflects that. So, we are neutral on the bill as it's written. However, I would say if the committee is interested in looking at more of the mechanics of how this should work, we would be happy to be a part of that, so. I would be happy to answer questions.

HARDIN: Thank you. Appreciate that. And-- questions? Senator Hansen.

HANSEN: Thank you, Chair Hardin. So, you're in favor of the county officials making the final decision about a directed health measure, or no?

BETH BAZYN FERRELL: We don't really have a position on that part of it--

HANSEN: That's the first time NACO has ever come out and not given a position on county officials' ability to do something. So, usually it's always--

BETH BAZYN FERRELL: Well, I mean-- we always like local control. You know, that's, that's very important. Our, our part of it is, though, we have such a diverse audience of county officials; our membership has very differing opinions, and so that's why we didn't take a position on that part of it-- the public policy part of it. As far as county officials being involved in making the decisions about what goes on locally with the health departments, then, yeah, absolutely. We need to be a part of that.

HANSEN: OK. Good. So, in one of the instances that Dr. Smith gave about somebody who has hepatitis A, you know, and it's a foodborne illness, right? And they're in a restaurant, and somebody found out

they had hepatitis A. And-- a directed health measure, the county-- you know, the county or city public health director said we need to go and arrest that person to save other people's lives. With-- and without county input, that'd be OK?

BETH BAZYN FERRELL: I think every situation is probably going to be different. I mean, the examples that we've heard today, there are a lot of different variables that, that go into that. You know, public safety is essential.

HANSEN: That's all right. I don't-- I don't mean to beat you up, I'm just kind of curious at, like-- it seems odd that usually when you're-- when we're saying we're going to give more local control, I'm going to give more responsibility to county officials, almost always, I think I've seen NACO come out saying, yes, we love this, we want more responsibility. But on this one, we're neutral. Was-- just is kind of odd to me, so. I thought you guys would be in favor, but that's all. But-- I just-- kind of see your point, though, too, so. About where you're coming from. Thank you.

HARDIN: Other questions? Seeing none. Thank you for being here. Those in the neutral. Welcome.

ERIC GERRARD: Chair Hardin, members of the committee, my name is Eric Gerrard, that's E-r-i-c, last name is G-e-r-r-a-r-d. I'm here today in the neutral capacity representing the Nebraska Association of Local Health Directors. I do want to be clear. I was directed not to testify on this bill, but I've spoken with Senator Kauth and, and she mentioned my name. I did want to acknowledge that, along with NACO, the statewide health directors did work with Senator Kauth in the 2023 session, 2024 session. So, I wanted to acknowledge that work. And then, I know there were some questions about kind of each of-- how the health department may work in each of your districts. I just want to commit to the committee if we can get you more information-- it sounds like Senator Meyer has good experience working-- well, he's been on the health board, so he knows the mechanics, how that works. So, if I can provide more information to the committee, I'm happy to do that. So, that's, that's why I'm appearing in front of you today. If you don't see me on Monday, it's because I was directed not to testify in hearing. So.

HARDIN: Questions? Seeing none. Thank you.

ERIC GERRARD: Thank you.

HARDIN: Those in the neutral, LB203. Seeing no more. Senator Kauth. Welcome back.

KAUTH: Thank you very much. And thanks everybody for saying and asking the really good questions. I do want to shout out to both NACO and Eric Gerrard. It-- they worked with me extensively, and that's exactly right. They have a really detailed plan for the mechanics of how this actually works. I do want to point out that the, the question about ratification is actually incorrect. When we say ratification, we mean there's a problem, it's an emergency. You make a decision with your group, and then once the emergency-- the-- at your next available meeting, you ratify it. So as I, I spoke about, the goal is to have these decisions made quickly, but you still have to have that sit-down in public to ratify what's happening. So, ratification doesn't mean you know that there's a problem until you wait for a month until your next board meeting. It just means at that next board meeting, you go through and give the public the reasoning and all of the decisions that were made, and then you ratify it, say, "Yep, this is what we did, this is what we agreed to, and this is why we did what we did." So I want to make sure everybody understands. The goal of this is not to complicate things. And if there are some issues, it-- the Lincoln-Lancaster board had some concerns; happy to work with them to figure it out. The goal is to say we need to make a decision quickly, but those decisions have to be made by the elected officials. Again, we're talking about not-- and I'm going to say this word wrong-- epidemiologically-linked. We're not talking about those, those illnesses that it's a contact trace, like one person to another, and you have to go down that list and get those people. We're talking about mass countywide directed health measures that affect everyone, regardless of their contact with anyone who's ill. That's what we're talking about. That's what we have to be very, very careful that we do not allow those things to be happening again, as Senator Meyer said. They got pretty extreme. You could have had people being pulled off the street because of these directed health measures. We want to make sure that our freedoms are safeguarded, even as we're safeguarding our health. So, thank you. And any more questions?

HARDIN: Thank you. Questions? Senator Quick.

QUICK: Yeah. Thank you, Chairman Hardin. I heard-- one of the questions I would have is, so what happens if they go to ratification, and there is, like-- I know how county boards can be sometimes; they're not always going to agree. Just like what happens in the Legislature, right? But what happens if maybe they go against what

original directive was, or if there's a lot of disagreement, or you have public [INAUDIBLE].

KAUTH: Well, at, at-- what the ratification essentially is saying is putting on the record that this is, this is what was discussed, this is what was presented to us, this was the vote we took, this is how we came to that arrangement. So it's a-- more a matter of here it is on the record. Then, going forward, if you say, hey, we think we screwed up, or hey, I don't like that, then it gets reopened to more discussion further. But it's just-- again, you want to be able to make that decision and take actions, but get it on the record so that people understand what happened.

QUICK: OK. Is that open to the public then, too, for ratification?

KAUTH: Exactly. Well, exactly like any other hearing would be.

QUICK: OK.

KAUTH: So, yeah.

QUICK: All right. All right. Thank you.

HARDIN: Other questions? I was just going to comment on the time piece again. There became some threshold for all of us-- and I'm referring once again to COVID-- where we knew that liberty had been strained. It was perhaps different for each one of us. State by state, it was handled differently, and so on and so forth. But there came a time when we sensed that, wait a minute. There are certain things we know now that we didn't know at the beginning. And so, ignorance in the truest sense of the word began to wane as we learned more about what was going on. And yet, there were places-- and thankfully, Nebraska was not one of those heinous examples of how liberty was trounced upon like some other states. California, are you listening? And we're thankful for that.

KAUTH: Yes.

HARDIN: But there was a sense in which a lot of time had passed.

KAUTH: Correct.

HARDIN: We've been discussing in the context of day-- of hours and days. We were dealing with years when we actually knew. Very different

things by, frankly, the middle of 2022 than what we knew by March of 2020.

KAUTH: Correct.

HARDIN: And so I, I think that's why I bring up the issue of time. There does come a threshold in that time where we have crossed over into the absurd.

KAUTH: I would agree wholeheartedly, which, again, is why making elected representatives the ones responsible-- that's really our only way to protect our freedoms in that manner. Because if it's an unelected bureaucrat who is making a decision--

HARDIN: Right.

KAUTH: Again, we saw that happen in, in Douglas County, where every elected official was against mask mandates in February of 2022 and it was still implemented. We had no recourse.

HARDIN: Yes. Any other questions? Seeing none. This concludes our testimony for LB203 and our hearings for today.

KAUTH: Thank you all very much.

HARDIN: I would ask everyone-- we are going to exec, crew.