HARDIN: Welcome to the Health and Human Services Committee. I'm Senator Brian Hardin, representing the real west, 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 today, 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. So on that note, how many of you are planning to testify today on LB554? OK. There's a few seats right up front here. And so kind of move up here, if you don't mind. Takes a moment or two to do that. 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 in the back of the table, at the back 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. Guess which part we often forget? Spell your first and last name. We need to 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'll 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 the red light indicates. You need to wrap up your final thought 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 bill. It's just part of the process as senators have other bills to introduce in other committees. A few final items to facilitate today's hearing. If you have handouts or copies of your testimony, please bring up at least 12 copies and give them 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 be cause for you to be asked to leave the hearing. Finally, committee procedures for all committees state that written position comments on a bill, to be included in the record, must be submitted by 8 a.m. 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 today introduce himself, starting with Senator Riepe.

RIEPE: Thank you. Chairman. I'm Merv Riepe, I represent southwest and south central Omaha and the fine little town of Ralston.

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

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

MEYER: Glen Meyer, I represent District 17, which is northeast Nebraska. It's Dakota, Thurston, Wayne and the southern part of Dixon County.

QUICK: Dan Quick, District 35, Grand Island.

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

HARDIN: John Duggar is our legal counsel and Barb Dorn is our committee clerk. Our pages today are Sydney Cochran and Tate Smith, who are both amazing students at UNL, and we're glad they're with us today. Today's agenda is posted outside the hearing room. And with that, we will begin today's hearing with LB554.

RIEPE: So it's nice to play to a full house.

HARDIN: Welcome, Senator Riepe.

RIEPE: Thank you, Chairman Hardin. Are you ready for me to go?

HARDIN: Take it away.

RIEPE: Thank you. Chairman Hardin again, and members of the Health and Human Services Committee. Good afternoon. My name is Senator Merv Riepe, and that's Merv, M-e-r-v, Riepe is R-i-e-p-e, representing, as I said earlier, Legislative District 12, and I am here today to introduce LB554. LB554 replaces the existing credentialing review program, commonly known as the 407 process with the Nebraska Health

Professions Commission. The 407 process has been in place for decades, requiring the information of temporary technical committees to review credentialing applicants and propose scope of practice changes. While this system has worked for some professionals, either in expanding their ability or protecting it, others have encountered inefficiencies, delays, and inconsistent outcomes. Many who have gone through the process without a favorable resolution describe it as tribalistic and protective of existing professional territories, rather than being centered on public health, public health needs. LB554 modernizes this approach by creating a permanent commission responsible for conducting these reviews in a structured, transparent and data driven manner. A key component of this legislation is its reliance on Nebraska's institutions of higher learning to provide independent, evidence-based analysis. The Commission will be co-chaired by representatives from two major academic institutions affiliated with public health, one from the University of Nebraska medical center and the other from Creighton University School of Medicine. This structure ensures that credentialing and scope of practice evaluates-- evaluations are based on workforce data, public health considerations, and national trends, rather than being driven solely by the stakeholder influence. The commission will also include representatives from key health regulatory bodies with professional and geographic limitations on membership to ensure broad and equitable representation. LB554 also provides for an annual appropriation of $300,000 to support the commission's activities, including data collection, analysis, public hearings, and reporting. Of this amount, 100,000 is specifically allocated to the Health Professions Tracking Service at the University of Nebraska medical center, ensuring comprehensive workforce data collection and assessment. However, that number is certainly amenable, and we are working to identify alternative sources for funding that in theory can remove the need for a state appropriation. The commission will conduct public hearings, evaluate workforce shortages, assess health care access, and submit annual recommendations to the Legislature. Unlike the current process, where changes must be initiated by an external applicant group, this commission will have the authority to proactively, but not implement, modi-- modifications to scopes of practice when public health data or emerging trends indicate a need. This ensures that Nebraska can respond more effectively to workforce challenges and evolving health care demands, rather than waiting for a referral and the ad hoc information of a review committee. Importantly, LB554 introduces safeguards to prevent conflicts of interest and ensures fairness. No member of the Commission will be allowed to vote on matters directly

affecting their own regulatory profession, a health profession in which they belong, or a health profession in which they may license. Additionally, by creating a consistent and pointed review body, LB554 reduces the political dynamics that have historically influenced 407 deliberations, leading to more object-- objective and predictable outcomes. You will likely see these dynamics play out in the testimony that follows. Many will argue to protect their own territory, even if it means rejecting a system that could ultimately benefit them. The financial incentives behind this resistance could be debated endlessly, but the reality is clear, and I emphasize, when we limit providers from practicing to the full extent of their ability and training, it is not the professions that sufferer, it is the patients. And in a system meant to serve them, that should be unacceptable. Ultimately, LB554 is about modernizing and improving how Nebraska evaluates the regulation of health professionals. By replacing the temporary, fragmented 407 process with a standing commission that is academically anchored, publicly accountable, and data driven, we can better ensure that credentialing and scope of practice decisions are made consistently and in the best interest of all Nebraskans. Thank you, Mr. Chairman.

HARDIN: Thank you. Questions? Senator Fredrickson.

FREDRICKSON: Thank you Senator Hardin. Thank you, Senator Riepe, for bringing this bill and being here. I have a couple of questions for you. You, you-- so you mentioned one avenue, this is kind of a bit more of a logistical question, you said, I'd be remiss not to ask you a finance question, you said you're looking for alternative sources of funding for this. Where-- what is that? What do you envision that being, would it be like through grants or like what, where--

RIEPE: Well, the thought was, just as we've heard before in this committee, we may look at the Excess Managed Care Funds. Or quite frankly, there are opportunities of private foundations that would have an interest, because this particular bill, in my opinion, LB554, has the greatest impact on the rural health care delivery. And rural health care delivery, in my humble opinion, is in a very serious situation. We talk about the deserts. We have to do a better job of putting together a plan, and there are foundations and organizations that will get behind that, I believe. And I am more than prepared to go to them personally or with expert people and some of those I know in the Omaha market that might very well, are very generous and would be willing to make this happen.

FREDRICKSON: That's good. My, my other question for you is--

RIEPE: Yes sir.

FREDRICKSON: So one aspect of the bill, as I understand it, is the actual makeup of the commission will shift from what the current 407 process looks like, who's actually on the commission. Can you speak a little bit more to how might, how would the process look different than what we currently have, I know, in terms of timeline and, and things along those lines.

RIEPE: I have worked closely with Doctor Khan, who the dean of, you know, of the Med Centers of Public Health, and also Doctor Shipman over at Creighton. And the idea here is to have a commission that is a step away, so it can be more objective, and it's more data driven, it's more factual driven, and it's more objective, and less conflicts of interest. And quite frankly, in my humble opinion, again, that has been pretty much dominated over the lifetime of the 407, with some people that-- feeling that they, they didn't get a fair hearing and that would be the intent of driving that to that piece. Underneath that would be, I believe those-- the-- they would be the standing co-chairs as it's drafted, and they would have then-- they would appoint, who have to be confirmed by the Legislature of members, and their standing positions there, I believe, I'm calling from memory here, but the medical director from DHHS and there are some-- so there's- and I believe that the director of DHHS is also a member on that commission, so that we're not trying to walk away strictly from DHHS. We just want more-- you know, less to be, less self-serving, and to make sure that we don't strictly have professionals who have self-interest to protect, that don't have an interest in the bigger picture as to where health care is going to go into the future.

FREDRICKSON: Sure. Thank you.

HARDIN: Other questions? Do we have a sense in terms of what the annual cost is of our current 407 process?

RIEPE: Of what the current cost is?

HARDIN: Yeah.

RIEPE: You know, I don't know that.

HARDIN: OK.

RIEPE: Someone I'm sure that will come forward may have that.

HARDIN: OK.

RIEPE: But all we do know is it's not free.

HARDIN: Just to toss it out, we know that part of what is going to come up in the next few minutes is safety and security of Nebraskans as we look at the possibility of altering this process. Can you speak to the cogency of what you're proposing and how it addresses safety and security concerns to make sure that, oh, I don't know, someone who is trained in dentistry doesn't perform lobotomies or something like that?

RIEPE: Well, and that's where this, this commission would look into this very seriously. The intent here is to try to use people at their highest training. Some of this is-- and not this particular model, I-- this was developed with the help of outside, but not any particular model. But I, I will tell you this. I have been studying and reading on the Australian model, and because they have Melbourne and Sydney and then they have the outback. So it's almost a perfect model for us to look at a state that's very urban and then rural to try to, to build something. And they are very specific, as we would be, about making sure that people don't exceed their scope of practice. And we will also have limits on terms of what they can and cannot do. We don't want to have them being free-for-alls out in other parts or any part of Nebraska. But we do want them to practice to the maximum of their ability. And I think that that, I go back to the rural, I think it's the only answer to look at the rural. We have to have a-- we need to have a multi-year plan and not just an incidental show-up that says, you know, I want to, I want to become a this, that, or whatever. You got to be-- you got to think short term, but you got to plan long term.

HARDIN: Thank you. Any other questions? Will you stick around?

RIEPE: I wouldn't miss it.

HARDIN: Oh, very well, thank you.

RIEPE: Thank you, sir. Thank you.

HARDIN: Proponents, LB554. It's those in the favor, come on up. Don't wait. Rush right to the front. Welcome.

ALI KHAN: Thank you, Senator Hardin. I will, I will remember to answer your question after my testimony.

HARDIN: Thank you.

ALI KHAN: Good afternoon, Chairman Harmin-- Hardin, members of the Health and Human Services Committee. I'm Doctor Ali Khan, for the record, A-l-i K-h-a-n. I'm a physician epidemiologist, a retired Assistant Surgeon General. I'm here to you-- today to testify in support of LB554 in my private capacity as a Nebraska citizen concerned about the health disparities in rural Nebraska. I may look like the dean of the College of Public Health, but he's a lot more handsome and charming than I am. LB554 creates the Nebraska Health Professions Commission, which is responsible for reviewing scope of practice proposals or proposals seeking to credential new professions. The Commission may also initiate proposals for scope of practice review. During these reviews, the Commission will consider the impact on public health and safety, including workforce shortages, health care quality, access issues, patient affordability, and it'll also have the authority to conduct fact finding. The commission would replace the ad hoc Technical Review Committee in the old 407 credentialing review process. So two questions. Why is the change needed? Here's three suggested answers. The health disparities continue to increase in this space, in this state, particularly harming those in our rural areas. Based on data from the Behavioral Risk Factors Surveillance System, major differences were found when rural and urban areas in Nebraska were compared between 2019 and 2022. And there's a reference to this document on the UNMC website that's brand new as of this month, that-- with the most recent data that looks at these rural disparities within the state. Let me give you three quick examples. People living in urban, large urban areas have better access to health care services, less likely to engage in risky behaviors. Large urban survey participants, compared to small, urban and rural respondents, are more likely to perceive their health status as fair or poor, less likely to forgo seeing a doctor because of cost, and a third one here is large urban participants were more likely to be screened for colo-- colorectal and breast cancer. And I can give you numerous other examples of these disparities in rural health care. Number two reason, the health care landscape's changing dramatically. We all see this. Many workforce roles are shifting, expanding to meet these changing needs. For example, advanced nurse practitioners-- nurses-- advanced practice registered nurses and public health dental hygienists have expanded roles. Numerous roles are also emerging to meet identified needs such as community health workers, doulas, and

others within our communities. And finally, at the same time, there are more barriers and gaps limiting access to health care services due to workforce shortages and affordability issues. In 2023, there were fewer family practitioners and general practice dentists than there were in 2017 here in this state. So that's sort of why it change. As for what are the benefits of the change, three-- I think I have three or four examples again. More flexibility and innovation within-- with the best evidence that allows all healthcare providers to work at the top of their scope of practice. And this includes potentially opportunities to restrict scope of practice based on specific locations.

HARDIN: Your red light is on, but please continue, Doctor Khan.

ALI KHAN: Oh, thank you, Senator Hardin, my apologies. I'll, I'll be very quick with these last two, two, three points. This commission would help to streamline the process and consider broader changes that are occurring in the health care system. The commission is designed to be more objective, provide more evidence-based recommendations, and has-- we heard from Senator Riepe, it would be co-chaired by the two large medical colleges here in the state. A proportion of the funding would be used to conduct workforce studies by the Health Professions Tracking Service. This is again about that data piece. What's the workforce data? Who are these individuals? What are they doing? What is their impact? And if you change their scope of practice, how are you monitoring that change to make sure that you're have-- improving access and improving quality wherever you've made those decisions. And finally, again, as we have better delivery models, this would be a way to modernize the scope of practice for those better deli-- models. I think I'll just stop there. The rest you have in your written notes.

HARDIN: Thank you.

ALI KHAN: Thank you, sir.

HARDIN: Questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Doctor Khan, for being here and for your testimony provided. Can you speak a little bit about-- so I'm, I'm, I'm understanding the function of the bill I think. But you know, we're talking a lot about scope of practice and, and possible shifts in scopes of practice. Can you talk a little bit about how if we as a state look to shift the scope of practice for a specific profession, can you talk about the relationship between that

and sort of maybe like a national professional organization? So, you know, Academy of Medicine, or National Association of Social Workers, like, how are we envisioning, you know, the scope of practice we're looking to allow for-- in our state with harmonizing that with maybe what national organizations might say is sort of the scope of practice for that profession, if that makes sense?

ALI KHAN: So thank you, Doctor Fredrickson, for that-- Senator Fredrickson.

FREDRICKSON: I got, I got a promotion.

ALI KHAN: [INAUDIBLE]. If you want a PhD come see the dean Ali Khan part, he can work on that with you, Senator Fredrickson. And I think this goes to Senator Hardin's question earlier about the safety and security of this bill for the, for our citizens. So, yes, the crede-- the prac-- the education of practitioners and national guidelines would feed into how you think about scope of practice. That would be modified by what we know going on across the United States and innovations as we think of scope of practice and what we're seeing in other countries that deal with this specific issue in rural areas, especially Canada and Australia, because they have the same, almost the same exact set of, set of issues, and then, to then sort of suggest that this would be what a scope of practice change would look like. The way this commission is set up, then that would be monitored to see-- potentially restricted to say you can have this scope, scope of practice change only in this area, not anywhere else. That scope of practice change would be monitored to say, did we really increase access, did we improve quality for our patients, did we include affordability for our patients, yes or no? And then that would be a continuous cycle to say, well, maybe that wasn't such a great idea. The other specific part about safety and planning is this process as envisioned and reported to me by Senator Riepe does not overstep the bounds of the licensing board. So the-- you-- the commission would make a suggestion for scope of practice, it would come to the Legislature, the Legislature would agree or not. And then it still goes back to the licensing board that goes, we hear that we should or should not do this. How, how do we implement that? How do we make sure that somebody has the appropriate additional education or the additional skills to be able to do X, Y, and Z?

FREDRICKSON: Got it. Thank you. That's all.

HARDIN: Other questions? Senator Ballard.

BALLARD: Thank you, Chair. Thank you for being here, Doctor. I, I have a concern about professional bias on the 407, how do you protect from professional bias on this, this co-- commission. So we-- scope of practices come to us, it's it becomes a turf war almost. And so how do you protect from that on this commission?

ALI KHAN: I believe that was, and I will not speak for Senator Riepe, I think that was one of his main motivations for trying to create this sort of apolitical, nonpartisan, no dog in the fight, the public health folks don't care, right? It's really about, at the end of the day, about outcomes within our communities, for our rural communities. Do our patients have better access? Are they, are they healthier or not? Right? And so I think part of that, part of the reason for the commission was to try to do that, to make sure you eliminate as much bias as possible in the process of how you make these decisions. Plus, the commission as it's established, the members should help do that. And at the end of the day, it's all, it's all evidence and data driven, right? It's the way at least this is structured. So that you see did you improve care of patients or did you not improve care of patients.

BALLARD: OK. Thank you.

HARDIN: Other questions? Senator Meyer?

MEYER: Thank you, Chair Hardin. Just to follow up on what Senator Ballard was alluding to. So we have a relatively independent commission that reviews scope of practice, but then it gets kicked back to the Licensing Board. And so once again, we're having someone, perhaps, that does have a dog in the fight, that the licensing board, perhaps not following up on the recommendations. Is there-- I know it's almost impossible to safeguard that, but there's still that opportunity for the professional bias, perhaps, or the particular medical discipline that the scope of practice is being expanded on the recommendation. So how do we get past that? Because I still think there can be a, a turf war, if you will, to, to use Senator Ballard's words, once it gets to the Licensing Board. The recommendation is one thing, but having it actually enacted upon in a positive way is another. And so is there any way to encourage the licensing board to act po-- act positively on your recommendations of scope of practice?

ALI KHAN: So, Senator, that is not an area of my expertise on how do you have the executive branch listen to the Legislative Branch. But I'm going to refer that to Senator Riepe when he responds on how that

piece works. The commission part, though, is to make the recommendation that then the Legislature would approve or not approve to send to the licensing board. There's-- I know we were framing this in bias, but as a clinician, I want to remind everybody that this is also about silos of excellence. And we need to maintain our practitioners working at the highest scope of their practice, providing the best possible care for their patients. And when that is their motivation, that is a good thing, right? Because they want to make sure that at the end of the day, the patient has the best possible care. And these other-- these professions, professional organizations obviously have the opportunity at the legislative level to chat with-- When these, when the recommendation goes forward to say we like it or we don't like it, I mean, so there is that opportunity there for them to opine on that. And, but again, I have no, I have no comments or no knowledge to talk about how do you then make the licensing board act on something that's been approved by the Legislature?

MEYER: So we should grant you more authority.

ALI KHAN: No. But.

MEYER: Thank, thank you very much.

ALI KHAN: Thank you, sir.

HARDIN: Senator Quick.

QUICK: Yeah. Thank you, Chairman Hardin. So like, could you expand a little more on, like on-- so I could see this maybe helping in the rural areas where we do have a lack of-- Could you expand on that some more?

ALI KHAN: I'm absolutely glad to. And that, that's always been the driver for this as you think about multi-- how do you put together in today's day and age multidisciplinary teams that take care of a patient as opposed to say, well I'm the pro-- I'm, I'm the provider, right? And so if you think about this the way some of our colleagues in other states and Canada and Australia have been looking at this, it's really about saying, well, we have a physician, we have a pharmacist, we have a dentist, we have a nurse practitioner. How do we make sure everybody is working at the top of their practice in a multidisciplinary fashion to provide care for this patient? And I think this is the way, if we, if this is done correctly, that's what

would happen, is that if everybody be working at the top of their practice and stuff that sort of, they are obviously licensed and allowed to do, but somebody else could do, well, maybe you move that down to somebody else who, who is in the community who could do that and has the skills to do that, but would not potentially always be doing that, given the way we're currently structured.

QUICK: Thank you.

ALI KHAN: Yes sir.

HARDIN: Other questions? Do you have a sense how other states are handling scope of practice related issues as you talk with other physicians and so forth?

ALI KHAN: It's so-- It's very heterogeneous, sir, across the nation on how people are approaching it. There are some efforts around-- Many of the efforts as they're moving forward is about sort of consolidating some of this, making it a little bit clearer and streamlined as a process as opposed to multiple, multiple layers to try to, try to get these done. And at the end of the day, they're really is about being more innovative. As I said, you can res-- if-- it's-- if-- You can restrict scope of practice. So if you have enough clinicians in this part of the state that do X, then there's no reason to assign other people authority to do X in that part of the state, because you got enough clinicians. However, in this part of the state, you have nobody who does it. Well, then maybe you need to think a little bit more creatively about who should be allowed to do it in that part of the state. So there's these sort of conversations happening right now to think about, we don't have to do this the way we always did it in the past. There may be other ways to do it. The pandemic also helped us think through this a little bit better. Because of the pandemic, a lot of clinicians across the field were allowed to do things that they, that they had the opportunity and ability and skills to do. I want to be clear, right. It's not like, hello, go do lobotomies, right? So they had the skills to do it in the knowledge to do it, but in typical practice did not do it. However, during the pandemic, when there was such a dearth of healthcare providers, with this massive influx of patients, those scope of practice guidelines were changed to allow people to do things they didn't routinely do, and we did not see this great drop off in, in quality of care for people across our nation.

HARDIN: Are you suggesting that there might be a difference in what's required in a rural versus urban area? Is that a possibility?

ALI KHAN: Given what providers, sir, are in a rural area compared to what your facilities are within an urban area? Absolutely. I think we should be thinking of healthcare differently based on what, what resources are available to you when-- with the, with the final thought of how do you provide the best care for that patient, no matter where they are in this state?

HARDIN: I encourage everyone watching, get out your Google and start looking up home rule versus powers granted. Thank you. Appreciate you being here.

ALI KHAN: Thank you Senator. Thank you, committee.

HARDIN: Proponents, LB554. Proponents. We're looking for opponents of LB554. How many of you intend to testify? I thought there might be a few of you. OK, good, you're up front, that's what I wanted to check and see. Opponents, LB54. Don't be shy. We don't bite, though the pages do know karate. So just letting you know. Welcome.

RUSSELL CROTTY: Thank you, Chairman Hardin. My name is Doctor Russell Crotty, to test-- that's R-u-s-s-e-l-l C-r-o-t-t-y. I'm testifying today on behalf of the Nebraska Optometric Association membership and serve as the current president. I do want to clarify that I'm not testifying on behalf of the Board of Health, but I have been a member of the Board of Health for the last four plus years. We do appreciate Senator Riepe's com-- commitment to improving Nebraska's credentialing review program. Our association has long supported modern-- modernizing the 407 process to ensure a more efficient, transparent, and fair review of scope of practice proposals. However, LB554 is not the right solution and would create more problems than it solves. Our key concerns with LB554 is that this could actually slow the review process instead of improving it. The primary goal of reform should be to streamline and expedite the process so the Legislature can make timely decisions on health care policy. LB554 does not shorten the timeline or improve efficiency. Instead, it consolidates all reviews under a single Health Professions Commission, which would be responsible for conducting every credentialing review. Given the pace of change in health care and the number of applicants submitted-- applications submitted each year, this centralized approach could create a backlog, delaying reviews and forcing professionals to wait even longer for consideration. This could potentially expand government bureaucracy and overreach. The bill grants the new commission the authority to initiate its own directed reviews, meaning it could independently decide to revisit the scope of practice for an

existing profession even when no application for change has been submitted. This is a significant departure from the original intent of the credentialing review program, which was designed to evaluate requested changes not to proactively challenge existing scopes. Allowing an unelected body to wield this kind of power sets a concerning precedent and creates unnecessary uncertainty for health care professionals. This could increase physician control over scope decisions. The commission's membership would be largely determined by Nebraska's two medical schools, and the commission would be comprised of individuals having little experience with the professions of most nonphysician providers. Under our current system, the Technical Review Committee already struggles with understanding the nuances of the professions they evaluate, let alone implications of proposed changes. LB554 does nothing to improve this. Under this bill, the technical phase of the 407 process would still produce a recommendation from people with no particular expertise on the education or training of professions under review. Furthermore, this comes with an unjustified $300,000 annual cost. I know, Senator Riepe talked about potentially finding some funding, but this would create a permanent new government entity with an ongoing price tag of $300,000 per year. This added expense is difficult to justify when there are better, more efficient ways to improve the credentialing process without adding new layers of bureaucracy. And finally, this fails to address the underlying issue of the 407 review criteria. Over the past year, stakeholders, the Board of Health and legislative hearings have repeatedly identified flaws in the criteria used to evaluate credentialing proposals. The current system focuses too heavily on proving an unmet need, rather than assessing whether a proposed change would provide public benefit. LB554 makes no attempt to improve these outdated criteria, meaning the fundamental problem remains unaddressed. A better path forward, instead of advancing LB554, we encourage the committee to consider the targeted reforms outlined in LB436, which more effectively modernizes the 407 process by reducing the review timeline from 12 months to 6 months, ensuring more timely decisions; clarifying evaluation criteria to focus on public benefit rather than simply providing-- proving need; and maintaining multiple levels of oversight, while ensuring those with direct expertise in a profession have a role in the technical review. For these reasons, we strongly urge you to oppose LB554, and instead pursue reforms that truly improve the credentialing review program without creating unnecessary delays, costs, and regulatory overreach. Thank you for your time and consideration. Happy to answer any questions.

HARDIN: Thank you. Questions? I've had-- heard LB436 is a fine bill.

RUSSELL CROTTY: Well.

HARDIN: So.

RUSSELL CROTTY: I hope you think so, Chairman. I'll be testifying on that here before too long. I will say, if I may, Senator Reipe's and, and Dr. Khan's comments, a lot of the goals that they have align with the goals that I have too, which would be to improve things for rural access. I just don't know that this is the way to get it done. In my opinion.

HARDIN: Can you tell us a little bit more about the, the last portion of your testimony, when you say a better path forward. It's, it's always the how questions--

RUSSELL CROTTY: Right.

HARDIN: --that are tough, right? How does this work?

RUSSELL CROTTY: We all can see there's a problem. What's the solution?

HARDIN: Yes. Can you give us, and wrestle with us for just a moment about how you, practically, would see moving things along in a, in a way that would help? Just talk to me over the fence.

RUSSELL CROTTY: Sure. I think two key things that are still an issue. One is that we're asking a group of people who don't understand a profession to debate the technical aspects of it and provide that information to legislators. That's a fundamental flaw. We need the experts in the room hashing things out. So I do feel like that's where LB436 is going to address that. And then furthermore, being a Board of Health member and sitting in a lot of 407 review processes, a, a big fault in the process is, is the criterion themselves. They're confusing, they're worded in a way that you have to vote no when you actually want to support it, or you have to vote yes when you want to oppose it. And, and that's been a source of frustration for everybody who has been in the process, including Board of Health members. So those are two of the key things. I think, again, I align with them and saying professionals should be able to provide care at the highest scope of their training. That is what essentially everybody who's trying to go for a scope enhancement is trying to do, is to utilize their training to their fullest potential to better serve the public. But it does become a turf war when there's opposition. So the 407

works pretty smooth if there's no opposition because it's-- it just goes through. But once there's opposition, it does become a, a tough process to, to utilize effectively.

HARDIN: Can you provide a peek into the board situation? Because one of the things I've noticed is there, there are, give or take, across the various boards, maybe 30 people who serve. If my math is correct, I don't think there's anyone that li-- lives west of North Platte who serves on those boards currently. And I'm just saying there's another three hours of Nebraska at 75mph past that. That's where I'm from. And so there is a concern of is there a tone deafness to the needs of the rural counties in Nebraska? Not that those are the only rural counties, but the urban rural divide. I know that's never been brought up before here in, in the Capitol, but can you speak to that a little bit for us?

RUSSELL CROTTY: Can you clarify on which boards you're referring to, on the Board of Health or on--

HARDIN: To my knowledge, none of them live to the west of North Platte at this time.

RUSSELL CROTTY: I, I do chair the Professional Boards Committee, a subcommittee of the Board of Health that is in charge of assigning who serves on the professional boards. And I can assure you, we take into consideration if we get an applicant that is from rural Nebraska, we give that some credence. You know, we're always looking for applicants to have a better representation. They're not always there because these board meetings are in Lincoln and they're driving those hours you mentioned to get here.

HARDIN: And, and we're mostly looking for sensitivity to that. And doesn't mean-- you might get someone from out my way, and they could be the least qualified person on the earth to, to be there. That doesn't magically make them qualified--

RUSSELL CROTTY: Sure.

HARDIN: --right. But it's, it's about that rural urban divide. And I guess, just speak to how-- does that get wrestled with?

RUSSELL CROTTY: It, it does.

HARDIN: And if so, how.

RUSSELL CROTTY: But it still needs to be improved, I would say. I, I consider myself rural Nebraska. I'm not as far west. I'm I'm in Auburn, southeast Nebraska, it's still for my patients a significant cost and drive to, to go see a specialist. So I think, I think the majority of board members are aware of it. And I think I'm, I'm at least doing my part to make sure that it stays at the forefront.

HARDIN: Very well. Thank you. Oh wait, Senator Meyer.

MEYER: Thank you, Chairman Hardin. It, it-- obviously, we're trying to address a problem here. What is the size of the problem? What-- how often is scope of practice rejected? How often is it approved? It would appear if we're trying to address the problem here with some legislation, that it would appear that we're not having sufficient approvals or scope of practice to, to essentially extend medical care to our underserved communities. So maybe you can't address that, maybe you don't have the numbers and it might be an unfair question for you, and perhaps someone behind you could answer that. But how often is, is scope of practice reviewed for an individual, and how often is it rejected or approved? Do you have any, any sense of that that can give me a-- some parameter?

RUSSELL CROTTY: I have a sense of it. I can speak to my own profession, obviously, more so than others. We've had-- for optometry, I think we are probably considered one of the professions that's gone through the most 407 processes, because we do have an ever evolving scope. We have had some victories, I guess you'd call it, and we have had rejections as well. There are steps in the process which have consistently voted against us. And we've still been able to achieve legislative change despite those. So there are certain parts of the process that are consistently rejecting us, but that doesn't always result in the final say. Most recently, our bill was for a specific procedure called selective laser trabeculoplasty. It's a, it's a laser procedure for glaucoma treatment, which I was trained to perform in Oklahoma when I went to school there. I graduated in 2013. So, long been a part of training for all optometrists coming out. Where the 407 hung up on our specific bill there was, what about all the doctors who graduated, you know, 20 years ago who maybe didn't receive that same training? And of course, we tried to address those concerns, saying, look, there's roughly about 20 other states that are already implementing this and doing this. And there's a complete-- a very safe track record of showing no significant complications. I think there's one reported case out of these 20 states that have had any complications. So we've provided that evidence, but are still getting

it hung up or rejected and not able to advance that scope. So it, it has been a concern for our profession.

MEYER: So the approval rate, one out of ten?

RUSSELL CROTTY: I would say--

MEYER: Two out five?

RUSSELL CROTTY: I would say-- other people testifying today might be able to answer that question. My guess would be, I think we've passed three out of six or so, 40, around 50%, maybe to 60% approval rating for the scopes that we've attempted.

MEYER: Well, apparently there seems to be an, an issue with approvals, which is why we're here today, quite frankly. So thank you, I appreciate that.

RUSSELL CROTTY: Thanks for your question.

HARDIN: Other questions? I think I know who that maybe one of those wags was that helped hang things up for that optometry [INAUDIBLE]. I think I know who one of those might have passed. Thanks for being here today.

RUSSELL CROTTY: Appreciate your time. Thank you.

HARDIN: Opponents, LB554. Opponents. Yeah.

HOLLY CHANDLER: It's a short chair.

HARDIN: It does keep you rather down, doesn't it.

HOLLY CHANDLER: Yeah. Feel kind of--

HARDIN: We do that on purpose?

HOLLY CHANDLER: I'm not surprised.

HARDIN: Sorry. It's, it's kind of a strange thing, isn't it? It doesn't sit up as high as it needs to. Welcome.

HOLLY CHANDLER: Thank you. Thank you. Dear Chairman Hardin and members of the committee, my name is Holly Chandler, H-o-l-l-y C-h-a-n-d-l-e-r. I'm here today as a member and past president of the Nebraska Association of Nurse Anesthetists, or NANA, in strong

opposition to LB554. I co-chaired a recent 407 credentialing review in 2022 with Tiffany Wenande, who is also a past president of NANA, and whose testimony has been submitted to you. Having gone through this review recently, we are both very familiar with the current 407 or credentialing review process. Some of you will remember my testimony from earlier this year regarding the need for this process to be reexamined. A few of the issues needing addressed include the arduous and often confusing statutory criteria, the lengthy timeline the reviews take, and how to enhance the value of advisory opinions given to legislators. LB554 does nothing to address the confusing statutory criteria used to evaluate applications, it does not expedite the 407 process, and it carries a $300,000 annual price tag. But it does have a hidden, dangerous agenda. It changes the composition of the Technical Review Committee, or TRC, to a more biased, self-serving commission. First, LB554 would replace one of the three reviewing bodies in the credentialing review process, the TRC, which originated as a multidisciplinary committee, to be replaced with the Health Professions Commission. Up to seven members of this commission would be chosen by the co-chairs, who would be representatives from two teaching institutions in Nebraska's Colleges of medicine. This would allow a situation where the commission chooses much of the board to be composed of like-minded individuals, in order to push an agenda. LB554 would also allow this commission of like-minded individuals the power to initiate reviews of a profession's existing authority. This alone is an overreach which far exceeds the intent of the credentialing review process. This means the commission would have the authority to, without any limits, originate their own subjects for proposals. For a commission to have this type of unmitigated power over every health care provider is unprecedented and egregious. Consequently, the public is at risk for decreased access and quality of care, increased health care workforce shortages, and increased cost of health care. The purpose of a process like the 407 is to educate yourselves, legislators, utilizing a fair and rigorous process with ul-- which ultimately protects the public. The absolute best way to do this is to provide a level playing field for all health care professionals by including nonphysicians in the process. Physicians are the only group with a limitless scope of practice, and all other health professions are the primary groups seeking to revise scope of practice. Expansions in scope have been a lifeline in Nebraska for our rural communities. These changes have helped immensely in the workforce shortage. They have helped fill the critical access hospitals in rural communities with nurse practitioners, nurses, optometrists, speech therapists, occupational therapists, and physical therapists. That list goes on

and on. LB554, driven by the medical community and their special interests, will obstruct any expansion to scope of practice for nonphysician providers. It will also give physicians the ability to limit existing scope. This will have negative ramifications on public health, access to health care, patient affordability, particularly in rural Nebraska.

HARDIN: Doctor Chandler, if I can encourage you to--

HOLLY CHANDLER: Speed it up?

HARDIN: A little bit, give us your best auctioneering voice.

HOLLY CHANDLER: I can do that. Second, it doesn't address-- it doesn't address the criteria. We, we went through the process. The criteria often resulted in re-votes by both the Board of Health and the TRC. Those would need to be addressed in any bill being proposed, and it does not address the long timeline. Because of the yearlong timeline that we experienced, we ourselves went through three separate chief medical officers during the process. So in conclusion, LB554 was not created to solve the problematic issues identified by recent participants of the credentialing review process. It doesn't address the criteria, the timeline, or propose a more collaborative solution. And it was written and created for one reason, which is to serve the interests of one group of health care providers. Thank you. I'm happy to take your questions.

HARDIN: Questions? Can I ask you to wrestle with something out loud for me?

HOLLY CHANDLER: Sure.

HARDIN: You say this provides for a commission to have an unmitigated power. Perhaps there are those who would feel like our current process has a little bit of that going on in regards to some of the turf wars. Can you kind of wrestle with that out loud for me just to educate me?

HOLLY CHANDLER: I, I don't disagree with you, and I think that's a really good rationale for why several groups came together and wanted to go through and revamp the process. Because the contentiousness of the turf wars is overwhelming, particularly for legislators when we're going through the process and then come here. I think that the other bill that you're going to hear that's proposed today, LB436, puts-- replaces the TRC with the health professions' own board. And when you think about it, those boards are tasked with protecting the public,

not with protecting that profession. And I think that is a really great way to sort of eliminate the contentiousness and the turf wars, because then everybody in the process is in the arena to protect the public.

HARDIN: OK. All right. Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here, and for your, for your testimony. That got me thinking a little bit. So can you kind of walk me through that a little bit more as well? Because I, I can certainly appreciate your-- what you're saying and, and your concerns about, you know, the public being the number one thing we want to protect, not a specific scope or, or a profession. How, how is this process what we're hearing about in LB554 different than what you referred to in LB436? Can you tease that out a little bit for me, like why--how is one more--

HOLLY CHANDLER: So LB554, virtually what it does is it replaces-- when you're going through credentialing review, there's there are, there are three entities. There's the Technical Review Committee, there's the Board of Health, and then the State Medical Examiner.

FREDRICKSON: Yeah.

HOLLY CHANDLER: LB554 replaces the Technical Review Committee with this commission. This--

FREDRICKSON: Yes. Yes.

HOLLY CHANDLER: This commission would have two co-chairs, which would both be members from the colleges of medicine, from the two teaching institutions in Nebraska. And then those two people would appoint whoever they deem relevant to their commission. That's a set up for, for what could very easily become a biased commission or committee or whatever word you want to use to describe it. The other bill, that TRC piece of the three entities would be replaced by the profession's own board. So if, if nursing wanted to change their scope, they would go in front of the Board of Nursing.

FREDRICKSON: Got it.

HOLLY CHANDLER: And it's important to keep in mind that that Board of Nursing works for the public and has the public's best interests in mind.

FREDRICKSON: Very helpful. Thank you.

HARDIN: Other questions? Thanks for being here.

HOLLY CHANDLER: Thank you.

HARDIN: Opponents, LB554. Welcome.

LINA BOSTWICK: Hello. Thank you. Senator, Senator Hardin, members of the Health and Human Services Committee, thank you for your time today. I'm not going to repeat a lot what Doctor Chandler said. I'm going to try to cut it shorter because we agree with those statements.

HARDIN: Well, thank you.

LINA BOSTWICK: Yeah, we oppose LB554, and I am Lina Bostwick, L-i-n-a B-o-s-t-w-i-c-k. One thing that we have found with this bill, it intends to initiate reviews on the specific professions' already existing authority for Nebraska credentialing program. Now, I do have a little history with that, as there was-- I've been a nurse for 40 years, about 30 of that in the clinical area and teaching with students as well. I've been in education for 20 years. Now, one thing that I can remember that happened in the past as a cardiac nurse is where we had physicians that were saying, you nurses can take out pacemakers. So when you have open heart surgery, a pacemaker is implanted, screws are put in your heart for a pacemaker. And that-- we don't always have to use them, but they're there in case we do. About three days post-op or two days post-op, those are removed. Now, there was a situation where physicians thought that we, nurses, should do that. And it really was saving time for them, if we're honest, because it takes a little while to do that. So in that scenario, our Board of Nursing and our representation on that 407 could say, no way. We nurses are not taught to do that. They don't do-- they cannot put in sutures, they can't take the patient to the surgery operating room to correct, you know, when there's bleeding. So definitely our boards protect us from what we can do and what we can't do. And being afraid of scope, something that we can do being handed down to us is something that we need to consider with a commission. So I just we are, we really want you to hear us that we oppose LB554 one healthcare discipline having more authority over another defeats the overall capacity of safe and updated care. Especially where there are multiple facets of an issue to be considered.

HARDIN: Thank you.

LINA BOSTWICK: Yes. Any questions?

HARDIN: Questions?

LINA BOSTWICK: So protects us in more than one way. Maybe we can do things, but maybe we should not because we haven't had-- we don't have that skills and knowledge.

HARDIN: So the clinical piece is going to suffer, you're saying.

LINA BOSTWICK: It very well could.

HARDIN: OK.

LINA BOSTWICK: If we're not clear on-- well, and then how are how-- what's, what's the process for, OK, say, say they allow us to pull those pacer wires. What's the process going to be? You know it needs to be education. What all are they going to have to teach us?

HARDIN: Can I ask you a different question?

LINA BOSTWICK: Yes.

HARDIN: A similar questions, I guess, that I, I asked Doctor Khan earlier. And that is, are you seeing anyone who does it better than us, this scope of practice thing, anywhere in the country? Or do we do it the best that it can be done in the universe?

LINA BOSTWICK: There's always room for improvement, right? Good answer?

HARDIN: You navigated that well.

LINA BOSTWICK: Yeah. Thank you. I really don't know. I think we do do a good job, but we can make, maybe, decisions more quickly if our boards can take a look at these scopes and give advice, advice on that, because they know the standards, they, they know the real life as well, what's happening out there. They know the standards, and, you know, what the practice is.

HARDIN: OK. Thank you.

LINA BOSTWICK: So, yeah.

HARDIN: Appreciate that.

LINA BOSTWICK: You're welcome. Mm-hmm.

HARDIN: Any other questions? Seeing none.

LINA BOSTWICK: OK.

HARDIN: Thank you.

LINA BOSTWICK: Thank you.

HARDIN: Opponents, LB554. And if we have other opponents, feel free to move forward and others might trade seats with you. And when the music stops, you know how that works.

AMY REYNOLDSON: Grab the cake?

HARDIN: Grab the cake. That's correct. Welcome.

AMY REYNOLDSON: Good afternoon, Chairman Hardin and the rest of the HHS Committee. My name is Amy Reynoldson, A-m-y R-e-y-n-o-l-d-s-o-n. I'm the executive vice president of the Nebraska Medical Association, and I'm testifying in opposition to LB554 on behalf of the NMA. The NMA appreciate Senator Ricky's interest in the credentialing review 407 process, and his desire to make sure that the process is robust and continues to support good decisions by the Legislature that balance access to care with patient safety. That's also what the NMA cares about. The current Technical Review Committee process has proven to be a valuable tool for vetting scope of practice proposals, making recommendations for changes to those proposals, and advising the Board of Health, the Chief Medical Officer, and Director of Public Health, as well as the Legislature on the merits of all those proposals. The individuals who are appointed to serve on the Technical Review Committees bring expertise from their specific health area, but they also offer practical experience from their perspective roles, respective roles. Those individuals are selected because they do not have a direct connection or correlation with the applicant, or those in possible opposition. While we can appreciate Senator Riepe's perspective that a more academic review of the proposals could be a valuable perspective, the NMA strongly believes that the practical perspectives of the Technical Review Committee has served Nebraska very well. While we agree with Senator Riepe's goals, the NMA urges the committee to maintain the current process of the 407. Over the past year, DHHS has made significant enhancements to improve the Technical Review Committee's work that they do, as well as the entire process. These changes have made the process more efficient, more

thoughtful, and more consistent. Most recently, the 407 review that the Nebraska Medical Association participated in was the Occupational Therapy Association application, which saw that the Technical Review Committee completed their work in just three meetings and over the course of three months. It was impressive. The NMA supports the continued work of the Department of Health and Human Services to build on the current 407 process, and we respectfully ask the Committee to not advance LB554. And because I might have a little bit of time, I would like to answer some questions, because the NMA participates in just about every 407 process at some degree.

HARDIN: Please take it away.

AMY REYNOLDSON: To answer your question, Senator Hardin, other states that are looking at this. I've been contacted and have presented our process to Oklahoma, Oregon, Wyoming, Wisconsin, South Dakota, Missouri. And of those states, three have already passed their own legislation to do something very similar.

HARDIN: I see.

So many, many of my colleagues are asking, what's going on? How do you guys vet this? Because it's just-- it's really challenging when you get down onto the floor of the house to vet out some critical patient safety issues, and it does get ugly at times, and we don't want that. And I think that's why this process was brought about by former Senator Don Wesley. We don't want that either. And I think a collaborative, proactive approach is the way to go. So that's how we portray it. And we give them kind of some talking points. If you can meet before the application's submitted, that's wonderful. Just at least so everybody knows what's going on. Right? So there are states that look at ours as kind of a gold standard model. But can we make improvements? Absolutely. Senator Meyer, to answer one of your questions, what's the rejection to accepted proposal. I've been here six and a half years. We've participated in 16 scope applications, we have one in the hopper ready to go that we'll be participating in, and I'm aware of two more coming down the pike. So we're going to have nineteen within seven years. And of those, only four did not get a favorable review, of which one, only one, that the NMA was in support of. All the others, we've been in opposition. So even one that we were in support of didn't get a favorable review. But that's the process. That's what we have to refine, we have to, we have to look at the whole process, and we have to look at it with our eyes wide open. So that's been my experience. I track them all and how the reviews went.

Now, did all of them come forward with legislation? I don't know that answer. I think the majority have. And of the 15 of the 16 that we've currently participated in actively. Almost all of them have approached us and other interested parties with information about wanting to present their ideas and kind of flush things out before they actually submitted their application process. And I will say that is very, very helpful, not only for, for us, but for them. It gives us a great opportunity to talk.

HARDIN: Sure. Questions. Senator Hansen.

HANSEN: Thank you. I ask this question because-- it's not really my question, it's one that's been brought to me from a couple people about the 407 process and the use of medicine in pharmaceuticals. Do you think-- I don't know, I'm just curious to get your opinion, I'm in favor in one way and not in the other. Whenever there's a new pharmaceutical that's going to be used or prescribed by a medi-- by a physician, should that go through the 407 process?

AMY REYNOLDSON: I think there's already a process that that goes through. It's called the FDA to get approved.

HANSEN: OK.

AMY REYNOLDSON: So I think there's a bigger process that that--

HANSEN: Yeah. I figured I, like, you know, there was kind of regulatory process that, exactly, it kind of goes through. But if the FDA approves of a pharmaceutical, but then the use of it on patients in Nebraska, I didn't know for sure for if the 407 process would be adequate, or even at all, you need-- no purpose even doing it at all.

AMY REYNOLDSON: I don't know that I can answer that.

HANSEN: It's fine.

AMY REYNOLDSON: Because I don't think that's what the 407 was developed for.

HANSEN: I just though I'd ask that. And one other, one other thing has to do with the role of the board of the profession that's going through the 407 process. Do you think they, they should play a greater role in the 407 process? I know it's been brought up by a couple people, which kind of makes sense to me, because if anybody really wants to make sure that somebody who goes through a scope of practice

change, that it's accurate and it's in the patient's best interest, would be the board of a profession, because there's two things I think they don't ever want to see happen is they get-- they see a colleague get sued, and they make their profession look bad. And so do you think they should play a greater role in the 407 process than what they have now?

AMY REYNOLDSON: Yes and no. I think some professional licensing boards have played a pretty significant role in applications already, and others haven't. I can only speak on behalf of medicine and surgery. I can tell you the Board of Medicine and Surgery has been discouraged to engage in any of the 407 process. And I think there's some inconsistencies within their, their support from whether it be the Attorney General's Office or the department. There's just been some-- that's-- when we convened a very large collaborative health care organization meeting in our office with more than 35 health care organizations pulled together to really vet through some of the challenges, that was something identified. It's not just us, but there's other licensing boards that aren't nearly supported as others. And so I think, I think that needs to be corrected before you start to put a technical review committee as the licensing board. So that's why I say I think, yes, in some instances and no one others. I, I appreciate when their licensing board members engage in those conversations, they come to our office or we go to theirs to talk about those applications. We find it very helpful. I just wish we could have our licensing board there with us as well.

HANSEN: Yeah, that makes sense.

AMY REYNOLDSON: That's been the challenge.

HANSEN: That makes sense.

AMY REYNOLDSON: Yeah.

HANSEN: OK. Thank you.

AMY REYNOLDSON: Yeah. Absolutely.

HARDIN: You mentioned a wonderful thing today, took place in terms of two months, three months in terms of a start to finish process. OT? Was that right?

AMY REYNOLDSON: Yes.

HARDIN: And that's good. That hasn't been normative for the last few years. So we can't hold that up. Holding that up as normative might be as, oh, I don't know, farfetched as-- imagine a football team that used to be really good. But what I would like to say is, thank you to all of you who participate in the 407. We need you. This group needs you. Senator Hansen makes his living in the medical world. Senator Riepe made his living in the medical world. The rest of us stayed at a Holiday Inn Express last night. We need your help more than ever. And we need you to be firing on all 12 cylinders better than ever. And so really, these, these bills really are about asking for that help, actually pleading for it, because we need you more poignantly than we ever have because of the medical deserts that are going on. I keep saying, and I'll say it again. We went through something tougher in COVID financially than World War I was. Than World War II was, us. But we're not acting like we went through something as cataclysmic as a world war. And yet, from a financial standpoint, it was. We're pretending that it's 2019. It's not. These are different times. And so we appreciate what all of you have done. And I want to make sure that all of you understand that. We're looking at refining all of this as we can. We're standing somewhere in the middle of the fire hose, and we need those of you at the end of the fire hose fighting the blaze to do it aggressively and more on target than ever before. So thank you for what you do. Thank you. Appreciate your time. Other opponents, LB554. Welcome.

KRIS ROHDE: Thank you. Good afternoon, Chairman Hardin and members of the DHHS. My name is Kris Rohde, K-r-i-s R-o-h-d-e. I am a certified registered nurse anesthetist, a CRNA, and I am here today as a member and past president of the Nebraska Association of Nurses Anesthetists, or NANA, to oppose LB554. I am passionate about advocating for my fellow CRNAs. My goals have always been to continue to ensure that CRNAs in Nebraska have independent practice, and are allowed to practice to their full education and training. LB554 could threaten the independent practice and scope that the CRNAs in Nebraska have fought, fought hard to obtain over the years. This bill does not serve the advanced practice provider in Nebraska well at all. Anyone who has ever been through a 407 technical review knows that it is not perfect. For example, it is a lengthy process, it can pose a barrier to workforce growth, and it focuses on inadequacies of the status quo instead of looking at how the public could benefit. NANA is committed to help solve many of the problems that it presents, but LB554 does not fix them. LB554 does nothing to shorten or expedite the review process. The proposed commission that will replace the Technical

Review Committee will not only review all new proposals involving health professions, but it will also initiate reviews of a profession's existing authority. This goes well beyond the original intent of the credentialing review committee. Policing of a health care profession should be left up to their professional boards, not a review committee or commission. In fact, one line that will be omitted in this proposed legislation makes me extremely distressed. The sentence, the director shall ensure that the total composition of the committee is fair, impartial, and equitable has been completely removed from LB554. This proposed legislation will have a very heavy influence from MDs, so the removal of that line is even more concerning to me, and it should concern every advanced practice provider without MD behind their name. LB554 also comes with a hefty price tag of $300,000 annually, which we've discussed a few times. In a time where people want less government spending, this seems excessive to me. In addition, there are no proposed changes to the statutory criteria. This will continue to have the proposed Commission focus on risks and require the proponents to prove the need to change the status quo. I urge you to, to oppose LB554 so all the professionals who are at risk with this proposal can work together for a more fair and just way to review potential changes to our licenses and scope of practice. Thank you for your time, and I'm happy to answer any questions you might have.

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

KRIS ROHDE: Thank you. That's why I make everyone go before me.

HARDIN: That's a good strategy. LB554, opponents. Any other opponents? Anyone in-- oh, do we have one? Very well, thank you. Welcome.

NICK WEBER: Thank you. Chairman Hardin and members of the Health and Human Services Committee, my name is Nick Weber. I'm a physical therapist and serve as president of the Nebraska chapter of the American Physical Therapy Association. I'm here to represent our membership of over 1,400 physical therapists, physical therapist assistants, and students of accredited physical therapy and physical therapy assistant programs in Nebraska. I want to start by thanking you for your attention to this topic today. My guess is one of the least known responsibilities of state legislators as you enter your job is the responsibility to determine the scope of practice for health care providers. In almost every legislative session, as we've heard, legislation is introduced to regulate a new health care provider, or expand the scope of practice of an existing health care

provider. This places an incredible burden on you all to balance Nebraskans' access to quality health care and minimize endangering their health, safety, and welfare. When it comes to scope of practice enhancements, what myself and the members of the Nebraska Physical Therapy Association want most is for you to be able to make informed decisions with a thorough understanding of all relevant information, and to be able to do so in a timely manner without compromising quality. It is our opinion that the current credentialing review program, or 407 process, is not consistently allowing you to meet this standard. Despite the good intentions of the Technical Review Committee, we have witnessed inconsistencies in procedure and efficiency. As the final decision making authority, we want you to be able to address workforce shortages and improve access to care by being able to count on a modern, efficient and fair credentialing review process. Unfortunately, we do not feel this bill addresses the issue at hand. For example, LB554 makes no changes to ensure the process is completed in a timely manner. In fact, LB554 allows the new commission to initiate its own proposals for scope of practice reviews, which goes beyond the current responsibilities of the Technical Review Board and thus just creates more potential for burden of the commission, which is likely to lead to even less efficiency than what the current Technical Review Board can offer. So for these reasons, we are in opposition to LB554. But again, we do appreciate your attention to this important topic, and we believe there is a way to address the issues stakeholders have identified without completely abandoning the current process. So I thank you for your time.

HARDIN: Thank you. Questions? Seeing none, thank you. Those in opposition to LB554. Welcome.

KENT ROGERT: Good afternoon, Chairman Hardin, members of the Health Human Services Committee. My name is Kent Rogert, K-e-n-t R-o-g-e-r-t, and I'm here today in opposition of LB554 on behalf of the Nebraska Dental Hygienists and the Podiatric Medical Association. I don't have anything really to add from what the other folks have said today, and you've had some good questions. I've been through a lot of 407 process technical reviews. I was involved in some of the changes while in the Legislature, and I've been involved in some of the changes while on this side of the desk, and I appreciate Senator Riepe's efforts to try and address concerns that we've been talking through the last couple of years. Senator Hansen had a legislative study over the summer. And my guess, I, I would come to say that in 40 years we went from what we thought we wanted to where we think we may not want. We're not going to get out of this thing in six months. We just need to continue to

talk about different solutions and different things. I will say that the department has made some pretty strong administrative changes within their midst, and I know one group just recently went through a 407 process and it went pretty well. There's-- I know the nurse practitioners have applied for one and they'll be going for one this summer. We'll be watching closely. But this, this particular proposal doesn't quite get to where we're wanting because it puts-- it does push things into one side versus the other, at least in, in the visionary, you know, thoughts anyway. I am happy to answer any questions, if you have any, about how this has been working.

HARDIN: Questions? Seeing none.

KENT ROGERT: Thank you.

HARDIN: Thank you. Anyone else in opposition, LB554? How about those in the neutral, LB54? Director.

CHARITY MENEFEE: Hi. Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Charity Menifee, C-h-a-r-i-t-y M-e-n-e-f-e-e. I'm the director of the Division of Public Health at the Department of Health and Human Services, or DHHS. And I'm here to testify in a neutral capacity for LB554. The credentialing review process has been instrumen-- instrumental in helping the Legislature make decisions for the past 40 years. Like all processes established in statute, there does come a time when improvements are necessary. DHHS has been working hard to make internal improvements. This effort has included hiring a new team member in August 20-- 2024, to manage the process, updating procedure manual to reflect the input from 20 plus stakeholder groups, clarifying the overall process and review criteria with plain language explan-- explanations. Creating an expectation that applicant groups communicate about their proposal with other stakeholder groups, including opponent groups, prior to the beginning of the review process. That's with an effort to speed things up. Implementing a separate orientation and training meeting for the Technical Review Committee members at the start of a new review process, and establishing a more efficient turnaround time between TRC meetings. While LB554 and LB436 both have good components aimed to further improve the process, both bills also introduce language that caused concern for the department. DHHS has provided the introducers of those bills with compromise language that combines the best of both bills; criterion language previously worked on and agreed upon by over 20 stakeholder groups, you've heard about that a lot today; and the

language that addresses the department's concerns. This compromise further streamlines the credentialing review process, building upon improvements and internal changes DHHS has already made. We believe this language will offer continued protections for the health and safety of Nebraskans. As Chairman Hardin has previously said, it is important that we balance safety and turf wars like never before. DHHS stands ready to partner with this committee to further improve the credentialing review process while balancing those competing interests. Thank you for your time, and I'll be happy to answer any questions you have on the bill.

HARDIN: Thank you. Questions? Can you speak to implementation of laws that are passed, or an inability, on a board's part, any of the boards' part?

CHARITY MENEFEE: Yes. Thank you for asking that question, Senator Hardin. I do want to make it clear that the boards and the department, the laws that are passed by this Legislature, we have to implement. So there's not a question on that side of things about the boards', professional boards' ability to decide whether or not to implement what you all pass. Those, those measures get passed, we implement the laws that you pass and they do as well. I think there could be confusion on the side of how discipline gets assessed and addressed through the boards. But as far as what the scope of practice is, that's what you all pass in law and that's what's implemented.

HARDIN: Does bias play a role in one side or the other, one board or the other? How does that work?

CHARITY MENEFEE: I do think that that is a concern of everybody. And, and I want to say that we agree with a lot of the folks here today. And I think both of these bills and what you're trying to accomplish in making sure that we have access to care that is safe and appropriate for Nebraskans, and trying to make sure that we're as fair as possible when making those determinations. So I think that one of the things that we want to look at and make sure that we're doing with the current technical review committee process and, and the process that exists going through the Board of Health and then the director, is that the way that that works is we are able to have unbiased opinions that participate in that process. So we don't have people that are a part of that scope change or new profession on the technical review committee, but they are part of the application group and process, so their voice is heard in, in that room. When we go one direction or the other, when we have just the board weighing in on

those, that's, that's pretty biased and from that board's perspective. And then on the other side, if we have a physician-heavy situation that people are concerned about, obviously bias can come in there as well. So we do want to work very hard to make sure that there are multiple perspectives involved across the process. That's where we have come up with trying to hear from all the different professions and make our recommendations to this group, and that's what we submitted to the introducers of the bills, with what we came up with, trying to look at both of the bills and all the feedback from all of the different bodies that we've gotten information from to make sure that we're considering those concerns as we move forward.

HARDIN: Very well. Thank you. Are there questions? Seeing none. Thank you.

CHARITY MENEFEE: Thank you.

HARDIN: Others in the neutral, LB554. Senator Riepe, will you come back? And we had online 2 proponents, 208 opponents, 0 in the neutral. Welcome back.

RIEPE: Thank you, Chairman.

HARDIN: When you get that many opponents, it usually means you're right over the target.

RIEPE: It certainly hit a nerve when you do. And thank you for being here. I just like to close with, while I am an Omaha senator in my seventh year serving on this HHS committee, I am committed to objective, evidence-based, equitable health care delivery that is less self-serving. I was at a conference several years ago, and a Vermont senator who is chairman of their Health and Human Services gave me a little plaque, and I still have it in my office, and it said, do hard things. This is clearly a hard thing. Gwen Howard, who was on here, served a number of years that said any Legislature, legislator is in dangerous territory to even talk about scope of practice, but it has to be talked about, because my argument gets to be. We've heard current-- 407 process works. But if yes, how is it improved health care delivery in an equitable manner across the state? And we have all the dialog that talks about deserts here and deserts there. We have to come up with some kind of a plan. Doing more of what we're currently doing is a road to destruction, and a road that we will not be able to afford and be able to deliver to the people outside, quite frankly, of our urban areas. And while I said I am an urban senator, someone would

say, you don't have a dog in a fight, but I do. I'm a health care administrator and I do not like the inequity of the whole situation. I want to conclude by restating what I had said earlier. When we limit providers from practicing to the full extent of their ability and training, it is not the professions that suffer, it is the patients. Thank you, sir.

HARDIN: Very well. Thank you. Questions? Can you wrestle for me for a moment, just with this clinical piece? Is it better to have the people who are out there doing it on, on the boards, and do they have the best read on this, or is it these trainers of those people who have the best bead on what best practices should be, who themselves are actually still practicing, I understand it, within the academic world. What is your sense of that?

RIEPE: My sense is it's impossible to have every one of every discipline on this board. I am also a believer in boards need to be manageable sizes to get anything done. You know, it's like the, I'll pick on the Nebraska Chamber of Commerce. I think they have like 30 people on the board, it's hard to get anything done when you don't have a manageable group.

HARDIN: Yeah.

RIEPE: And I think that if you get a, a group that's committed to objectivity and equity and evidence-based stuff, obviously they cannot or should not be making decisions without proper input, and they will have a better opportunity to do that, not only within the state and within the practitioners in the state, but to be able to look at other academic situations as well. Years ago, medicine in, in the '50s or thereabouts, medicine was all about the physician is the captain of the ship. This is the 21st century. The movement now is public health. We have to worry about equity, we have to worry about people that aren't being served, and it's more of a model. And people could say, well, it's going to cost more money. I know it came up several times, what are we going to spend $300,000? I'd like to caution and tell them, we spend $300,000 very rapidly around here. And number two, it assumes when saying that, that the cost of running the 407 process is free, and it's not.

HARDIN: Very well. Other questions? Thank you. This concludes--

RIEPE: Thank you, sir. I appreciate [INAUDIBLE].

HARDIN: --our hearing on LB554. Next up will be LB676 and Senator Hansen. And so we'll transition the room a bit. Fellow Nebraskans, we need you to be less friendly than you are. I know it's difficult. We'll get going in about 60 seconds. LB676. Senator Hansen, welcome.

HANSEN: Thank you. Good afternoon, Chairman Hardin and members of the HHS Committee. My name is Ben Hansen, that's B-e-n H-a-n-s-e-n, and I represent Legislative District 16. I'm bringing LB676 in response to the overwhelming number of requests I have received from women and mothers who are looking for more birth options in Nebraska. This hasn't been just a recent issue. Since coming to Lincoln as a senator, mothers have been reaching out and asking if there's any way we can offer the same options as other states when it comes to birthing opportunities. LB676 does this by creating more options for certified nurse midwives, or CNMs. LB676 does three things. It gives nurse midwives full practice authority, it removes location restrictions, and it includes CNMs in the Nebraska Hospital Medical Liability Act. So let me address some excess liability cap first. I have worked with the Nebraska Hospital Association and the Nebraska Medical Association, whose main concern with the bill was the addition of CNMs to the liability fund. I do want to make, make it clear that both those organizations were very helpful and very friendly in working with this bill, and they probably have, probably have some good insight on maybe some positive changes we can make, and one of them was this liability fund. Per their request, and after further discussion, I am bringing AM324 to remove section 11 of the bill where it adds CNMs. I confirmed with both the NHA and NMA that they approve of this. The remainder of LB676 remains the same, however. With the bill, the Collaborative Practice Agreement requirement for certified nurse midwives will be removed. According to the Federal Trade Commission, collaborative practice agreements restrain trade without improving patient outcomes. We see this to be the case in Nebraska. While CRNAs have been able to practice without a physician's oversight for more than 20 years, and NPs for more than ten, nurse midwives are the only advanced practice registered nurse group that has not been allowed to practice independently. It is interesting to note that more than half of Nebraska's counties lack maternity care. These practice agreements have not improved rural community birthing outcomes, but actually hindered them. CNMs are being boxed out instead of allowed to help. You will also hear from following-- you will also hear from following testimony on how difficult it is to find a physician to enter an agreement with physicians. Nurse midwives are being forced to pay doctors to get collaborating agreements, and many times these

doctors are located hundreds of miles from where the CNM actually practices. Nurse midwives are not, are not a highly compensated group, their main concern being women and their desire for low intervention birth. Yet they are being forced to pay a highly compensated group of physicians just to serve women. In fact, 48 other states have fewer restrictions on CNMs, giving Nebraska the reputation of being one of the worst states for midwifery practice among an industry run by women. This brings me to the last portion of LB676, removing practice res-- removing location restrictions on nurse midwives to make us current with the rest of the country. Nebraska is the only state in the country where certified nurse midwives are banned from attending home births. Home births are becoming more and more popular around the country, but here's the difference between Nebraska and the rest of the states. In every other state, a mother can have a baby at home with a CNM who has been trained and educated in nurse midwifery. Certified nurse midwives are registered nurses who have thousands of hours of clinical experience, and must earn graduate degrees and sit for board certification. The midwives use their expertise to provide safe and effective care in the setting a woman chooses. However, in Nebraska, you can have a baby at home, but someone who specializes in birth, practices, practices midwifery, and is trained in identifying issues, can't be there. The message we send to women is that you can have a home birth here, but you can't have anyone help you. That seems a little counterintuitive, but that's just the way it is right now in Nebraska. Besides the Philippines, we'd be the only place on Earth to make home births illegal if we kept mothers from being able to choose where they give birth. That would be crazy. Instead, we have kept home births legal, but we make having qualified midwives to help and support women illegal. Here's why Nebraska should pass LB676. Mothers have the right to birth in a location they think is best. This is what is happening. And just like the rest of the country, home birth is location where more and more women in Nebraska are choosing to give birth. Oregon is a good state to look at for trends. I like trends. They have, they have one of the highest home birth rates in the country. Unassisted births in Oregon have a prenatal [SIC] mortality rate of 11.52 deaths per 1,000 births, compared to the hustle rate of 1.4. This is a devastating reality. But let me point out that this number is for unassisted births. Unassisted births are the only type of births in Nebraska-- that Nebraska provides as an option outside of a hospital. So right now, that's what we have, unassisted births in Nebraska. Now, if we look at home births attended by licensed midwives in Oregon, they only have a mortality rate of 1.6 deaths per 1,000, very similar to the hospital rate. Unassisted births, 11.6. Assisted

births 1.6. Nebraska makes these types of births illegal. This is why the American College, College of Obstetricians and Gynecologists support the CNM standards when saying they, quote, respect a person's right to make a medically informed decision about their birth attendant and place of delivery. It's because home births are much safer when attended by licensed midwives. Studies show that states with the highest rates of home births have full CNM integration, better maternal outcomes, and maintain comparable neonatal outcomes to hospital births for low-risk pregnancies. Nebraska is falling behind. Opposition to CNM autonomy often comes from physician groups citing safety concerns, despite evidence showing midwifery led care improves maternal outcomes. Bottom line, LB676 is safe for mother and babies. Other states do not have full practice authority requirements or location restrictions. It's time Nebraska joins them. I'm glad Senator Riepe in his closing made some good points about equitable health care throughout Nebraska. He is right. We need to open up options for equitable care throughout Nebraska, especially in rural areas of Nebraska, where we do not have the type of care that a lot of mothers want or expect. This bill, along with some other ones, do exactly that. And I, I, I feel like I'm more brave after what Senator Riepe said too, because I, if I-- for years I used to be known as a scope of practice Senator, so all the scope of practice bills came to me. I've retired from that now, so other, other Senators have taken that, so. But with that, colleagues, I do hope that you can support LB676, because this is a very good bill that a lot of mothers are really hoping for and expect. So thank you, Mr. Chairman.

HARDIN: Thank you. Questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Senator Hansen, for being here, for bringing this bill. I also feel more brave because of Senator Riepe's presence. [INAUDIBLE]. But, no, jokes aside, I-- so I'm sorry if I missed this a little bit, so, so you passed out the amendment on here as per section 11. So can you briefly. I didn't have a chance to review.

HARDIN: That was the part you stepped out on. So basically, one of the largest concerns that organizations such as the Nebraska Hospital Association, Nebraska Medical Association had was the liability fund--

FREDRICKSON: OK.

HARDIN: --that physicians and others contribute to.

FREDRICKSON: OK.

HARDIN: So if there's a liability issue, that fund can then help them in that process.

FREDRICKSON: OK.

HARDIN: If this bill were to be passed, then certified nurse midwives would be included in that. They had a concern that putting that pool of individuals in that liability fund might risk the fund in general.

FREDRICKSON: OK.

HARDIN: Or the money that's in there. So with the amendment, we decided to take that part out. So they're not included in that fund.

FREDRICKSON: Got it. OK. Thank you.

HANSEN: Addressing one of the main concerns.

FREDRICKSON: Great. Thank you.

HARDIN: Other questions. Senator Quick.

QUICK: Thank you chairman Hardin. So with that, is there, would they have access to, or need liability insurance of some kind?

HARDIN: To my understanding, they have to carry it anyway.

QUICK: OK. OK.

HARDIN: And there are some that limit it, but there are some that do provide it.

QUICK: OK. And they can probably expound on that more later.

QUICK: OK. Thank you.

HARDIN: Other questions? Will you stick around?

HANSEN: Oh, yeah. Thank you.

HARDIN: Wonderful. Proponents, LB676. Welcome.

ELIZABETH MOLLARD: Thank you. Chairperson Hardin, members of the committee, thank you for the opportunity to speak today. My name is

Libby Millard, L-i-b-b-y, M-o-l-l-a-r-d. I am a certified nurse midwife, and here as president of the Nebraska affiliate of the American College of Nurse Midwives. I'm here today to express our strong support for LW676. As you've heard, Nebraska's maternal mortality rate is rising, largely because we don't have enough maternity care providers. Too many families must travel long distances for prenatal care, and in over half of Nebraska counties there are no maternity providers at all. Certified nurse midwives are the answer to expanding access to maternity care and improving health outcomes in our state. Decades of research show that midwifery led care results in fewer cesarean births, fewer preterm births, and healthier moms and babies. In fact, births attended by nurse midwives are associated with a 19% lower risk of infant mortality. Yet Nebraska's outdated practice restrictions limit access to this proven model of care. Nurse midwives value collaboration with physicians, but we should not be legally bound to them in a way that limits access to care. We want to collaborate freely like other health care providers. In reviewing 34 physician supervision agreements, which I provided you with the data, in Nebraska I found the average distance between a physician and a midwife was 279 miles, clear evidence that the doctors signing these agreements are not the ones performing emergency C-sections. Meanwhile, the physicians that we do collaborate with every day support our care. But often they don't want to be legally bound to us either. This system forces midwives to pay physicians, sometimes in other states, just to practice. Right now, several midwives in our affiliate cannot practice at all simply because they cannot secure or afford a physician agreement. This is a pay to play system, not a patient safety measure. LB676 removes this barrier, expanding access to safe, high quality maternity care while preserving true collaboration. This bill also makes economic sense. Midwife led care lowers health care costs by reducing unnecessary interventions while improving outcomes. States that have modernized midwifery laws have seen more midwives enter the workforce, more women receiving care, and no increase in adverse outcomes. Nebraska should follow suit. Midwifery care transforms lives. We are not asking for anything radical, just the ability to practice to the full extent of our education and training to provide safe, evidence-based care so we can help more Nebraska families. LB676 makes that possible. Thank you. And I'm happy to answer any questions.

HARDIN: Thank you.

ELIZABETH MOLLARD: Yeah.

HARDIN: Questions. Senator Ballard.

BALLARD: Thank you. Thank you for being here. I want to make sure I understand this. So current practice, midwives have to pay physicians, and then the physician does what?

ELIZABETH MOLLARD: They sign an agreement--

BALLARD: That's it.

ELIZABETH MOLLARD: --and that agreement-- so there are situations where-- and there are so many people that actually signed agreements that are doing something. They most often employ midwives and they sign an agreement for them. So there are people who have that relationship. But if you look at the data overall, it is not the people signing the agreements that are the ones that are providing the backup care that midwives do need, and we do need to collaborate with physicians. The unfortunate thing is that this legal bureaucracy here has created a piece of paper that physicians tend not to want to sign, even if they're willing to work with midwives, because it basically attaches their license to ours. And anyone who's a licensed person knows that we want to have our own license, and we want to be responsible for the care that we give, and not necessarily someone else's. But we're willing to collaborate with other people when they need help or a consult or something like that. So yes, people are paying thousands of dollars monthly, and that's been going on for a long time, to get somebody to sign the paper. There are actually websites out there called collaboratingdocs.com. I mean, this is an industry that's been created.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here and for your, for your testimony. Kind of-- I have a couple questions, but they kind of piggyback off of that. So that's fascinating to me. So when you say there's, like, these arrangements where you can find a physician to collaborate with online. So this could feasibly be a physician who's not even based in our state.

ELIZABETH MOLLARD: Correct. And I provided you with some data. You will see that there's somebody who's signed eight agreements who lives in Bethesda, Maryland. So, you know, this is not somebody who's there to help a woman who needs a C-section really fast. And so I think that sometimes opposition will say, like, we need these agreements or else,

you know, terrible things are going to happen. Well, these agreements are not really the true nature of what we intended them to be. You know, the thought was we would have somebody there that's saying, I'm going to back you up. Well, I mean, it's a liability for physicians that, that they don't need, and they can still help us and be less liable, and we can work and collaborate, like how other, you know, health care providers collaborate with one another.

FREDRICKSON: Sure. Sure. In your testimony, you spoke a little bit about it, and I'm an Omaha based senator, so I'm thinking that you said that there's some physicians that employ midwives like within their practice for some people.

ELIZABETH MOLLARD: Correct. Yes.

FREDRICKSON: I'm, I'm maybe assuming incorrectly, but I'm assuming that that might be in more of our urban areas where you have more robust reproductive health care options around that versus rural areas where there might be more of a challenge with that. Is that fair to assume?

ELIZABETH MOLLARD: Correct. Correct. Yes.

FREDRICKSON: And then my final question for you is you mentioned that currently we have limited, or we have a lot of restrictions in Nebraska related to the practice. Is that specific to home births or does that also apply to hospital births as well?

ELIZABETH MOLLARD: It also applies to hospitalers. So we are the only state that doesn't allow home birth. But when we look at all of the other states, 48 states have less restrictive statutes. While we're using, throwing around the word collaborating agreement, things like that, technically, the way it's written, it's actually a supervision agreement. And so we and Georgia are the only ones that actually have that strong of a restriction. It's also what ties us so much to the physician's license, and why they often don't want to sign it. So.

FREDRICKSON: OK.

ELIZABETH MOLLARD: Yeah.

FREDRICKSON: Sure. Thank you.

ELIZABETH MOLLARD: Yeah.

HARDIN: Other questions? Se-- Senator Quick.

QUICK: Yeah. Thank you, Chairman Hardin. So with that, the-- would this-- this would allow you to actually have your own practice or you could still partner with, like, a physician, or a family practice, or an obstetrician--

ELIZABETH MOLLARD: Right.

QUICK: --or with hospitals?

ELIZABETH MOLLARD: Yes. So we could become business owners, but we absolutely still need to work with physicians, and we want to continue to work with physicians. Most nurse midwives will continue to work in hospitals. It would give us the opportunity to open more birth centers. And then there would be a a small group that may want to do home birth as well.

QUICK: I have a second question if that's OK. And so, on, on other advanced practices for nursing they have like their-- they have to work in labor till the-- like if--

ELIZABETH MOLLARD: Yeah.

QUICK: --and but do, do-- can you talk about the training and your education and what's required?

ELIZABETH MOLLARD: Yes. Yeah. So we have to get a bachelor's in nursing first. Then we have to sit for the NCLEX licensure. Then we're required to work as a registered nurse. And then after that point, after you have that experience, you can apply to the graduate midwifery program. And then people get either a master's or doctorate. And they complete additional clinical training during that time. And so by the end, we've had about 6 to 8 years of education with thousands of hours of clinical experience.

QUICK: But do you have-- is it required that you work in labor and delivery for a certain period of time, or not?

ELIZABETH MOLLARD: So it is-- it's not explicitly stated that way. You would have to have worked as a registered nurse, and I would say most people do work in labor and delivery because you have to learn that content either way. Midwifery training is both clinical hour based and competency based, and so you're not going to reach your competencies

unless you have that experience. So if you don't have it, then you're going to be doing more clinical hours later to make up for it.

QUICK: OK. Thank you.

ELIZABETH MOLLARD: Yeah.

HARDIN: Senator Meyer.

MEYER: Thank you, Chairman Hardin. Thank you for being here today and your testimony. We talk about our underserved communities all the time on this committee, and it's, it's a glaring problem we have in the state of Nebraska. How is the distribution of the certified nurse midwives? What's the distribution? Is it predominantly in the urban areas? Are we seeing the opportunity for, for you folks to practice in the rural areas? What, what is their distribution?

ELIZABETH MOLLARD: Yeah. So we are predominantly in urban areas. And that part of that has to do with the agreement that we have right now. When I spoke of midwives in our affiliate who would like to be working, I know of three that are living in rural areas who have all of this training and certification and are not able to practice. And so, so it's not that people are not in those areas ready and willing and wanting to do this. It's more so that the opportunity isn't really there. And we're hoping that through this, that we would be able to create new jobs for those people that are already ready to go. So we have a midwife who's traveling into-- lives border states. We have people traveling into South Dakota, into Wyoming, who are in the areas that, you know, you're talking about, that you go three hours left of Nebraska. That could be here.

MEYER: If, if I may, Chairman, just, just one follow up. So essentially, what limits their ability to practice their profession in Nebraska is the inability to find a physician that they can contract with, or it's a prohibitive cost, so it's not practical from a financial standpoint.

ELIZABETH MOLLARD: That's correct.

MEYER: OK. Thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you. Thank you, Chairman. Thank you for being here. It would seem to me that you have some advantage here, because you would

be in a position to give referrals of high-risk mothers to an OB-GYN, so that they should play nice with you, because they would be a benefit from those referrals. If I were a OB, that's where I would want to be. I guess the other question. Are you striving to get what we ultimately had to do for, or chose to do for clinical nurse practitioners, and that was to allow them to be independent practices. Because we had a number of them were forced to have contracts with sometimes up to $20,000.

ELIZABETH MOLLARD: Right. I will top that.

RIEPE: And we said we didn't-- You know, and I understand where the physicians come in, because liability is a huge concern, particularly in maternal and infant care. But is that, would that be an interest of your, your clinical nurse practitioners to be that you wouldn't necessarily have to have a physician?

ELIZABETH MOLLARD: Correct. Yes. That's exactly but that's exactly, a full practice authority.

RIEPE: And, and, and I want to understand that clarification because you're-- I have to understand that you're, you're, you're different than the licensed midwives.

ELIZABETH MOLLARD: Correct.

RIEPE: OK.

ELIZABETH MOLLARD: There is no other licensed midwife in Nebraska at this time. So.

RIEPE: OK. OK.

ELIZABETH MOLLARD: So we are the technically the only one with a licensure.

RIEPE: So you have a monopoly.

ELIZABETH MOLLARD: Oh, yes. We're do-- we're thriving. Yes.

RIEPE: It's called free market. Good for you.

ELIZABETH MOLLARD: Yes. And we do refer our high-risk mothers, and we do have great relationships with obstetricians. So I want to be sure that we're not throwing anyone under the bus, and we want, we will

continue to work with them, that's the nature of our work. It's more so that these regulations in actual practice, are just restricting our ability to provide care to Nebraskan families.

RIEPE: I would also think it's critically important for early diagnosis of a high-risk mom. Maybe she's a diabetic or something like that.

ELIZABETH MOLLARD: Absolutely.

RIEPE: The sooner the better.

ELIZABETH MOLLARD: Absolutely.

RIEPE: OK. Thank you, Chairman.

ELIZABETH MOLLARD: Other questions? Senator Quick.

QUICK: Thank you, Chairman. So and also I wanted to ask about, like, so, like, so you have private pay or you have people that are self-insured and then Medicaid. So is there, is that. I mean I'm sure you're al-- already dealing with some of those that [INAUDIBLE].

ELIZABETH MOLLARD: Yeah, we-- throughout the United States midwives do tend to see a higher population of Medicaid insurance. In Nebraska, we do take all payers. So yeah. So and it-- so it just depends on the distribution of kind of where you live and you know, that kind of thing. But for low-risk pregnancies throughout the US we do tend to serve that population more. So.

QUICK: OK. Just one other question. But on the Medicaid reimbursement rate, do you think that-- is that ample, or is it too low or how do you--

ELIZABETH MOLLARD: No, it's not ample. But, but we all know that, right? But we're still going to provide good care. Yeah.

QUICK: Yeah. That's right. Yeah.

ELIZABETH MOLLARD: So.

QUICK: OK. Thank you.

HARDIN: Other questions? Thank you.

ELIZABETH MOLLARD: Yes. Thank you.

HARDIN: Proponents, LB676. Thank you. Thanks, sir.

CATIE MILLER: I've got the baby that keeps talking, so.

HARDIN: No problem. Thanks so much.

CATIE MILLER: Thank you. Hi.

HARDIN: Hi.

CATIE MILLER: My name is Catie Miller, C-a-t-i-e M-i-l-l-e-r. I'm super excited to be here today in support of LB676. For a lot of women, picking a provider is not a big deal. They see who your mom saw or who their friends see or recommend. But as a labor and delivery nurse, picking a provider was a huge deal for me. Working in the hospital, I got to see the behind the scenes of delivery. I saw an episiotomy given without informed consent. The OB made a cut on a woman without even saying a word, and as they were leaving the room, the OB said, oh, by the way, I made a little cut to help the baby out and give you a coup-- gave you a couple of stitches. You'll feel just fine. She was needed in surgery downstairs, and I made the cut to speed things along. I saw OBs do aggressive perineal massages. I saw OBs pressure women to go against their birth wishes so many times I lost count. I saw a lack of education, a lack of informed consent, and an attitude of doctor knows best. I knew when I got pregnant with my first that I would never put myself in the position that many women put themselves in. And I would choose somebody who supported what I wanted. Don't get me wrong. OBs are very good when it comes to surgery. If I ever needed a surgical birth, there are many OBs I could trust to do it well. OBs just don't know what unmedicated, uninterrupted, and completely physiologic birth looks like. In my almost six years working on a local hospital, I never saw birth like what I just described. I saw unmedicated births once in a very great while, but they were never undisturbed or physiologic. I chose to go to the certified nurse midwives at the birth center here in town. I had three wonderful births with them, two at the birth center and one at the hospital. They supported me so well. I went back to my hospital job and felt so bad for the women who didn't know what really good maternity care was like. Midwife patients get longer prenatal appointments and more information about their birthing options. Their patients seek them out because they value the natural minded approach, and you can't get that with most OBs. I not only had babies with the midwives at the birth center, but I was a nurse working with them. I loved going in as a nurse for birth center deli-- deliveries that felt

calm, intimate and noninvasive. We took care of low-risk birthing women. Each woman had a nurse and a midwife devoted to them. All of that changed when the only freestanding birthing center in Nebraska got shut down by upper management. We don't have birth options here in Nebraska now. It is pretty much hospital birth or home birth without a licensed midwife in attendance. I know several nurses who became licensed midwives and then left the state of Nebraska so they could actually practice to their full potential. It is time for that to change. Women deserve the right to birth where they feel safe and comfortable, and with the care team that they want to attend their rates. It's time Nebraska catches up. Let midwives operate to their full potential. Give women great maternity care. The more options women have, the better care they receive. Thank you guys so much.

HARDIN: Thank you.

CATIE MILLER: Questions?

HARDIN: Questions? Seeing none, thank you.

CATIE MILLER: Thank you.

HARDIN: Proponents, LB676. Welcome.

LYDIA RHODES: Hi. My name is Lydia, L-y-d-i-a, Rhodes, R-h-o-d-e-s. I'm a certified nurse midwife, and I've worked in Omaha, Nebraska for the last 20 years. As a CNM, I have always served in a hospital and worked alongside physicians. This relationship is invaluable to me and I have no desire to change that. This bill is not about changing that relationship with the physicians, and it certainly has nothing to do with my respect for them. There is no question that I need their support and their backing. LB676 is primarily about three things, and I'm going to spend most of my time on two. One of them is for us to have our ability to own our own practice. In the state of Nebraska, I am unable to be the primary owner of my practice. I am blessed to currently work with a physician who has allowed me to be a co-owner, technically, in her practice for the last eight years, but without her, I wouldn't be able to have my own practice. This is huge. There is not only the business and the monetary side, but the benefits go way beyond that. Ultimately, in Nebraska, if a majority owner moves or no longer wants to be a part of your business, then your practice shuts down immediately. So in 2016, when my previous physician decided to move, I faced losing my entire practice, although it was a thriving practice and I was delivering 120 babies a year, seeing 60 to 80

patients a week, and had raving reviews online. In Nebraska, a practice can shut down literally overnight, simply because you no longer have a physician who is willing to be a majority owner of your practice and sign a piece of paper. Additionally, this bill is about having full practice authority. 35 states currently have full practice authority. However, in Nebraska, in order to practice, I must have a practice agreement with a physician. I currently have several physicians supporting me at the hospital I practice at, and I would want their support regardless of the piece of paper. But the technicalities this imposes are unexplainable. Last year, at a moment's notice, there was a change in the requirements by the hospital, and without a few additional signatures on my practice agreement, I was informed that I could immediately no longer continue to take call coverage until I had those signatures on that paper and faxed to the administration, even though I had physician call coverage. Over the next 12 hours, I literally ran around town getting signatures so I could submit these and resume call for my patients. This had nothing to do with actually having coverage or safety. I had physician support and physician coverage, but technically It changed my ability to practice for my patients, literally with just that one phone call. It was a technicality of what we call the practice agreement. This bill takes away that detail. A midwifery practice not group or hospital-owned in this state will always be built on sand unless this passes.

HARDIN: Thank you.

LYDIA RHODES: Mm-hmm.

HARDIN: Questions? Seeing none, thank you. Proponents.

HOLLY CHANDLER: I'm back. Chairman Hardin and members of the committee, my name is Holly Chandler, H-o-l-l-y C-h-a--n-d-l-e-r, and I'm here today, again, as a member and past president of the Nebraska Association of Nursing Anesthetists, or NANA, in support of LB676, which would allow certified nurse midwives, or CNMs, in Nebraska to practice to their full scope of practice. This proposal aligns our fellow APRN colleagues' practice with the consensus model. CNMs are highly trained, highly skilled professionals who are essential to providing comprehensive, quality health care, especially in the areas of maternal and newborn care. CNMs are educated to provide prenatal, labor, delivery, and postnatal care. Their expertise has been proven to improve health outcomes, reduce unnecessary interventions, and provide families with a more personalized and supportive birth

experience. Supporting this bill and allowing CNMs to practice to the full extent of their training and their certification, is a natural step towards better health care in Nebraska, particularly in our rural and underserved communities. As you are all aware, Nebraska has large OB deserts and the current restrictions prevent CNMs from fully utilizing their education, experience and skills while limiting their ability to provide care in those areas. NANA supports this simple and effective way to expand access to essential health care services, and we appreciate that the CNMs have collaborated and brought forth an amendment to remove participation in the Excess Liability Fund and fully support this bill with that amendment. In conclusion, by allowing CNMs to practice to the full extent of their training, we're taking a forward thinking step toward better maternal and newborn health in our state. I urge you to support LB676 and help ensure that CNMs are given the opportunity to serve Nebraska families to their full potential. Thank you.

FREDRICKSON: Thank you for your testimony. Any questions from the committee? Seeing none, thank you.

HOLLY CHANDLER: Thank you.

FREDRICKSON: Next proponent. Welcome.

REBEKAH KNOBELOCH: Hi. Good afternoon. My name is Rebekah Knobeloch, R-e-b-e-k-a-h K-n-o-b-e-l-o-c-h, and I am a registered nurse and a mother of five. I was a patient at Integrated Women's Health under the care of the nurse midwives when I was pregnant with my third son in 2017. He was due in September that year, and we experienced a major disruption in June when we were told that we may need to find a new provider less than three months before delivery, our provider was neither moving nor leaving, but because of an expiring practice agreement, our certified nurse midwife was not going to be able to continue providing us care as of July 1st. This was a completely unnecessary and inexcusable stressor to me and the other pregnant women who were receiving safe, evidence-based care at the hands of the certified nurse midwives. It was unnecessary because this is not the standard for other advanced practice nurses in the state of Nebraska. As a registered nurse, I am aware that other advanced practice registered nurses, including nurse practitioners and CRNAs, are not required to have a practice agreement in our state. They have full practice authority, and with full practice authority, situations like the one I described in my pregnancy would not have happened. We can do better and we must do better for the women in Nebraska and LB676 will

do that. It will bring nurse midwives under the same standard that already exists for their advanced nurse-- advanced practice nurse counterparts by giving them that full practice authority. Thankfully, in the 11th hour, a physician did sign a practice agreement and I was able to continue care with my midwife. That child, as well as my first, were born in the hospital, and I'm grateful for the care that we received both of those times. It is worth noting, though, that the CRNA, who could have put me to sleep or inserted a needle in my spine during those hospital births, did not need a practice agreement to do so. Yet the certified nurse midwife who was attending my low-risk birth did. I fully trust the CRNAs, and I believe they should have their full practice authority, I just also believe the nurse midwives deserve equal treatment. My other three children were born in birth centers, one in Texas, two here in Lincoln. I was able to make a decision with my provider about the best and safest place for me to give birth for each of my five children. As a registered nurse, I am passionate about evidence-based practice. Midwifery care and birth centers have strong evidence supporting their safety and their benefit to women. As a woman and a citizen of our beautiful state, I'm equally passionate that we provide safe options and that we support a woman making choices with her provider. Thank you.

FREDRICKSON: Thank you for your testimony. Any questions from the committee? Seeing none, thank you. Next proponent. Welcome.

EMILY WAY: Good afternoon. My name is Emily Way, E-m-i-l-y W-a-y, and I'm here today to testify in support of this bill. I was born and raised in Nebraska, attended UNL, and obtained a degree in bio-- biological systems engineering. My hope was to contribute to the field of biomedical device engineering in my home state. However, after graduating, I struggled to find a job in Nebraska that aligned with my degree, which led me to move to Wisconsin to accept a job there. Before moving, I gave birth to my first child here in Nebraska under the care of an OB/GYN. While I am very grateful for a healthy delivery, my experience was highly clinical. The medical model of care felt impersonal, focused primarily on following procedures and hospital policies rather than my individual needs and preferences. In Wisconsin, I had my second child under the care of a CNM, a certified nurse midwife, and the difference was profound. My midwives provided holistic, patient-centered care that prioritized my autonomy, informed decision making, and my emotional well-being. I felt heard, respected, and empowered throughout my pregnancy and especially my birth experience, which I did not have with my first. This model of care made a lasting impact on me. When we find out-- found out we were

expecting our third child, my husband and I made the difficult decision to move back to Nebraska to be closer to family, knowing I would likely have to give up on my dream of working as a biomedical device engineer. I embraced my role as a stay-at-home mom, but never stopped reflecting on my past and looking towards my future. With much consideration and prayer, I found a new calling to become a certified nurse midwife myself. For three years I've been working towards this goal, and will be graduating in May with my bachelor's degree of nursing, with plans to continue my education and do grad school to become a CNM. With my third and fourth child, my experience with midwifery care in Nebraska has been noticeably different from what I received in Wisconsin. Despite the dedication and compassion of my Nebraska midwives, their ability to provide care was hindered by restrictive laws, and it really pains me to admit this because I've loved all my midwives. But their difference in autonomy, skill, confidence, and authority due to these restrictions was undeniable. I have some specific examples I can give you, but I don't really have the time. Furthermore, I believe this law needs to be changed before any sort of CNM graduate programs can be created in this state. Then that can make a huge difference in our maternity care deserts. Right now I'm looking at costly out of state private universities to be able to get my master's degree and CNM certification. Nebraska's restrictive laws limit the practice of midwives. It not only affects Nebraska families seeking high quality maternity care, but directly impacts my ability to pursue this career in my home state. I don't want to move again to pursue my calling. I urge you to support this bill so Nebraska families can receive compassionate, evidence-based care they deserve without driving providers like me to leave Nebraska. Thank you for your time and consideration. Do you have any questions?

FREDRICKSON: Thank you for your testimony. Any questions from the committee? Seeing none, thank you for being here. Next proponent. Welcome.

BECKY SHERMAN: Hi. Hello to the committee. My name is Becky Sherman, B-e-c-k-y S-h-e-r-m-a-n. I am currently the legislative chair for Nebraska Friends and Midwives, a consumer based nonprofit, and I'm here as a representative for them in support of LB676. I have testified before the Health and Human Services Committee for the past decade plus, in favor of removing practice restrictions on certified nurse midwives in Nebraska. Consumers in Nebraska wholeheartedly want this important legislation to move forward, a movement that has been around since 1983. That's 42 years. As wise women often do in the shadow of defeat, we gather each time to discuss and plan the next

step. Conversation centers on the fact that Nebraska is choosing to pass on vital legislation that would ensure that our CNMs have the autonomy to practice to the full degree of their certification and training. I often have to explain to families baffled that Nebraska remains stuck in the middle of the 20th century, that we put together complete resources full of statistics, data, journal reviews, ACOG statements, testimonies, and much more. We present it with confidence, knowing that we have safety, efficacy, and consumer desire on our side. And all it takes to dismantle the science, the data, the facts, the case studies and global support for midwifery are one or two people with high credentials who have little to no experience working alongside an actual midwife, with minimal observation of the true genius of the midwifery model of care. They just get to walk in and say, nah, this isn't good. Midwives are dangerous. Families are ignorant. Babies will die. Stop the bill. Big words in a state that only received a D from the March of Dimes. Nebraska Friends and Midwives, we cannot pay a witness to fly in. We cannot pay a lobbyist. We only have "M and Ms." We have mothers and midwives who will accept nothing less than midwives who are fully supported and able to practice without restrictions. Nebraska is not benefiting from the current system of midwifery care. In fact, we are suffering and doing very poorly, and there are midwives in this room with clear solutions. It is embarrassing and shameful that midwifery legislation in Nebraska is technically a millennial. 42 years is long-- is not long enough? Is it enough for power, money and games to win? That's up to you guys.

FREDRICKSON: Thank you for your testimony. Any questions from the committee? Seeing none, thank you for being here. Next proponent. Welcome.

KAREN McGIVNEY-LIECHTI: Good afternoon. Thank you. I'm going to say my name before the light comes on, because it's long and it takes up time. I'm Karen McGivney-Liechti, K-a-r-e-n M-c-G-i-v-n-e-y-L-i-e-c-h-t-i. There we go. I'm a certified nurse midwife who has had the privilege of caring for women and babies in our community for over 20 years. I urge you to support LB676 to allow nurse midwives to have full practice authority, as you have heard, just as all the other advanced practice registered nurses in our state. This bill brings us into alignment under the same standard. The practice agreement for midwives has often been very difficult and detrimental to my ability to provide care. If a physician decides to move, leave, or retire, we are left scrambling in order to continue for our caring for our patients. When my employer decided to close our OB/GYN clinic in 2017, my practice agreement also expired. I was in a

panic whether I should transfer all my patients and hope that a physician would sign by the deadline. A community physician signed my practice agreement on June 26th. Later that year, with the help of my current employer, I opened a freestanding birth center. I believed, and still believe, that women deserve evidence-based care and safe choices for where they give birth. We saw positive outcomes, empowered mothers, and healthy babies. Last summer, my employer closed the birth center. Although disappointed in their decision, I'm not surprised. Birth centers are usually opened and run by certified nurse midwives. We're the expert in low-risk, low-intervention birth, and we have the passion and the heart for it, and the night shifts. Without the changes to our laws, patients can lose care from their nurse midwife at any point during the pregnancy, as you've heard. Nurse midwives are not able to open safe, evidence-based birth centers, and families in Nebraska are left with fewer safe options. We will continue to fall behind the other 49 states in our area. Women in our state deserve better. We can do better. Removing the practice agreement does not mean not working with physicians or hospitals. Many of our patients deliver in the hospital out of preference or out of necessity. Three of my seven grandchildren were born into the skillful hands of physicians in hospitals, and I am personally very grateful. I urge you to support this bill, not just for midwives like me, but for the mothers who deserve safe evidence-based choices. Thank you.

HARDIN: Thank you.

KAREN McGIVNEY-LIECHTI: Thank you.

HARDIN: Questions? Seeing none, thank you. Proponents, LB676.

REBECCA WELLS: I'm Rebecca Wells, that's R-e-c-c-a [SIC] W-e-l-l-s, and I grew up here in Nebraska, got a nursing degree at Union College, taught nursing there for a number of years, and went back and became a midwife. Worked 14 years out in Hastings, but I-- and then moved back to Lincoln. I have not worked under my Nebraska CNM license since 2012. My husband had retired early and I decided to do locum tenens. So that's where you fly out and do coverage at another place. And I actually ha-- got licenses in Montana, and later in California. I had a midwife in Montana, I went up and did her vacations for five years, so I could do short term things, be gone not too long from home. So I worked with an independent practice up there. There was no practice agreement. She had physicians that she regularly collaborated with and referred to. And when I filled in for her, that's what I did. In California, when I got my license out there, they-- if you look at a

map, they have it a little different. You are able to be independent on low-risk women out there. But if you have high-risk, you don't have to have a practice agreement, you just have to have some agreed upon protocols. But what I want to say is the 407 review did not work for us. We had one in 2020 for certified nurse midwives, and the Technical Review Committee supported full practice authority for certified nurse midwives. Nothing came of it. I looked through my files in preparation for this and guess what I came upon, Senator Riepe? A letter to you dated February 28th of 2017. You were chair of this committee and we were looking at getting rid of the practice agreement. So this is something I-- once, once COVID hit, the travel nursing dried up because you had to quarantine for 14 days once you got there. So basically I have really-- I'm not practicing anymore. I've kept my license active just in case, but, you know, the sad thing is here in Nebraska to, to get a practice agreement with a doctor doing deliveries, I don't want to be doing nightti-- nighttime deliveries at my age anymore. But I'd love to be working a day or two a week in an office setting doing women's, women's health. That's what we're trained to do. People think of us as just birth, but we also do women's care through the lifespan, from menarche to menopause. So I would love to be doing something like that. Or, you know, maybe office pregnancy visits. But without-- you know, I'm not going to be given a practice agreement when I'm not going to be doing nighttime deliveries for a doctor that's hiring me. So anyway, I hope that you will pass this bill on this time.

HARDIN: Thank you. Questions? Senator Meyer.

MEYER: Thank you, Chairman Hardin. Your testimony caused me to come up with a question. You said you practiced in Montana, and doctors were more than happy to take referrals and things of that nature.

REBECCA WELLS: Oh, yeah. Mm-hmm.

MEYER: And so in Nebraska, we have to have a signed agreement in order to-- for you to practice your profession. Is that strictly based on liability? Do you find doctors in Nebraska that would be willing to work with you? Or-- and maybe it's a question that should have, should have been presented to all the other ladies.

REBECCA WELLS: you know, I, I don't quite understand it? I had this for you, but it's outdated. This, this was a picture of the states that still required a practice agreement. However, North Carolina, as of October of 2023, no longer require one. So it's us and Georgia. And

Georgia is a F on the March of Dimes report card, and we're a D. California, they're, they're I think a B minus but, I mean--

MEYER: I guess what I'm trying to get at is do we have physicians in this state that are willing to work with a certified nurse midwife, but it's the liability--

REBECCA WELLS: Oh, I'm sure it--

MEYER: --exposure, is that, is that the, is that the stumbling block?

REBECCA WELLS: You know what? I'll tell you what. There's something called vicarious liability. There's been articles written about it in the past. But when-- there is a thought that possibly they would have more liability if they-- somebody supposedly under them. It's much better to not have that practice agreement. And then everybody is responsible for what they do. And I think, you know, I, I think doctors would be much-- I don't think they like this practice agreement thing, unless they like it because they want to be able to hire midwives to do their nighttime deliveries. So they might be against it because they like the control.

MEYER: Thank you.

REBECCA WELLS: you know? Does that make sense?

MEYER: It does. Thank you.

REBECCA WELLS: Yes. And I'll tell you what. California, as far as the home birth thing? Home birth is occurring. California, they have certified nurse midwives. They actually have prof-- midwives that are not nurses. Also, they have the lowest maternal mortality rate in the country of 10.5. And, you know, ours is like, I think it's 20, 21 or something or, you know. And of course, Georgia, the other state with supervision, they're like 40. It's terrible. But-- So it can be safe.

MEYER: Thank you.

HARDIN: Other questions? Seeing none, thank you. Proponents, LB676. Welcome.

JENNIFER JACOBITZ: Welcome. Good afternoon. I'm Jennifer Jacobitz only when I'm in trouble, but J-e-n-n-i-f-e-r J-a-c-o-b-i-t-z. And I'm here for this bill. I'm a nurse midwifery student in Nebraska. I've been a registered nurse for 20 years. I've done L&D for at least 17 of those.

So tons of experience working with moms in laboring and birthing. And just in the last year, felt like I was called to go back to school to become a midwife. So in grad school now. So I wanted to talk about the education a little bit. Libby did cover it some, but just it's uniquely rigorous. We don't just do clinical hours, we must prove competency in all aspects of pregnancy, birth, and postpartum care. I do have a sheet in there that kind of compares, like, what a midwife student is required for hours and for births, versus like a family practice, versus an obstetrician. And keeping in mind the family practice and those obstetricians would be doing C-sections, forceps, vacuum, things that the midwives don't. So a certified nurse midwife is required to do 750 clinical hours, plus 35 births to be able to sit for boards and take a test, that's a national recognized test, in order to be certified as a nurse midwife. In comparison, if you're a family physician, you have to do 20 deliveries. If they want to be doing additional training to be doing pregnancy related care, then their requirement is 80 deliveries and 400 hours or four months of obstetrics related clinical. My current experience is with family practice physicians and I'm amazed at their work. But the antepartum care is one piece of their very complex day of seeing patients of all ages. For midwives, it's all we do all day long. So we are definitely coming in with a lot of experience. We're definitely competent. ACOG as well as ACNM, both leading organizations for OB/GYNs and for midwives, issued a joint statement saying that certified nurse midwives should have full practice authority. So that is their, their statement. So despite this, when I graduate, I'm not sure where I'll work. Not because Nebraska doesn't need more midwives, but because I need to have a contract with a physician to be able to practice. I live in rural Nebraska, right in the center, by Grand Island. I live in Prosser, teeny-tiny. I'm married to a farmer. So I'm not going anywhere. But my ability to work and care for my community is based on, not my skills and education, it's based whether a physician, who may not share my approach to care, which is often different than theirs, and may not be willing to sign a piece of paper. And many aren't. That's a problem across the state that you've been hearing. And I'm not alone. Other midwives in Nebraska also married farmers, and they remain unemployed despite completing the rigorous training. We were on an ACNM meeting just last week, and two of the students out of us, the three of us, one was going to practice in Wyoming and one was going down to Arizona. I got all my schoolbooks from somebody in Lincoln who was moving to Minnesota to join the almost 300 midwives in Minnesota who have better practice environments, and leaving a state that has somewhere around 50. So I want to provide holistic women's

health care. Midwives want to stay in Nebraska. But outdated laws make it difficult, if not impossible. It's time to remove the barriers and allow nurse midwives to practice to the full extent of our education and training. Thanks.

HARDIN: Thank you. Questions. Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. My question is just a comment. One of the things you handed out, this chart that kind of outlines all of the training, that's actually very, very helpful. So thank you for doing that.

JENNIFER JACOBITZ: Yeah. I credit Libby for that one, she helped me with--.

FREDRICKSON: OK. Thank you, Libby, whoever you are.

JENNIFER JACOBITZ: I gave her information I'm not going to take credit on it.

HARDIN: Other questions? Senator Meyer.

MEYER: Thank you, Chairman Hardin. I found it interesting in your testimony that there's three in your community, essentially two others like yourself, that are training to be a midwife but can't practice in your community. And, and I know where Prosser is. I, I have friends there. I don't know if it's an underserved community being close to Grand Island and also Kearney, but in all probability, it is. So, so often on this committee, we, we consider the underserved communities. How do we get medical care out into the underserved communities. And here we have an opportunity in this community to provide for that. And, and, and you're not allowed to practice. So it's more of a comment than a question. But if our efforts are to provide increased medi-- medical care, or medical care in, in some fashion or-- in our underserved communities, it would appear that we have some opportunities. We just have to recognize those and take advantage of them. So I appreciate your time today. Thank you.

JENNIFER JACOBITZ: Yeah, I-- in response to that as well. So Prosser is dead center of Kearney, Grand Island, and Hastings. Kearney has never hired midwives. The obstetrician that practiced wasn't really in favor of hiring them. I don't know if that context has changed. Grand Island has two only that they have, and they sometimes will have a little resistance. And then Hastings does have two or three, a third one that just started. But yeah, sometimes it's your, your faith

factor or different things, that they're a little bit more resistant of signing a contract with you. So.

MEYER: Well, thank you.

JENNIFER JACOBITZ: Yeah.

HARDIN: Other questions? Seeing none, thank you.

JENNIFER JACOBITZ: Thank you.

HARDIN: Proponents, LB676. Welcome.

LINDA HARDY: Thank you. Turn to the correct page. Chairman Hardin and members of the HHS Committee, my name is Dr. Linda Hardy, spelled L-i-n-d-a H-a-r-d-y. I'm a registered nurse with a PhD in nursing education. I've been a registered nurse in Nebraska for over 48 years, and a nurse educator for the past 21 years. I'm the current president of the Nebraska Nurses Association. I am speaking on behalf of the NN-- NNA with the endorsement of our LARK, our legislative committee. The NNA wishes to express support of LB676 and to thank Senator Hansen when he comes back for introducing the bill. Oh, he's over there. Sorry. So I'm going to alter my testimony on the fly, because I don't want to repeat things that you've already heard. So first of all, NNA is strongly in favor of nurses practicing to the full extent of their education and their scope of practice, whether it's an advanced practice nurse or a registered nurse, as clearly laid out and clearly covered by our Board of Nursing. I've worked with the Board of Nursing, developing a nursing program at a university here in Lincoln. I know the rigor that they require, believe me. I took many, many curricular pieces, many classes to the board, went back, revised them, took them back. They, they are paying attention to scope of practice and safe practice for Nebraskans. The American Nurses Association is also in strong support of full practice authority for all APRNs, including certified nurse midwives. You've heard this before, but I'm going to restate this. Nebraska is a rural state with maternal care deserts. The March of Dimes report showed over 51% of our counties in Nebraska are defined as maternity care deserts. In rural Nebraska, it can be difficult for nurse midwives to find a physician to supervise them just because of the scarcity of positions. So removing the requirement for a signed practice agreement with a physician has the potential to improve access for maternal care in rural areas of Nebraska. Developing a collaborative referral network would be less difficult, but would still offer the resources needed to provide safe,

effective maternity care to the citizens of Nebraska. In summary, the NNA strongly supports LB676, and we ask the committee to advance this bill.

HARDIN: Thank you.

LINDA HARDY: And I made it to the yellow.

HARDIN: You did an amazing job. Questions? Seeing none, thank you. Proponents. Hello.

DANIEL NOOR: Thank you. My name is Daniel Noor, that's D-a-n-i-e-l N-o-o-r, and I'm from Omaha. I am a husband and a father. I moved here from Tennessee a few years ago. Tennessee has many birth options. We have-- it has many good hospitals like we do in Nebraska. It also has many good birth centers. And many people choose to have home births there. In Tennessee, certified nurse midwives can attend home births and operate birth centers, and they don't have the physician supervision restriction that we have in Nebraska. Certified professional midwives, CPNs, are also free to do these-- to do things-- have freedom as well. Many, if not most, people in the history of the world have been born at home. Scholarly studies have shown that home births are safe as well as births at birth centers. There's a few, I footnoted a few articles that-- studies that indicate that. In Tennessee, in the rare cases when transfer to a hospital from a home or a birth center is necessary, midwives in Tennessee will accompany the parents to the hospital so they can provide continuity of care, working with the local doctors that they have, they have good relationships with. Despite not having this, they don't have the same restrictions, but they do have good relationships with the doctors and value that. Many of my friends in Tennessee have had home births with well-trained, experienced, caring midwives. They love the personal care that midwives provide, and they love being able to give birth in the peace and comfort of their own homes. The births went safely and well, as most home births do, and my friends couldn't be happier with the choice they made. Most states do give this freedom. So when I moved to Nebraska, I was shocked to discover that we don't have the freedom here that most Americans have. I was shocked to find out that Nebraska is the only state in the nation that doesn't allow CNMs to attend home births. I was also shocked to learn that Nebraska is one of a handful of states not allowing CPNs to practice freely. I've al-- it's already mentioned some of the, the restrictions that are on, that are on CNMs, so I won't skip that part. But according to a 2023 report, 52% of Nebraska counties are maternity care deserts. But in

Tennessee, only 33% of counties are maternity care deserts. That's actually the national average. If-- but if CNMs had the freedom to attend home births and operate birth centers, they could help with this problem as they do in Tennessee and other states. Currently, there are almost no birth centers in Nebraska, and these restrictions lead many Nebraskans to travel out of state for their maternity care. The restrictions on CNMs are outdated and should be changed. CNMs should have the same freedom that they have in 48 other states, and parents should have the right to choose their maternity care, or they have the right and they should have the freedom to do so. So please vote to give Nebraskans that freedom that Tennesseans and most Americans enjoy. Thank you for your time and your service. Please vote for LB676.

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

DANIEL NOOR: Thank you.

HARDIN: Proponents, LB676. Hi.

MALIA WALTER: Hi. My name is Malia Walter, M-a-l-i-a W-a-l-t-e-r. And so midwives just-- don't just do birth. They do women's care. That care starts for women around my age. I have been lucky to receive tips for my body, something I wish that other girls my age had more access to. Midwives should also be able to start their own businesses, which is currently limited due to the physician agreement. Families are searching for health care that fits their needs. For some of that includes from physicians, nurse practitioners, physicians assistants, chiropractors, and for others, it includes midwifery care. I'm hoping that you will all support this bill to give more girls my age access to health care that fits their needs.

HARDIN: Thank you. Questions? Thanks for another perspective. Appreciate that. Proponents, LB676. Hey, Barb. Thank you. Welcome.

CALI MARSH: My name is Cali Marsh. That's spelled C-a-l-i M-a-r-s-h. I'm a labor and delivery nurse and student nurse midwife. I've had the opportunity to see the amazing work that midwives do and the impact they make. Midwives don't just deliver babies. They see patients in many stages of their lives, including throughout pregnancy and postpartum, through menopause, for gynecologic concerns, and even for primary and newborn care. They are highly skilled providers who hold either a master's or doctoral degree, and have dedicated much of their blood, sweat and tears to ensure they provide the most competent care.

Patients are known to express their gratitude for a midwife's ability to provide empathetic care during perhaps their most vulnerable moments in life. Nebraska not allowing full practice authority puts a great barrier to all of what has been mentioned, as it remains one of the most restrictive states in the entire country. There are professional organizations who support midwifery practice, such as the World Health Organization, who claim that midwives are capable of providing an astonishing 87%, I'll say that again, 87% of all sexual, reproductive, and maternal health care needs. Keeping this in mind, nurse midwives would be the answer for the maternity health care crisis that many rural communities are facing right here in Nebraska. As a student nurse midwife, the lack of full practice authority has held a heavy weight on where I will go on to practice in the future. I love Nebraska and I do not want to leave, but these restrictions are driving me to a state that will allow me to serve my patients to the best of my ability. After all, we are not asking to practice outside of our scope or outside of our competencies. Rather, we are asking to provide our fullest potential as independent health care providers. From all of the nurse midwives here on one of the coldest days of the year, we need full practice authority. Thank you.

HARDIN: Thank you. Questions? Seeing none, thank you. Proponents, LB676. Welcome.

JOYCE DYKEMA: [INAUDIBLE]. Thank you, Chairman Hardin, thank you members of the committee. My name is Joyce Dykema, J-o-y-c-e D-y-k-e-m-a. I am a certified birth doula, postpartum doula, a childbirth educator and serve as director of communications at Doula International which is an international doula training and certification organization. I'm also a mother of three, who received midwifery care for all three of my births. I still receive midwifery care for gynecological services, and I am on staff with Malone Center's Maternal Wellness Program as the doula mentor. I'm testifying today on behalf of Malone Maternal Wellness. We are pleased to express our strong support for LB676, as well as LB374, which was last week, in support of increasing access to midwifery care for Nebraska families. As a nonprofit program aimed to improve perinatal health for Nebraskans at increased risk of maternal mortality and morbidity, and neonatal and infant mortality and morbidity, we believe these bills are a crucial step in advancing maternal health care, and ensuring that families have access to the resources they need during and after pregnancy. Malone Maternal Wellness provides BIPOC child bearing families in Lincoln and Omaha with evidence-based perinatal services from pre-conception to two years postpartum. We have witnessed

firsthand the challenges that many of our clients face in accessing respectful, evidence-based, patient centered care for low-risk pregnancies and low intervention births. Increasing access to midwifery care by granting certified nurse midwives with full practice authority, removing their location restrictions for families who desire and qualify for home birth, and adding nurse midwives to the excess liability cap, will improve perinatal outcomes for all Nebraska families, not just our clients. Midwifery care, as you have seen, have heard from everybody, especially when compared to obstetrician and family physician care for pregnancy and childbirth has been shown by medical research to increase rates of spontaneous vaginal birth, reduce rates of caesarean, reduce forceps and vacuum, reduce rates of episiotomy, and at no increased risk to neonatal outcomes. Increasing the percentage of pregnancies with midwifery care in the United States has been projected to result in billions of dollars in cost savings. Up to 3-- 30-- sorry, excuse me. 30,000 fewer preterm births, which is a major cause of newborn and infant mortality, and reduced costs for private health care plans, Medicaid programs, employers and employees. For 70 years, Malone has been a voice for change based on the needs of the communities that we serve. As the trusted voice of our families and birth workers that serve our community daily, we strongly support the passage of LB676 and thank everybody for their support. Thank you.

HARDIN: Thank you. Questions? Seeing none, thank you. Proponents, LB676.

LAUREL BULOW: Hello.

HARDIN: Hi.

LAUREL BULOW: My name is Laurel Bulow. That's L-a-u-r-e-l B-u-l-o-w. Thank you for having all of us today. I come to you today as a mother of five beautiful children, all birthed with the assistance of midwives, specifically CNMs. I have experienced firsthand their medical competency and unmatched ability to come alongside a woman in one of her most vulnerable states, bringing life into this world. From my first pregnancy, I saw an OB for their first trimester until I realized there was a birth center available in Bellevue. The first office I experienced was kind and I'm sure still very good at their jobs. There wasn't necessarily a negative reason why I switched, but the appointments consisted of about 40 minutes, 30 of which were waiting and being seen by a nurse to take vital signs before an extremely quick chat with my OB. The switch at the birth center was night and day. The appointment was not rushed, and the majority of my

time there was spent in meaningful conversation, forming a genuine relationship with my midwife and asking however many questions I needed. From then on, I knew this type of personalized care was what was best for me and my family. Fast forward to my first labor there. I arrived at the birth center about six centimeters dilated, and three hours later she told me six and a half centimeters, although I learned later it was still six. She was trying to be giving me hope before suggesting a more invasive intervention such as pitocin, which would have likely been suggested or even strongly pushed at the hospital, my midwife had me laying in, in an exaggerated sideline position for 30 minutes on each side, and an hour later I was fully dilated. And if you do not know this, six to ten is pretty quick in an hour. My first healthy baby boy was born an hour and a half after that. So I mention this because it is one example of midwives acute attention during labor and knowledge of a woman's body, and the many noninvasive ways you can assist in a birth, like switching positions, using different techniques to help the mother relax during contractions, etcetera. I went on to have two births at the birth center in Bellevue called the Midwife's Place before they closed in 2017 for reasons that people are saying today when it comes to the agreement. Conveniently for me, a birth center opened in Lincoln in time for my third birth, and my third and fourth births were with The Good Life Birth Place in Lincoln, who, Karen, you heard earlier. This past fall, during my fifth pregnancy, I moved an hour outside Lincoln. I knew I would either have to drive into Lincoln to go to the birth center; switch to a hospital closer to my house that did not offer the same thing, so that would be Beatrice or Crete; or pursue home birth with the extremely limited options available. I decided to continue care with my midwives that I had known for years. I know, I've known these women for years with my five births, when a huge bomb was dropped on them and all of us. CHI suddenly gave notice of the birth center closing for truly no good reason. The birth center's outcomes were amazing. The numbers were growing, people were coming all over the place. It was simply a less profitable avenue for CHI than hospital births, and that is a fact. In the end, as my niece mentioned at the hearing for CPMs last week, I ended up driving to St. E's for my birth and an hour in the dark and rain about one in the morning, making it with only five minutes to spare. A little bit of a close call. Women in Nebraska want birth center birth, and they want home birth. But the existing restrictions make birth centers close quickly or even not open at all, and limits midwives from practicing fully, as they do in almost every other state, or a majority, majority of the states, in the case of

CPMs as well. So I asked you all to look at the evidence and desires of Nebraska women and please support this bill. Thank you.

HARDIN: Thank you.

LAUREL BULOW: He woke up just in time.

HARDIN: Questions. Senator Fredrickson.

FREDRICKSON: Thank you. Who do you have testifying with you?

LAUREL BULOW: This is Hezekiah. He's three months old.

FREDRICKSON: Three months old. Well, it's always exciting. Well, it's always exciting to have a little life in here.

LAUREL BULOW: Thank you. Thanks for having me.

HARDIN: Thank you. Proponents, LB676. Welcome.

DANA WOCKENFUSS: Thank you. Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. I am Dana Wockenfuss, D-a-n-a W-o-c-k-e-n-f-u-s-s. I've been a Nebraska resident for 17 years and have traveled from Norfolk today. I'm grateful for Senator Hansen for introducing this. Rural families face significant barriers in accessing maternal health care due to pr-- shorter provide-- shortage of providers. My lived experience and my only pregnancy was through the COVID 19 pandemic, during which I realized how limited my birth options were and still are. With only one certified nurse midwife in northeast Nebraska and attending a home birth as a CNM provider being a felony, I had to choose between delivering at home without a provider or medical support, or in a hospital with additional COVID protocols. I chose the hospital, and in doing so, I experienced a loss of bodily autonomy during my birth. The provider took medical interventions without my informed consent, a fundamental right in health care. Decisions were made for me and not with me. This violation of trust and autonomy had lasting impacts on me as a brand new mother. I experienced postpartum anxiety and more than seven months of physical healing with additional physical therapy needed. And that experience left a resounding lack of trust in the safety of my care in any future pregnancy. I will not give birth in a hospital again. Nebraska's current laws do not encourage me to go through the intense process of growing and birthing another infant. If we are serious about improving the overall health of our society, this is where it starts. We must prioritize supporting families during the

critical period of welcoming a new baby. The postpartum phase is not just about recovery. It sets the foundation for maternal well-being, infant development, and the long-term health of the entire family unit. When mothers feel safe, heard, and in control of their birth experience, outcomes improve not just in the birthing room, but in the months and years to follow. By expanding certified nurse midwives' ability to practice without a physician's oversight and without restricting where they are providing care, you can give families the ability to choose the birth provider and the setting that best supports their needs. Supporting LB676 is not just about birth. It's about strengthening families, communities, and the future of our state. Thank you for your time and consideration.

HARDIN: Thank you. Questions? Seeing none, thank you. Proponents, LB676.

CAROL GREENLEE: Some people said I spent too long crawling around on the floor catching babies, and now my knees are shit.

HARDIN: Oh, no. So sorry.

CAROL GREENLEE: Oh, yes, there. Sorry. My name is Carol Greenlee, C-a-r-o-l G-r-e-e-n-l-e-e. I have been a registered nurse in Nebraska, I worked in a lot of small towns like Alliance, Central City, and some bigger places too, in OB since 1973. So this is my 52nd year of being a nurse here. I returned from Grand Island to the Lincoln area because I had an opportunity to go to midwifery school and practice here in Lincoln. And the only reason I had to come back to Lincoln to do that is because of the practice agreement stuff. In 1997, I became the 15th licensed CNM in Nebraska. It has been my honor to deliver over 2,300 babies here as a CNM. I have also assisted at over 500 Caesarians. In 2016 I left my home state and went to Utah because I was tired of being on call half my life, and working 70 or 80 hour weeks, which was the requirement of my employers who had signed my practice agreement. I took call for them as well as my partner, I was on call for five people, and I got called a lot, and I still worked four and a half days a week in the clinic. I went to Utah-- I want to tell people it is time for Nebraska to acknowledge that we are highly educated and safe professionals. For example, there is a list of complications that CNMs must consult with at the hospital in Lincoln. The list of consults required of a family practitioner in the hospitals in Lincoln is almost identical. But those family practice doctors do not require, are not required to have a practice agreement. They consult with higher level providers. There are three levels of physicians providing

obstetrical care: OBs, family practice, and also neonatologist and perinatologists. So we are just one on that rung. I could quote you a bunch of statistics about better outcomes with midwives, and some would argue that this is because we care for lower-risk patients. But I would say it is because we listen, observe, and anticipate needs for higher level care when indicated. When I left Lincoln, I went to Kearney, which was-- where induction was the norm in the hospital. Lots of interventions for low-risk patients. The first month I was there, the caesarean rate was 50%. I couldn't stand it. That's when I went to Utah, where I worked in birth centers and I did some home births. Not a great big fan of home births, you have to take a lot of stuff. And my knees are bad.

HARDIN: Ms. Greenlee, we're in the red. But can I ask you? You've, you've probably delivered several people in this room.

CAROL GREENLEE: I have. Well, I have delivered several of the college students of some of the women in this room.

HARDIN: I see. Very well. And so I've got a question for you. Why do you think we're the last to do this?

CAROL GREENLEE: I like living in a conservative state, and I like that we want safety for our women. I know that Kearney has a reputation of being a place where mid-level practitioners can't practice very easily because there are rules. You know, there are the rules here about practice agreements, and there-- every time you want hospital privileges, there are lists of the things that you can and can't do to get privileges to practice at a hospital. Malpractice is out of sight for home birth. But-- and I think a lot of physicians see us as competition. But I can take care of 80% of women. And I also did well-woman care, which is a great need, as Rebecca said earlier, and especially in smaller places. I live in Elmwood now. There was a fa-- a nurse practitioner who tried to open a clinic so that people would have some immediate care in the community, and she didn't last very long. And I, I went down there and I said, I would love to help you. I could do prenatal visits. I don't want to be on call anymore and do deliveries in the night. I'm old. But I could-- there's a lot I could do yet.

HARDIN: What's the malpractice cost, roughly?

CAROL GREENLEE: I don't know current numbers. I don't know the current numbers. Thousands of dollars.

HARDIN: OK.

CAROL GREENLEE: It can be up to a third of the money you get for taking care of somebody in their pregnancy.

HARDIN: OK. Understood. Any other questions? Thank you. Appreciate you being here.

CAROL GREENLEE: Thank you.

HARDIN: LB676. Proponents. How many other proponents do we have? Do you-- OK. You're all up kind of close to the front. That was my idea. Welcome.

AMBER WALTER: Hello, and thank you for letting me come. My name is Amber Walter, A-m-b-e-r W-a-l-t-e-r. I'm a certified nurse midwife in Lincoln, Nebraska. I've been practicing midwifery for almost eight years. I want to let you know why I became a midwife. I used to work as a labor and delivery nurse. I enjoyed helping women and families go through labor and birth. However, I started to notice how some women's requests for the births were not always met with enthusiasm, or were dismissed as not being good for them. Requests as easy as not delivering on their backs, trying different positions for labor, wanting a water birth, or wanting to know the risks and benefits of interventions. They are searching for informed consent and shared decision making, and sometimes have been met with resistance. I noticed that midwives were great educators during labor and tried to honor birth requests as long as it was safe for the mother and the baby. I was lucky to have midwives around me, see the passion for my birth, and to encourage me to become a midwife. On a side note, Carol Greenlee. Once I became a midwife, I saw women not only for birth but also for women's health. I have found thyroid cancers and breast cancers, not because I signed a physician's agreement, but because I had extensive training and education and certifications to become a midwife and apply these skills into practice. I have been able to help women throughout health care trauma, and gain their confidence that they have a voice and what does or does not happen during their care. I have appreciated mentorship from physicians and midwives both, and I have continued to gain knowledge in my career with different conferences and research articles. I have kept up with the standards of care and research-based care, not based on a physician's agreement, but to continue to be a good practitioner for those I care for. I have interviewed multiple applicants who have turned down midwifery jobs and say they do not want to be a midwife in Nebraska, and fear of

losing their jobs because their physician may not sign their agreement, or may not continue to sign an agreement, or their ability to own a business. I have heard many Nebraska nurses say that they would like to have become a midwife, but don't continue their education due to our laws. It is important that we take these steps and vote to pass LB676. This can encourage more midwives to practice in Nebraska and continue to improve access for women's health care. Thank you.

HARDIN: Thank you. Questions? Seeing none, thank you. Proponents, LB676.

AUDREY CHEEVER: Hello. I'm honored, I'm honored to be here today. My name is Audrey Cheever, A-u-d-r-e-y C-h-e-e-v-e-r. I'm a labor doula, a mother of two young girls and a home birth transplant from Oklahoma. Living in Oklahoma at the time of my first pregnancy, I pulled out my phone, typed midwife in the Google Maps search bar, and was delighted to find that just 15 minutes away from my house was a birth center with home birth midwives. It was a group of well-organized certified professional midwives, and one delightful certified nurse midwife who was no longer delivering babies but was caring for women by providing annual exams, birth control, testing and screening, and being the prescribing professional, so the birth center and the CPMs could have the medications and equipment that they needed. My first birth was fairly typical as I birthed our baby girl at home in our small duplex. I could go into detail about how skilled the two midwives were or how safe and comfortable I felt, But the midwives there were CPMs and that bill was two weeks ago. Today we're talking about CNMs. What I will tell you is this. I went into their office a year later, not as a patient, but as a concerned mother, knowing that I was moving to a state that does not allow CNMs in homes or to practice independently out from under a medical doctor's care, and I was worried what to do. They confirmed that at the time there was only one birthing center. CNMs could not attend home births and to be careful for who I looked for if I desired a home birth, as when there is no recognized licensure, anything goes, and they still wished for me to be safe. I asked them how they did it, how they were able to get where they were able to serve their community. Mothers, they said, not the midwives, doulas, or the doctors, but mothers who wanted to see a change and have birthing options for their own bodies and babies. I provided an attached document outlining the basics of who might come in contact with a mother or baby, from those first flutters to the chaos of postpartum. In talking with other birth professionals and hearing those around us not in the birthing world, there seems to be some

confusion as to was what a certified nurse midwife is and why they matter. This document hopefully will clear some of that up for some. Allowing CNMs in homes not only puts professionals in places where maternity care's scarce, but it also gives options for people who are looking for safe, trained midwifery care. This bill, if passed, would also help CPMs not allow-- now, allowing them to collaborate with CNMs, and work together to provide not only more care, but safe, well-prepared care. My other birth of our second daughter occurred nearly two years ago. Knowing I felt confident in my knowledge and my ability, and not wanting to take up one of our few CPMs that might be willing to take a home birth, I found a CNM who would care for me, who'd care for me despite her suspicion of me not showing up on delivery day. I planned for an unassisted delivery ten minutes from the hospital. There was no reason I couldn't deliver at home and was low-risk until 34 weeks. I told my CNM something was wrong and that it was not pre-eclampsia, despite the fact that I had most all the symptoms.

HARDIN: You're in the red, but I want you to continue.

AUDREY CHEEVER: I'm going to try. And she listened to me. Exactly a week after my--

HARDIN: It's just us.

AUDREY CHEEVER: Exactly a week after my first symptom, we were transferred to Omaha. We were transferred to Omaha with two of the maternal-fetal medicine doctors, one down here and the one in Omaha, for an amniocentesis and a C-section to save my 7 pound daughter, who was 3 pounds water weight. And six weeks later in the NCU, she came home and is thriving. I'm so glad my midwife listened to me and that even though it was unlikely I was going to come to her for delivery, that she still took me and that she was able to refer me when obviously there was no way my daughter would have survived a home birth. On another note, I was surprised when the bill came and I owed more for my C-section, $5,000 totaling $4,000 despite having good health care when my home birth, home birth originally in Oklahoma with no insurance cost only $3,000. I will take any questions.

HARDIN: Questions? Senator Fredrickson.

FREDRICKSON: More of a comment. Just thank you for your willingness to share your experience with us. Appreciate that.

AUDREY CHEEVER: Thank you.

HARDIN: Other questions? Thanks for being here. LB676 proponents. Welcome.

SUZANNE GOODDING: My name is Suzanne Goodding, spelled S-u-z-a-n-n-e G-o-o-d-d-i-n-g. And I first want to apologize. I lost my mind and spoke up because one of my midwives was here for one of my children. I live just north of Lincoln. My husband and I have eight children. All of them were born under the care of certified nurse midwives. Did you know that not all women want an epidural? It's not the worst experience of our lives. Giving birth in a safe and comfortable environment, with a trained professional of our choosing, it can be an empowering time and one of the best experiences of our life, getting to meet our newborn baby. We've had a different midwife at each of our births. Several of them are here. We've given birth in hospitals, we've given birth in birth centers. We're given birth in a birth center inside of a hospital. Babies three four and five were born at the birth center up in Bellevue. This facility was an hour away from our home. We lived in Lincoln. We chose to make that drive. We thought it was worth it to be able to have the experience that we wanted. We loved that place. It was an excellent blend of natural care with a more homelike environment. Sadly, this excellent option was forced to close. So for our next baby, baby number six, we were encouraged that there was a birth center in Lincoln that had opened in our hometown. However, when we went, we were informed we couldn't have our baby there because there was a rule from their supervising doctor that you could not have baby number six or more. We were saddened to hear that, but we were told that we could drive to Omaha and do a birth center birth inside of Emmanuel Hospital. It's not quite the same walking through a hospital system, but we were thankful for that option and we chose to make the drive. Later, the Lincoln Birth Center did change that rule and we were planning to go there for our seventh baby. However, she decided that she wanted to be come-- she wanted to come breech, and my midwife bent over backwards to find a physician that would be willing to let me have a vaginal breech delivery, and it went really well. There was more drama there than needed to just because of the extra hoops to jump through, but really it wasn't much more difficult. But we had a, I had a safe and good delivery there. For our three month old, the one I'm holding, we were again planning to use that Lincoln Center, but in the middle of our pregnancy, we-- it was announced that that birth center would close the following month. This led to a time of uncertainty. We didn't know what we wanted to do. Having been in hospital births, even positive ones, that's not where I

wanted to have my baby. We considered other options, but in Nebraska, you know that there are very limited options. So we ended up delivering at a hospital. We had a birth with no extra complications. The only extra service that we had was a quick ultrasound to make sure that that baby was head down. It wasn't when we got there, but ten minutes later he was head down and we had a wonderful water birth experience. It was about the best experience that you can have as a delivery at the hospital. But it still wasn't where we chose to give birth. We were dismissed nine hours after delivery, which is actually longer than I've been at birth centers. So we went home, 12 hours total at the hospital, and our bill was more than double what it would have been at the birth center setting, with no extra services needed. My husband and I are lifelong Nebraskans. We've been-- we have had many times over the years that we wished we lived in another state just because of the birthing options or lack of birthing options in Nebraska. Passing this bill would expand birth options in our state that we love, we call home. It could alleviate the issues that we ran into. We just want the freedom to birth our babies in a comfortable, safe, and affordable, affordable environment of our choosing. Thank you.

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

AUDREY CHEEVER: Thank you.

HARDIN: Proponents, LB676. Well.

ZIARA YORK: Thank you all for being here today. My name is Ziara York, Z-i-a-r-a Y-o-r-k. I am a certified holistic doula working primarily with minority women in Nebraska. I have witnessed firsthand the systemic barriers and inequities embedded in our healthcare system. Time and time again, I see my clients, strong, capable, educated women facing dismissive treatment, lack of culturally competent care, and outright discrimination in hospital settings with obstetricians. For many of them, care from a certified nurse midwife in a setting of their choosing is not just a preference, but it is a lifeline to safety, dignity and autonomy. Yet, Nebraska remains the only state in the nation where CNMs are banned from attending home births. This is not just an outdated policy, is a direct attack on reproductive justice and the right to choose how and where, and where we give birth to our babies. Currently, minority women, as in black women and native North American women face disproportionately higher rates of maternal mortality and morbidity. In fact, according to the CDC and March of Dimes, women who look like me are anywhere from 2 to 5 times more

likely to experience maternal mortality and severe morbidity than our counterparts, our counterparts. At the same time, we have current evidence and research which shows us that these disparities in our outcomes actually disappear when women birth in out-of-hospital settings and have access to personalized care. Meaning that this issue goes beyond socio economic status, it goes beyond race, it goes beyond education level. It is the hospital system that has repeatedly failed us. Home birth with a skilled midwife offers a safe, empowering alternative for those who have been traumatized or marginalized by the way our medical system currently operates around maternal health and well-being. Now, this is not to say that removing these restrictions will also eliminate collaboration of midwives and physicians, as we've heard today. Nor will it eliminate the responsibility of the boards and physicians to work on bettering the system that currently exists. But this bill passing, LB676, will allow home birthing families to better integrate themselves into the system by giving the midwives who want to serve them a space to do so as well without being restricted. Midwives provide personalized, holistic care that centers the needs and values of the birthing person. They listen. They respect traditions. They prioritize informed consent. These are things my clients are too often denied in the hospitals. By supporting LB676, we can take a vital step towards addressing these disparities together. This bill is not about just legalizing home birth midwifery. It is about freeing families to make the best choices for their bodies and their babies. It's about giving marginalized women who are disproportionately harmed by the current system, the option to birth in an environment where they feel safe, respected, and supporting. The current law forces families to choose between unassisted home births or hospital births, both of which carry unnecessary risks when CNMs could provide a safe middle ground. This is not just illogical--

HARDIN: If I could encourage you to wrap up your thoughts.

ZIARA YORK: Yes. Gotcha. It is cruel and inhumane, and it disproportionately impacts communities of color who already face enough barriers to equitable care. So with that, senators, I urge you to pass LB676, free certified nurse midwives to do their jobs, free families to make their own choices, and free all women from a system that continues to fail them. The time for change is now. Let me ask you to free the midwives. Thank you.

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

ZIARA YORK: Thank you for your time.

HARDIN: Proponents, LB676. Welcome.

ALEXANDRA WALLACE: Hello. I was sitting at home watching, and I said, I have to come. So sorry that I'm out of breath and pregnant. So give me a minute. My name is Alexandra Wallace, A-l-e-x-a-n-d-r-a W-a-l-l-a-c-e. Try being pregnant and running with a two-year-old. When my husband and I decided that we wanted to have our first child, we, like most couples, assumed that the journey would be pretty straightforward. Growing up as a pastor's daughter, surrounded by a bit of exaggerated information about reproduction, I learned that the saying is true, you never know until you try. And after a year of trying, experiencing a chemical pregnancy, our OB/GYN's response was, we don't cry over spilled milk. That was a turning point for us. I knew that what I needed was a provider who would offer compassionate care, someone who would listen to me, believe me, and support me, and the choices that I wanted to make for me and my family. Being an African-American woman in a predominantly white society, that was very important so that I could live. We found that support in midwifery care, and it aligned with our desire for a natural birth, and gave us the option to deliver in a hospital if needed. Our plan was clear. Very clear. Minimal interventions. Yet when the labor progressed longer than the OB/GYN on call was used to, they used fear as a tactic to get me into a C-section, implying that something was wrong with my baby. The experience was far, it was a far cry from the birth that we had envisioned, and that is still something that I think about today. In the months that followed, I experienced two more pregnancies ending in heartbreak. After my first loss, which required a D&C, the OB/GYN performing this procedure responded to my concerns with the cold and callous words, the baby is dead anyway. Those words still echo in my mind. My second loss was an ectopic pregnancy and it nearly cost me my life. Despite my pleas for an ultrasound, I was dismissed repeatedly and subjected to unnecessary tests, an MRI and an EKG, both of which we are still paying for in our hospital bill today, none of which addressed my actual symptoms. All the while I was slowly losing blood, two liters in total. And considering the human body holds about five, I know I'm incredibly fortunate to be alive today. Getting there. Now, I navigate-- now as I navigate my current high-risk pregnancy, I once again sought midwifery care. And though I'm als-- I've been referred to a high-risk OB/GYN, through this experience, one truth has become abundantly clear. Families deserve the right to choose the care that aligns with their needs and their values. I've carried four pregnancies, and welcomed one beautiful child into the world. Yet the most significant challenge I faced throughout these journeys has not

been my body. They've been the hospitals that I failed to listen, to believe, and care with compassion that every family deserves. Thank you.

HARDIN: Thank you. Questions? You've had quite a journey.

ALEXANDRA WALLACE: I wish that wasn't my story, but unfortunately, one in four women experience that. And I think that they get to choose how they want to care for their bodies and their families. And I'm not against hospitals. My pregnancy is with the hospital right now, we're receiving great care, but we chose that. And were-- we were referred by a midwife because they have great relationships with hospitals. So I just felt it important that you know.

HARDIN: Well thank you.

ALEXANDRA WALLACE: Yeah.

HARDIN: LB676.

HEATHER SWANSON: I think I might be the last one.

HARDIN: OK. Welcome.

HEATHER SWANSON: Chairperson Hardin, committee members, thank you for your time today. My name is Heather Swanson. H-e-a-t-h-e-r S-w-a-n-s-o-n. I'm here to testify on my own behalf in support of this bill. I'm a certified nurse midwife, born and raised in Kearney County, and I currently live in Long Pine. From assisting with bill drafting to sitting on the407 Technical Review Committee, over the span of 22 years, I've been involved with multiple efforts to remove CNM practice restrictions. This is the 10th time I've testified specifically on this topic. I want you to be able to make an educated decision, but I'm tired of having to reeducate about what we do, the types of-- the different types of midwives, and the outcome data on those we care for. 407 was supposed to serve that purpose, and the first one, which was supportive of full practice authority, was apparently not enough for this body. I'm also tired of asking for senators to draft or sponsor a bill, and then being told no when they realize NMA will likely oppose it. I realize legislative change can be a long process and often compromises are needed. But it's been nearly 40 years since compromises were made to get CNMs licensed, and I'm tired of wandering around feeling exiled from my home state. I felt called to be a midwife while listening to mothers when I was young talk about how they couldn't find a midwife and, and have the birth

experience they wanted. In response to that, I decided to become a midwife, and serve the area where I grew up. While I was at UNL and nursing school, frustrated about Nebraska laws, I enrolled in a direct entry distance program. Then my dad told me that I needed to finish nursing school, go the legal routes, and work on getting laws changed because being an underground midwife hiding what I do was not the way to live. So I went to grad school and returned to Nebraska to work for a practice that was going to open a birth center, and then was greeted by some hard lessons related to turf battles. Around that same time, I got involved with a consumer requested bill similar to this one. I recall Senator Landis saying something like, I thought we already took care of this after that 407 review. Obviously it didn't pass, and the years of coming down here began. For a while, I split my time between Nebraska and South Texas, where I was the director and lead midwife at a birth center practice, but also did home births. Thus far, my time there was the pinnacle of my professional work, but it was about 1,100 miles south of home. I tell you all this in hopes you'll appeal to someone who just wants to do her trade, because over the last 22 years, people said, come with the stats, come with outcome data, come with financial savings, demonstrate consumer demand, do a 407, do another 407, wait, try next year. And we did. And we provided you some of the ex-- and I've provided you with some of the examples of what we've already shared in the past. There's some info sheets from 2009. There's been no meaningful change. Not enough people cared about the stats we shared or the great testimony we had. I sit here now with 23 years of APRN experience, three additional degrees which I would not have spent the money or time on if we had full practice authority. I've sat on my national board of directors with the, the experience, and that experience solidified that I picked a great profession, and that I'm not going to participate in restraint of trade or what I consider to be legalized extortion so I can practice here. I will practice as a nurse practitioner, but until laws change, I'll practice out of state as a CNM. I also sit here recently diagnosed with bilateral breast cancer, which has caused me to reflect on stresses and things that contribute to poor immune health. I've had a great life-- I've had great life-- some great life experiences. But I've also spent a lot of my professional life doing jobs that I really didn't love, or in areas where I didn't really want to be. And I've wasted a lot of time away from home and wandering down here asking for-- asking for this body let certified nurse midwives out of exile, stop pushing us out of state. 40 plus years has been long enough. Thank you.

HARDIN: Thank you.

HEATHER SWANSON: I was supposed to be the closer to answer questions or to respond to questions, but you guys didn't really have any, so thanks for listening.

HARDIN: People ahead of you have done an amazing job. But tell me this. Let's say that theoretically, hypothetically, there was some state that was perhaps the last across the line. And theoretically, there might be some people out there who were actually helping in some underground capacity in some hypothetical world. How much of that might be going on in a state like that? Do you know?

HEATHER SWANSON: I think I followed that. I think there's a lot of stuff, probably. I mean, we've come to you-- I think we've asked very fair things.

HARDIN: I've asked you this same question before.

HEATHER SWANSON: I think this is turf issues. I, I, I love the physicians that I collaborate with. I collaborate with maternal-fetal medicine docs all the time, family practice docs in Valentine.

HARDIN: But is it your sense that maybe it's, it's going on? Because I, I come from a rural area, and it's a long ways away, not only from certified nurse midwives, it's, it's sometimes a long ways away from law enforcement, even at a 170 miles an hour in a Charger it's a long ways away. And so I'm just curious, is it, is it your sense that maybe this is going on and maybe passing a law like this might be helpful to--

HEATHER SWANSON: Well, I think it's helpful. I mean, you're also speaking [INAUDIBLE], but as a former UNL track athlete, I feel like we're-- I mean we're already losers. Women are losing regardless. I'd like to get us across the finish line. That'd be great. So I hope you guys will help us do that.

HARDIN: Ok. Thanks.

HEATHER SWANSON: Yeah.

HARDIN: Any other proponents, LB676. Oh, yeah.

BALLARD: I have a question.

HARDIN: Yes, take it away, Senator Ballard.

BALLARD: The financial see. How has this changed in the last almost 2-- almost 20 years on this? Is it. You said the midwestern state of Nebraska is about $1.3 million. Is that still, still the case?

HEATHER SWANSON: You know, to be honest with you haven't looked that, that up since then. That was data-- The people at that time were saying, well, what's happened in other states? Have other states looked at savings, and it just happened to be voilà, Washington state had this great state review on how much nurse midwives are saving, I couldn't speak to that. There's probably more people that could. I kind of felt like we'd brought that to you guys before, to this body, I mean, not to you guys because I, I'm hopeful things are gonna change. But we brought that before and nobody cared. Nobody cared how much money we could save. Nobody cared about the birth outcomes. So, I mean, we, we need C-sections, we need physicians, we need a model of care that allows for collaboration, and referral, and consultation, but nurse midwives practice around the world and, you know, pretty good outcomes, and I am-- I practice out of a hospital, and I will say that when I, when I choose-- when I was in Texas and we chose who's going to stay at the birth center, who's going to go home, we were very selective because we don't want people to have that outcome. I don't, I don't want something to happen and be negligent and then get sued either. There's all these things in the back of our mind about, like, we want the best care for those we provide care for. But I also want to be respectful of what people wants, and I think we can do a ton better here. And I would love to-- I'm not going to pay somebody to be my collaborating physician. I've spent-- Thankfully, I live, I live right now close to South Dakota. I go to, I go up to the-- a facility up there that's a federal facility, and I'm a licensed independent practitioner, and now I'm on contract. But when I was a full-time employee there, I had full med staff privileges. When I walk in the door, people are excited to see the nurse midwife. Our OR's closed down so we don't purposely do deliveries there, so they love it when there's a specialist practitioner that can take care of things. So-- and I'll probably, I'll probably end up moving to south central Nebraska, close to Kansas. If things don't change, I'll probably go there. If this doesn't change, but the CPM bills change, I might reduce the level of what I can provide care for and maybe take the CPM exam. I mean this is-- I love Nebraska. We have-- I have women in the areas where I've lived. Up north, there's Amish women that are looking for a midwife. I think this is just such an injustice to have-- I mean, thank you for hearing this, but I feel like we've had long

hearings. This is-- might be the longest CNM hearing, though. We've had long hearings year after year and-- Yeah, sorry. I mean, obviously I didn't feel like the numbers were making a difference to people, so that's why I didn't look at them. So. But I think we'd still make a lot of money or save a lot of money.

BALLARD: I agree. So thank you.

HEATHER SWANSON: Yeah.

HARDIN: Other questions? Thank you.

HEATHER SWANSON: Yeah. Thank you.

HARDIN: Proponents, LB676. Opponents, LB676. Welcome.

TODD PANKRATZ: Welcome. Thank you, Chair Hardin and the Health and Human services committee. I'm Dr. Todd Pankratz, T-o-d-d P-a-n-k-r-a-t-z, an OB/GYN at Hastings, Nebraska, past president of the Nebraska Medical Association. In my practice in Hastings, we deliver over a thousand babies a year. A couple of years ago, over a three year period, we delivered babies from 58 counties. I currently work with 25 rural hospitals across the state where we help them with their care of, of women. I'm testifying today on the behalf of the Nebraska Medical Association in opposition to the green copy of, of LB676. However, we appreciate Senator Hansen's willingness to collaborate. We look forward to working with him and the certified nurse midwives to find a responsible path forward that priorities patient safety. I would like to address three aspects of the bill. One, the authority of the certified nurse midwives to attend home births, participation in the Nebraska Excess Liability Fund, and, three, independent practice. As an OB/GYN, I work with certified nurse midwives daily. We have a deeply-- and we deeply value our partnership in providing care. The nursing background and advanced training make them well suited to manage low-risk pregnancies and delivery. I have actually partnered with midwives in my practice for the last 27 years, and they have consistently enhanced both our practice and our patient experience. We currently have three midwives in our practice, and we actually are training midwives for the Frontier Nursing Program, and we have one training right now to go to North Platte. However, the ability to conduct home births safely presents a different set of challenges, particularly for us in rural Nebraska. The Nebraska Medical Association is committed to Senator Hansen's-- or the Nebraska Medical Association has committed to Senator Hansen that we are

willing to work with him and the certified nurse midwives on an amendment that will allow cert-- certified nurse midwives to attend out of hospital births. But we need to be thoughtful about appropriate guardrails and collaboration to support this. The reality is that home birth safety varies significantly between urban and rural areas. In urban areas, most people will live within 30 minutes of a hospital. They have paid, trained EMT staff who can respond to emergencies quickly. However, many of the areas in rural Nebraska face severe maternity care shortages, with no limited-- or with limited or no labor and delivery units. We have restricted blood supplies in these hospitals, and we have a volunteer based emergency response teams that limit the ability to respond to emergencies and transfer to a higher level services. These limitations make responding to the emergencies much more difficult and increase the risk for both mother and babies. In smaller hospitals, an unexpected emergency from a planned home birth, one that the hospital is not aware of and unprepared for, creates further strain on resources and can discourage providers from continuing to practice obstetrics. In urban areas, most people live, again, within the hospital with a trained EMC staff. Where I currently practice, I have patients who are traveling 125 miles one way for births, and a lot of the services in between are not equipped to take care of these patients. Given these challenges, we must ensure that any expansion of midwifery practices not, does not inadvertently put patients at risk by overlooking the despar-- the disparities--

HARDIN: Here in the red, Dr. Pankratz.

TODD PANKRATZ: OK.

HARDIN: But keep going.

TODD PANKRATZ: OK. The next part is we appreciate the-- Senator Hansen's willingness to remove the ex-- Nebraska Excess Liability from, from LB76 [SIC] and then back on the independent scope. In addition, we, we-- to the authorize certified nurse midwives to attend out of hosp-- we talked about that already. So we're just looking for some help. We want to provide some-- we understand that they provide the primary care for females and newborn cares up to 28 days. We feel like this is-- needs to be better defined. We appreciate the expertise of certified nurse midwives in pregnancy and delivery care, but we feel that this broad authority, which could be interpreted to include independent management of serious chronic conditions, is outside their training. The Nebraska Medical Association is committed to working with Senator Hansen and certified nurse midwives on an amendment to

LB676 that allows certified nurse midwives to practice independently for low-risk pregnancies, while ensuring collaboration for higher risk causes. Our goal is to strike a balance that supports the nurse midwifery profession while maintaining the highest standard of patient safety. We respectfully ask the committee to hold LB676 while we work together to develop language that reflects these priorities. Thank you for your time and consideration.

HARDIN: Thank you. Questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hansen. Thank you for being here and for your testimony. So I was reading through it, so it sounds like you had kind of three primary concerns about the bill, one of them being the liability piece. My understanding from the introducer's opening was that that had been removed, OK, so that-- OK, so that-- the other piece there. So you'd mentioned specifically the, the home birth piece. I was curious, do you have any thoughts on I know folks have talked a little bit about birthing centers as well. Do you have any thoughts on a birthing center versus a home birth?

TODD PANKRATZ: Well, I-- you know, again, as long-- Birthing centers, I feel, are, are safe alternatives for people as long as they're, you know, within that response where you can respond to emergency. So, you know, a birthing center 30 miles from a hospital that does not have labor and delivery services, that does not have that ability to respond to emergencies is not a safe environment for a birthing center. But yes, I think delivering outside of a hospital, in a birthing center with trained, qualified people and the protocols for emergencies, perfectly safe.

FREDRICKSON: Thank you.

HARDIN: Other questions? Senator Meyer.

MEYER: Just one briefly-- Thank you, Chair. So once again, we, we concern ourself, and rightly so, with the underserved communities. Here in Hastings, I would classify that personally as a well served community, quite frankly, and obviously with your talent and business there. So what suggestions do you have of us enhancing medical care in our underserved communities? It would appear that this is an opportunity to do that. And so I-- and, and I understand your concerns, obviously, and I, and I empathize with those, but we need to come up with some solutions. And I know it's, it's, it's not a quick fix or anything. What are your suggestions as to how we can expand

Medicare [SIC] on underserved communities if we don't take opportunities like this?

TODD PANKRATZ: Well, from an OB standpoint, right now, I think there's only 40 hospitals in the state that do deliveries. So that's the biggest barrier to health care in rural Nebraska, is, is the distance that people have to travel to find a hospital that has that services. In our area alone, in the last two years, four hospitals have closed their labor and delivery services: Henderson, Aurora, Saint Paul, Broken Bow. Central City doesn't do them anymore. You know, Red Cloud doesn't do them anymore, Franklin doesn't do them anymore. So these hospitals are not offering these services anymore. So to, to, to answer that question, if you want to expand services, this is going to be a whole complex overhaul of the system. You need a better training. We need a nursing staff who can do labor and delivery. That's one of the biggest reasons people, these hospitals stop doing labor and deliveries, they don't have the nursing staff to do it, who's comfortable and trained to do it. We're short of nursing staff across the whole state. We're struggling, even in Mary Lanning to find nurses to cover all the services that we offer. We need, you know, training programs. Besides nurse midwives, we need training practices for family practice docs so they can be comfortable doing C-sections and deliveries of some of the patients who risk out of the midwifery care. We need an overall of, you know, of patient health. You know, shortly, 41% of all Nebraskans are going to risk out of midwifery care because of obesity, hypertension, all the other things that play a role with that. The access to health care in Nebraska is, is, you know, a significant, complex issue.

MEYER: I appreciate your concerns. I think you really want to, you want to provide the best possible care as safely as possible. I would welcome any suggestions you have that-- of the many things that you have itemized as deficiencies in our health care delivery in the state of Nebraska. Work with the committee, work with us to try to find some solutions. I-- hey, I, I don't think there's a bad idea anywhere, quite frankly, right now, and we certainly need to think outside the box in certain cases.

TODD PANKRATZ: And, and I'm working with the Nebraska Medical Association on some of these different ideas. And we started a task force that is looking at partnering with a lot of different people, and we're going around the state right now and developing those partnerships with people and starting to, to hopefully solve some solutions.

MEYER: And I've had conversations with those folks also, and I support their efforts, and I appreciate their efforts in trying to come up with some solutions. So thank you.

TODD PANKRATZ: Yeah.

HARDIN: 49 states have this. One does not. It begs the question, because each of those other 49 states have urban areas and suburban areas and rural areas. I'm from a rural area. I asked a question of someone earlier, in a roundabout way, how much of this is going on underground. Right now, it seems that the options we have are to make it to one of those 40 hospitals, or go figure out how to do it the way it's been done for thousands of years on the earth on your own is kind of a challenge.

TODD PANKRATZ: Yeah.

HARDIN: And so I'm wondering, in this age of the medical desert as we keep referring to it, is there some sort of middle ground that can be reached, particularly on a bill like this one? I just want to kind of, again struggle through it with me, if you will, to help me understand how do we embrace the worlds of safety, security, that sensitivity.

TODD PANKRATZ: Well, I think it's--

HARDIN: I know Senator Hansen's heart enough that he's always very concerned that we embrace the world of choices and that sort of thing. And so I, I'm just presenting all of the potpourri of challenges with this, and I think you have a better way of thinking through it than I do. So I'm, I'm taking advantage of the free advice.

TODD PANKRATZ: Well, I think the, the challenge, the-- it's going to be a partnership with everybody to solve this. And you're going to have to think outside of the box to look at this. But at the end of the day, we still have to realize that we don't have hospitals in some of these places like you're talking about who will make home birth safe. I mean, if somebody starts bleeding, if somebody ends up where, you know, if they have a large baby or they risk out of midwifery care and you're still 50 miles away from a hospital, because I can do it at home does not make it safe.

HARDIN: How how do we go about that process of identifying a higher risk birth in ad-- in advance, right? If we can do some prognostication, how might that work in a context of something like this?

TODD PANKRATZ: Well, I think it comes back down to partnerships. Like we're covering 25 hospitals. So on Wednesday mornings I drive 125 miles to McCook. So I leave my clinic, go to McCook, and I see patients there. I help the family practice doctors there. They have my cell phone calls, cell phone numbers, and I take their phone calls and answer their, their questions on these high-risk patients. Sometimes we have to put them in an ambulance or a helicopter and send them to us. Sometimes I can talk them through that process, but we need to build those safety nets across the state where people can turn to a clinic and, and ask for that help. We need to have that ability that, that makes it possible that more docs are willing to travel to some of these smaller communities and bring that help to them from that standpoint.

HARDIN: If I can ask for a generalization, and I realize every situation differs, is there a particular time when you kind of go, OK, if this mom can make it through this week that-- without a high-risk designation, they're, they're probably OK. Kind of when does that happen?

TODD PANKRATZ: So there are, there are going to be people who, at the very first visit, will automatically risk out of midwifery care. And the midwives have defined what those levels are already. And then as you go along, sometimes you don't know until an hour before. But, but most of the time you can figure out who those high-risk people are. And if we have that system set up in, in rural Nebraska as to which family practice Doc can step in and help that midwife, or doesn't have to go to another place. But you need to take the time to develop all those relationships across the state of Nebraska.

HARDIN: OK. Other questions?

MEYER: Just, just one--

HARDIN: Senator Meyer.

MEYER: --if I may, Chairman. We want it safe, we want it available. What's the greater risk. Having nurse midwives in communities, helping with births? Or having no one? What's, what's the greater risk?

TODD PANKRATZ: I, I don't think that's a fair question to ask, because if you're in a community-- hey, I gave them the respect of all their stuff and you guys said that I would get the respect here, too.

MEYER: And I appreciate that.

TODD PANKRATZ: So, I mean, the issue is, is not the fact that what's safe and what's not safe, the fact is we need to develop teams and we have to develop the plans on what are we going to do if something doesn't go well. And you have to have those resources. And if, you know, something goes bad in, you know, let's just say Red Cloud, Nebraska. The local fire department comes, picks up the patient from the house, takes it to the local Red Cloud hospital. The Red Cloud hospital then has to transfer it to Hastings. And then in rural Nebraska right now, we do not have the resources to get planes and helicopters and ambulances out to everybody. And so when you start having, you know, a mom die, a baby die with a volunteer service, that's traumatic for them too. And now all of a sudden you lose that ability for, you know, your local ambulance drivers who are willing to show up for an emergency.

MEYER: I think you described the dilemma that we have in our rural communities very accurately, and I, I appreciate your viewpoint. Thank you.

TODD PANKRATZ: So at the end of the day, it's we got to work on this, because I know it's happening, we, we have them happen in our area and they-- the bad outcomes get sent to our emergency room. But we have to develop a way to solve all this so it's safe for everybody. Not everybody is going to win on every situation, but I think we can work through this if we're given that opportunity. And urban is different than rural. And we have to remember that. You pass the same rules for urban, for rural Nebraska it's not going to be that same outcomes.

MEYER: Thank you.

HARDIN: Other questions? Seeing none. Thank you.

TODD PANKRATZ: Thank you.

HARDIN: Opposition, LB676. Welcome.

MEGHAN CHAFFEE: Thank you. Chairman Harm-- Hardin, members of the Health and Human Services Committee, my name is Meghan Chaffee, M-e-g-h-a-n C-h-a-f-f-e-e, head of government affairs for the Nebraska Hospital Association. The NHA is opposed to the green copy of LB261. NHA's primary concern is adding certified nurse midwives to the Excess Liability Fund. While certified nurse midwives play an important part in maternal health care, expanding coverage under the fund poses significant risks to patients, providers, and the fund. The fund was

created in 1976 to provide an additional layer of protection for patients in the event of catastrophic medical malpractice claims. The Department of Insurance administers the fund as outlined in the Nebraska Hospital Medical Liability Act, and the fund acts as an excess layer of coverage beyond what providers purchase in the private market for medical malpractice. The fund is made up of surcharges on liability insurance paid by hospitals, physicians, and certified nurse anesthetists. It's a cr-- it's a crucial component of health care delivery in Nebraska. And the act, the Hospital Medical Liability Act and how it is administered helps draw providers to Nebraska because medical malpractice is affordable thanks to the fund. NHA is concerned that adding certified nurse midwives to the fund, who have not previously paid into the fund for the past almost 50 years, could jeopardize the sustainability and viability of the fund, given there are risks with pregnancies and childbirth. Adverse outcomes, especially those with high-risk births usually are complicated, expensive, and can reach the cap of the fund, which is $2.25 million. We would ask Senator Hansen and the committee to remove their addition to the Excess Liability Fund, and we appreciate Senator Hansen's willingness to work with the NHA, and we're happy to continue those conversations. Thank you.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you. Thank you for being here. You're smart. You're an attorney. Are there any options outside of the Excess Fund? Or is it just it would have to be a totally separate fund?

MEGHAN CHAFFEE: It'd have to be a separate fund.

RIEPE: That would be expensive. OK.

MEGHAN CHAFFEE: It certainly would.

RIEPE: So there aren't a lot of good other options.

MEGHAN CHAFFEE: Right.

RIEPE: Apparently. OK. Thank you very much.

HARDIN: And yet everyone would have some kind of malpractice anyway.

MEGHAN CHAFFEE: That's right, that's right. They would purchase it in the private--

HARDIN: And so how often does someone exceed what their malpractice requires?

MEGHAN CHAFFEE: I don't know the answer to that. The frequency, I couldn't answer that, I'm sorry. I can find out, though. Well, try to find out.

HARDIN: That would be great. I'm an insurance guy, so I kind of have an idea. Other questions? Seeing none.

MEGHAN CHAFFEE: Thank you.

HARDIN: Thank you. LB676, opposition. No one else? Anyone in the neutral, LB676? Going once. Going twice. Very well. Senator Hansen. Welcome back.

HANSEN: Thank you. And thank you, members of the HHS committee for bearing through all that. It's very good information and kind of gives us a lot of perspective on where to go with this. And I'm going to bring this up again like we did with the CPM bill. If you look and see who came to testify, that tells you a lot about where this is important, who it's important to. We had mothers. We had CNMs come testify. You mean just like the CPM bill, we had mothers, we had families, we had fathers, we had everybody come testify. And the people who come and testify against it typically represent organization. I saw no mothers who had a bad experience with CNMs or CPMs come testify against this. I think it tells you something with the safety and efficacy of nurse-- midwives and nurse midwives, especially with this bill. I just thought that's a good observation, but I do actually, I do appreciate the opposition that did come in to testify. They, they, they provide clarity to maybe some things we need to work on. They voiced their concerns, which I think are very important. We always talk about unintended consequences when it comes to bills. Passing something like this without working with them can sometimes have unintended consequences. We have CNMs out there practicing, but the collaboration between them and the medical community and medical doctors and OB/GYNs, I don't want to, like, strain that where they need to work together. And the same thing with certified professional midwives. We need to make sure we listen to them and do our best to address their concerns as best we can, but without stifling the bill too much. Senator Meyer had a question about the distribution of midwives. I think you kind of-- one of the questions I think you had of a testifier. There are midwives all over Nebraska right now delivering babies without licensure. Right? It's

technically legal in the state of Nebraska. What we're trying to do, not with this bill, but also the CPM bill, is make-- put some guardrails in place and some licensure so we can actually see who's doing it and kind of help them out best we can, so. And I know we always talk about brain drain, some of you kind of alluded to that a little bit too. We are seeing a lot of people leave our state because they're either wanting to have babies out of the state from CNMs in an independent setting, or CPMs, or they want to actually practice themselves as a CNM. I-- Becky Sherman, came and testified for Nebraska Friends of Midwives, and I always appreciate when she comes. She's, she's feisty.

FREDRICKSON: Feisty.

HANSEN: She talked about safety, efficacy, and consumer desire, and she's exactly right. When it comes to mothers who want to have their children, have a choice to have their children in different settings, it's safe, it's effective, and there's desire for it. There has been for many years, if not decades. And I think this is our chance now. And Senator Hardin, you kind of alluded to your hypothetical world about is this happening underground? Yes.

HARDIN: OK.

HANSEN: I just don't know of anyone to say it, you mean. And when it is, it's still safe. We can make it safer, or we can maybe help make it safer. The theme for today, it seemed like, was with, with this bill and others, is practice within your scope of your training. That's exactly what this bill is about. Practicing within your scope of your training. And each level of choices mothers might have on how they're going to deliver their child, there's different levels of training. CPMs have some. CNMs have more. Family physicians have more. OB/GYNs have more. And it all depends on where that mother wants to deliver her child, or the type of care she needs. Sometimes the CNM or midwifery is not appropriate, but we trust their training to refer them where they need to go. And I don't want to mess up that collaboration because I think that needs to happen. And I think is where Doctor Todd, I missed your last name, so I apologize, he was right about the idea that we need teamwork. And so I think this is a good way that we can collaborate to have good teamwork. And again, I don't wanna strain that at all. He did have some concern about home births when it comes to the bill. And I wanted to allude to the fact that according to our own Nebraska vital statistics, the mortality rate of home births, 6.9. The mortality rate of hospital births, 6.2.

That's our own Nebraska vital statistics. I don't know how much more data or research I can give you telling about the safety of home births. It's the same as hospitals. And actually, I just saw this today, which I thought was kind of interesting, and all the medical professionals in the room would appreciate this. This comes from the Lancet. Anybody who's familiar with the Lancet, that is the gold standard when it comes to research journals. The Lancet series on midwifery concluded that, quote, national investment in midwives and in their work environment, education, regulation and management is crucial to the achievement of national and international goals and targets in reproductive, maternal, newborn and child health. I thought that was very interesting. The Lancet. You know, I've given other examples. ACOG again, which is another gold standard we always talk about, talks about their approval of midwifery. And I think also the testifier from the NMA brought also another good point. He actually made our point for us about maternal health care deserts, he agrees there are maternal health care deserts. And I can't remember for sure which Senator alluded to that, maybe Senator Meyer, about what do we do about that? This is a good bill to approach that. And so I would much rather have a midwife out there helping a family as opposed to having to drive really, you know, 100 some miles away to a hospital. Or maybe they don't feel that's appropriate for them. He is right, this is a significant and complex issue, and we do need to think outside the box. And we-- you do need to do collaboration and teamwork, just like every other state has done. This isn't new. States have figured it out. I don't know why we haven't. I can give you some, some of my ideas maybe why. I'm not going to. But this is a significant, complex issue that 48 other states have figured out. So. I think that's pretty much all I had. So thank you, Mr. Chairman.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you. Can you help me a little bit with the how might we approach the excess liability issue?

HARDIN: The fund, you mean?

RIEPE: Well, the one that the hospital association expressed, that--

HARDIN: That's what the amendment does. We, we specifically take them out of that, yep. That addressed their concern. And that was a big concern the NMA had, which is, which is legit. I mean, they have a concern about maybe even those-- I feel like it's not a higher risk pool of people getting into that liability fund. They do. And so they

have a concern that that might have some effect on the fund in general.

RIEPE: Fair enough. You addressed it. Thank you.

HARDIN: Other questions? Seeing none.

HANSEN: All right. Thank you.

HARDIN: Thank you. This concludes our hearing on LB676. We had some online activity. Oh, let's wait, roll the drum. There were 299 proponents, 5 opponents and 2 in the neutral.

FREDRICKSON: OK. We will resume with LB436. Senator Hardin, you're welcome to open.

HARDIN: Thank you, Vice Chair Fredrickson. And good afternoon, fellow senators of the Health and Human Services Committee. I'm Senator Brian Hardin. For the record, that's B-r-i-a-n H-a-r-d-i-n, and I represent the Banner, Kimball, and Scottsbluff counties of the 48th Legislative District in western Nebraska. I'm here to introduce LB436, an HHS Committee bill as chair of the HHS Committee. Since 1985, the credentialing process, also known as the 407 process, has been an effective tool for state legislators in reviewing the changes in scope of practice or new credentialing for health professionals. An applicant submits a proposal for change of scope or new credentialing. The Technical Review Committee, made up of six members and one designated by the Board of Health to serve as the chair, reviews the proposal, as well as the Board of Health and the director of DHHS Division of Public Health. A report is issued by each to the Legislature in an advisory fashion. Last year, in response to concerns about the effectiveness of this process, the HHS committee held a hearing on the interim study, LR397. This study examined the role of the Technical Review Committee as well as the scope of practice criteria, application requirements, and coverage of health professions. This hearing revealed many concerns about how the Tech-- Technical Review Committee should be run; time frames of the application process, unclear criteria used in this process, and DHHS staffing issues. LB436 is an approach to make changes to the current 407 process. The role of the Technical Review Committee would be limited to those professions that don't have a licensing board. The criteria is worded better to provide clearer direction for the Technical Review Committee, Public Health director, and Board of Health. Neutral recommendations are provided. Finally, the process is

shortened up to six months instead of 12 months. I have heard some good reports on the 407 process recently. However, one good report does not mean that all of the issues and concerns have been fully and finally resolved. I look forward in hearing-- to hearing all of the testifiers at this hearing, and would be happy to answer any questions, though those far more brilliant than I are behind me, why waste your time?

FREDRICKSON: You're far too humble. Any questions from the committee? Seeing none. We will now take proponent testimony for LB436. Welcome back.

RUSSELL CROTTY: Thank you. Senator Frederickson and the Health and Human Services Committee. I am again Russell Crotty, R-u-s-s-e-l-l C-r-o-t-t-y. I appreciate your time in listening to ongoing ways to improve the 407 process. I'm testifying today on behalf of the Nebraska Optometric Association membership and serve as the president. I want to clarify that I'm not testifying on behalf of the Board of Health, but have been a member of the Board of Health for the last four plus years. Those of you on the HHS committee who participated in the 407 interim study last fall may recall that I chaired a subcommittee on the Board of Health tasked with providing feedback to D-- DHHS on ways to improve the 407 process. So I feel that I can provide some unique insights. Significant administrative and procedural improvements have been made during the past year to the 407 process and making it more consistent, more organized. And I applaud Nebraska DHHS for, for these significant efforts. However, it is in my opinion that there are other needed improvements discussed during the interim study hearing that require statutory change. LB436 addresses those changes. One of the most important changes involves the criteria on which proposals must be evaluated. The current criteria imply that the status quo is adequate unless it can be proven otherwise. Instead, we need to assume that allowing change, advancement, and increased access to care is essential and necessary in health care unless there's convincing evidence that the risks outweigh the rewards. LB436 makes those changes. It also clarifies that reviewers consider any additional education and training that would be required by the proposals, not just the education and training that exist today. That's a critical element of scope enhancements for many professions. Another key change requiring legislative action involves utilizing more technically knowledgeable reviewers to conduct the first phase of certain reviews. The testifier following me will address this provision in LB436 more fully, but involving professional licensing boards and conducting technical reviews will improve the efficiency

and help shorten the timeline of the 407 process, while also producing a more informed recommendation to the Legislature. That's based on the perspectives of peoples with expertise in that field and technical understanding of a profession. I see firsthand how our credentialing process, the 407, needs to better serve both providers and patients. This system was designed to help the Legislature assure that providers of health care services can serve patients to the fullest extent possible, while at the same time ensuring public safety. But with the increasingly rapid evolution of health care, it has become slow, inconsistent, and a barrier to making timely public policy changes in Nebraska. Delays mean patients face longer wait times, fewer provider options, and reduced access to essential care, especially in rural areas. By expediting the process and shortening reviews to six months, LB436 ensures Nebraska can respond more quickly to changing health care needs while still maintaining a rigorous review. In conclusion, at its core, LB436 does not reduce the state's ability to carefully and thoughtfully review proposed public policy changes, it strengthens it. It will produce a more efficient, transparent, and effective review, review process. The Legislature remains the only decision maker, but it will now have more timely and well-informed recommendations to guide policymaking. We cannot afford to let Nebraska fall further behind in health care access and workforce development. I urge you to support LB436 and help build a credentialing system that works more effectively for both providers and the patients we serve. Thank you for your time, and I'm happy to answer any questions.

FREDRICKSON: Thank you for your testimony. Any questions from the committee? Seeing none. Thank you. Next proponent for LB436.

_____: This is just a copy of the, the bill.

ROBERT VANDERVORT: Thank you.

FREDRICKSON: Welcome.

ROBERT VANDERVORT: Thank you. Good evening. My name is Dr. Robert Vandervoort, V-a-n-d-e-r-v-o-o-r-t. During my 40 years of practicing optometry in Nebraska, I have directly participated in all of the 407 reviews for my profession. In addition, I served on the Board of Optometry for the last 11 years, and as chair of the board from 2021 until my term ended last November. Therefore, I have unique experience and understanding the problems this bill corrects, and how LB436 will function should it be enacted. Imagine that I asked you to explain the

difference between open angle glaucoma, angle closure glaucoma, and combined mechanism glaucoma, as well as the effectiveness and risk factors of the treatment protocols for each type of those glaucomas. No one other than an optometrist or ophthalmologist would likely understand the question, much less answer it. Yet the last four Technical Review Committees for optometry over the previous 25 years were asked to comprehend that question and many others with the expectations that they come to understand the subject matter well enough to make sound, fact-based recommendations to the Legislature about a proposed change in scope of practice. This is not a realistic expectation for the four laypersons and three healthcare professionals on the TRC, who have no specialized knowledge of eye care. This problem is not unique to the TRCs for optometry. Each profession impacted by the 407 process has its own vocabulary and esoteric subject matter. This bill solves this problem by having the existing regulatory board serve as a technical review committee for their respective professions. Some will say, isn't that the fox guarding the henhouse? There are several responses to that question. First, the primary purpose of all regulatory boards is to protect the public. Public safety guides all discussions, decisions, and recommendations. The boards are not advocacy bodies for the professions. The Legislature already trusts the boards to safely implement and oversee changes in scope of practice that the Legislature authorizes. Why would you not then trust the boards to recommend what changes in statute are appropriate and safe for the profession? Second, all regulatory boards, including public members, in my experience, the laymen-- in my experience-- I'm sorry. Second, all regulatory boards include public members. In my experience, the lay members are outstanding. They will not be steamrolled. Third, the TRC reviews conducted by the regulatory boards will abide by all of the rules and regulations of the 407 process for Technical Review Committees, and produce a truly balanced report that's factual and technical-based for the Legislature. And fourth, please remember that the boards, acting as the TRC, will be providing only one of three advisory opinions and perspectives for the Legislature. This bill grants no additional authority or weight to the first phase of the 407 process. In summary, LB436 will provide the Legislature with a more informed and more balanced technical assessment of the pros and cons of a proposed change in the scope of practice for a health care profession, and I urge your support. Thank you, and I'd be happy to answer your questions.

FREDRICKSON: Thank you for your testimony. Any questions from the committee? Seeing none, thank you for being here. Next proponent. Welcome back.

HOLLY CHANDLER: Thank you. This will be my last time today, I promise. Dear members of the committee, good afternoon. My name is Holly Chandler, H-o-l-l-y C-h-a-n-d-l-e-r, and I'm here today on behalf of the Nebraska Association of Nurse Anesthetists, or NANA, and I'm a certified registered nurse anesthetists, or CRNA, and a past president of, and member of NANA. A few of you may remember me from my testimony last September before this committee, in favor of a revision of the credentialing review program to make it a more clear, collaborative, and credible process. With a focus on public health and safety, we politely asked at that time that you review and provide feedback on recommended changes, and support legislative efforts to improve the credentialing review criteria and process. Today, you have in front of you LB436. LB436 achieves those goals. Through engaging in a technical review program recently, NANA is able to recognize the program was designed to serve and protect public health in our state in order to provide a thorough review and analysis of those seeking new credentialing or those looking to alter their scope. The program's purpose is also to help advise you, the Legislature, as to public policy changes that best respond to the evolving health care environment. During our experience with the credentialing review process, there were moments of confusion and concern. The old statutory criteria are confusing and resulted in questions and concerns during each stage of the process. Much of the confusion involved the double negatives that are included in the criteria. This confusing wording led to revotes and need for clarification at both the Technical Review Committee and the Board of Health meeting to be assured that each member was voting as they had intended. LB436 addresses the credentialing review criteria, making them clearer and easier to understand and more succinct. Second, the prolonged time involved in the review process was tedious. A year is a broad time frame. I believe the review timeline could and should be, be shorter. And as a result of the long time span, as I mentioned ear-- in my earlier testimony, we wound up interacting with three different chief medical officers at DHHS. A more concise and defined timeline would help all interested parties to plan and schedule their time commitments, and LB436 addresses the lengthy timeline involved in the 407 process and shortens it to a more manageable timeline. Last, I would like to mention the lack of opportunity during the 407 process for each side to collaborate with reviewers in an effort to identify

common ground or alternative solutions that could be offered to the legislator-- Legislature. The format of meetings is largely confrontational or oppositional, leaving reviewers to essentially choose sides in debates. LB436 proposes a collaborative process by utilizing three entities for review. It proposes replacing the TRC with the proposed profession's own board, keeps the Board of Health and the State Medical Examiner, and this embraces the aspirations of a fair and collaborative process, and eliminates the difficulty of finding volunteers and educating them regarding professions they are unfamiliar with. The credentialing review program was intended to be a detailed and informative process to educate state senators about proposals for new and changing scopes. Unfortunately, through the inconsistencies and contentious nature of the process, the current credentialing review process merits improvement. By adopting LB436, the credentialing review process would become clearer, shorter, more collaborative, and more collaborative, meaning that you as state senators could have a better picture of how and why the three entities voted the way they did, so you can make the most informed decision for Nebraska citizens.

FREDRICKSON: So we're at the red part, but you can wrap up when you get the chance.

HOLLY CHANDLER: Two sentences. As technology and education advances, having a clear, collaborative, and credible process in place would improve care and access for Nebraska citizens with a focus on public health and safety. We politely ask that you support LB436, which supports all Nebraska citizens and all of their providers. Thank you, and I'll take any questions.

FREDRICKSON: Thank you for your testimony. Questions from the committee? Seeing none. Thank you. Off the hook. Next proponent. Welcome back.

KRIS ROHDE: Thank you. Thanks for having me again. Senator Fredrickson and the committee members, my name is Kris Rohde, K-r-i-s R-o-h-d-e. I am still a certified registered nurse anesthetist, and I'm here as a proponent of LB436. Any health profession that has gone through a 407 credentialing review is aware it is not a perfect system. There are several challenges in the process, and NANA would like to be part of the solution to these problems. The credentialing process has multiple issues we would like to address, some of which include the following items. The process can be extremely lengthy, at times taking over a year to complete. There are inconsistencies in outcomes due to lack of

protocols for conducting the review. It can actually be a barrier to growing the workforce. The effectiveness of the technical review phase is questionable, as the reviewers often struggle to evaluate which competencies are appropriate for these professions. LB436 will modernize the credential review program by improvising efficiency, transparency, and an accountability while ensuring legislative oversight. This will be accomplished by streamlining the review process. This allows each profession's licensing board to serve as a technical reviewer for the scope of practice proposals, ensuring expertise driven evaluations. A profession's licensing board protects the public, not the profession. Because there are public members on the licensing boards, these members will represent Nebraskans and their interests. Independent reviews will be given to the Legislature, including opinions from the Board of Health and the Director of Public Health. Public hearings will continue to take place, which gives stakeholders opportunity to voice any concerns and ensure transparency. LB436 will focus on the benefits of the change for the public, rather than focusing on defending your profession. This will help encourage constructive recommendations, hopefully decreasing the adversarial debates that frequently occur during a review, which sometimes can be entertaining. This bill will also expedite the timeline, making sure reviews are completed within six months. This will help reduce delays in addressing the shortages in health care, which will improve access to care for Nebraskans. Thank you very much for your time and I am here to answer any questions you may have.

FREDRICKSON: Thank you for your testimony. Any questions from the committee? Seeing none. Thank you.

KRIS ROHDE: Thank you.

FREDRICKSON: Next proponent. Welcome back.

LINA BOSTWICK: Hello again. It's good evening now. My name is Dr. Linda Bostwick, L-i-n-a B-o-s-t-w-i-c-k. Chair Hardin and members of the Health and Human Services Committee, thank you for your time. On behalf of the Nebraska Nurses Association, the overarching organization for more than 30,000 registered nurses in Nebraska, please understand that we support LB436. We see that this 40-- this would change the 407 process by modernizing, modernizing it and streamlining Nebraska's credentialing review. It's critical, with a mix of professional disci-- disciplines in health care for each specific discipline to provide its expertise from the standpoint of standards that we have skills, research, evidence-based practice, and

years of real life practice. I can share a little bit about my 407 experiences, where I was part and part of giving input while the board of the nurses-- the Nursing Board practice individual sat in the corner of the room and couldn't say anything. And they're the people that are going to have the statistics to really answer the questions, because that's what they work with every day. So let's see, I'm going to skip some of this, you have it in front of you. Let's see. You know really for the example I just gave, the very reason the right person for the specific health care discipline must be at the table. The statutory criteria on which proposals are evaluated focus on better assessment of benefits, and if the benefits outweigh the risks to the public. Shorter time frames will achieve efficiency with the profession's licensing board review proposal in the initial phase of this process. The language in the bill also clarifies that there would be three parts. So we strongly urge the committee to support the amendment. And that's LB436. Any questions?

FREDRICKSON: Thank you for your testimony. Questions from the committee? I, I have one. So you kind of mentioned your own experience sitting through a 4O7 process.

LINA BOSTWICK: Yes.

FREDRICKSON: I want to make sure I heard you correctly. So you were talking about a discussion or that was going on and there was someone from a board that was in the room that was unable to [INAUDIBLE].

LINA BOSTWICK: It was the, the nursing state board who it was in charge, you know, of the practice of registered nurses. And she was able to be there, but, you know, they just can't, they couldn't say anything. And now with this change, they would be right at the table. And they're the ones that oversee our practice and know the levels of practice.

FREDRICKSON: So they aren't actively participating in the conversation, right? Yep.

LINA BOSTWICK: Right. No, no, not at all. That's why I was there to do that.

FREDRICKSON: OK. OK. Great. Thank you.

LINA BOSTWICK: Yeah. You're welcome.

FREDRICKSON: Other questions? Nope. Seeing none. Thank you for being here.

LINA BOSTWICK: OK. You bet.

FREDRICKSON: Other proponents for LB436. Welcome back.

NICK WEBER: Thank you. Good evening again. Vice chair Frederiksen and members of the Health Human Services Committee, my name is Nick Weber, spelled N-i-c-k W-e-b-e-r. I'm a physical therapist and serve as president of the Nebraska chapter of the American Physical Therapy Association. On behalf of our membership of over 1,400 members, I want to express our support for LB436. As I said earlier today, what we want most is for Nebraska legislators to be able to make informed decisions regarding scope of practice with a thorough understanding of all relevant information, and to be able to do so in a timely manner without compromising quality. We feel LB-- LB436 improves the current credentialing review program, or 407 process, in three ways. First, it enhances the efficiency, transparency, and accountability of the scope of practice reviewers. Utilizing the licensing boards as technical reviewers for scope of practice ensures another expertise-driven evaluation of a proposal in addition to the independent opinions of the Board of Health and the Director of Public Health, ultimately leading to what we hope is your opportunity to be better informed as the final decision makers. Secondly, LB436 also makes an important shift in the focus of scope of practice reviews by emphasizing how the proposed changes can benefit the public, and lastly, by mandating that reviews are completed within six months, which we believe will help you all address the workforce shortages and access to care issues we currently face here in Nebraska. So in closing, I hope you will support LB436, as it represents a commonsense solution to Nebraska's growing health care challenges. Passing LB436 will streamline the patient centered credentialing process and ensure useful advice and perspectives are delivered to the legislators, and that benefits patients, health care professionals, and legislators alike. So I thank you for this opportunity to discuss with you and welcome any questions.

FREDRICKSON: Thank you for your testimony. Questions from the committee? Seeing none. Thank you for being here. Next proponent for LB436. Seeing none, any opponents to LB436? Welcome back.

AMY REYNOLDSON: Good evening. Good evening, Vice Chair Fredrickson and members of the Health and Human Services Committee. My name is Amy

Reynoldson, A-m-y R-e-y-n-o-l-d-s-o-n. I'm the executive vice president of the Nebraska Medical Association and testifying in opposition of for lLB436 on behalf of the Nebraska Medical Association. I've appreciated the committee's interest in the credentialing review process and Senator Hansen for bringing the interim study to explore this. The Nebraska Medical Association has been actively engaged in the credentialing review process since it was established in 1985 when LB407 was introduced by former state Senator Don Wesley. LB407 was introduced to create a mechanism for vetting scope expansion initiatives for health care professionals to better inform the members of the Legislature. Over the last six and a half years, my time at the NMA, we've engaged in 15 of the 16 review processes and recognize that there are lots of opportunities to make improvements within the program. The NMA approached the Department of Health and Human Services in the fall of 2023 about challenges that have been experienced and recognized from both parties, applicant group and opponents, and then proceeded to coordinate a coalition of health care provider organizations, which was more than 35, to discuss and provide more details to the department. The department leadership's been very responsive and diligent about collaborating with all the interested health care organizations to strengthen the program, and I will say they participated in every meeting, took every call, very interested in what the feedback was that came from the entire coalition. I do want to recognize that the bill language before you was not what was a product of that coalition. The NMA does not believe it's necessary or appropriate to change the Technical Review Committee structure as outlined in LB436. And I would disagree with Dr. Vandervoort, and I believe the structure does provide a thorough vetting of the applications by including multiple health care providers and public members who currently serve on different licensing boards, to engage in the review of the application and learn from the interested groups about potential benefits, as well as potential concerns and areas for improvement. As I discussed in my comments on LB554, NMA believes that the current TRC committee structure has resulted in appropriate and thorough review of the 407 proposals LB436 will replace the current TRC with members of the applicant group's licensing board. This change would create some very challenging dynamics, and I want to explain the two different dynamics. The first would be you're asking the applicant's licensing board to vote on an application from their own colleagues that does not perhaps provide an unbiased position, when you have your own colleagues sitting before you who might be your coworker, a fellow co-owner of your own establishment, your own clinic. You're asking

them to take an unbiased approach to determine if the application is safe and appropriate for Nebraskans. I think that's really complicated. I also think for those applicants that are governed by a licensing board, but do not have the same scope as the members of the licensing board, are now potentially faced with an even more uphill challenge to get any support on their application. So take for example--

FREDRICKSON: you're in the red, but I'll--

AMY REYNOLDSON: I'm sorry.

FREDRICKSON: Please continue. Yeah.

AMY REYNOLDSON: Take for-- and I'm almost done. Take, for example, physicians. Physicians are on the Board of Medicine and Surgery with one public member. If a physician assistant organization wanted to expand their scope, which we have worked with them on a successful application to modernize their scope and expand it, but if they wanted to expand their scope, then they would have to come before the Board of Medicine based on this application, or this bill language. I think that's going to be really challenging for physician assistants. I think it's also going to be really challenging for dental hygienists, dental assistants, licensed mental health practitioners, pharmacy technicians, opticians, physical therapy assistants, and several other health care related professions who report up to their licensing board that has a different scope authority than they do. The NMA asks the committee to hold LB436. Give the department time and space to continue their program improvements, which have already strengthened the Nebraska's 407 process. I also want to, I also want to state, we do recognize the criterion is not favorable. It's very confusing. Very, very confusing. We believe, as well as we've heard from the department-- I can't speak for them but have had a conversation-- we do believe there's a path forward for changing the criteria through rules and regulations, as the current 407 statute provides. So we do believe there's a path forward for that. As I mentioned, we were involved in 15 of the 16 TRCs, the TR-- 407 applications. The TRC process works. 12 of the 16 had favorable. The four that did not have favorable, three of those four, we were in opposition. We do our work, but we were never given an opportunity to meet with the applicant group before the 407 started to have any type of dialog. And two of those 407s, we begged to have those conversations with the applicant group. One of them was mentioned in a previous testifier when the certified nurse midwives were part of a bigger 407 application through

the APRNs in 2020, we begged. We are on record in multiple hearings asking them to reach out, let's schedule a meeting to talk. We see some areas we can work with you on. They refused. OK? So we can only do what we're given to work with. But 12 of the 16 had favorable reviews. I think the TRC works.

FREDRICKSON: Thank you for your testimony. Questions from the committee? Senator Hansen.

HANSEN: Thank you, Mr. Vice Chair. And so I-- Do you have the bill in front of you?

AMY REYNOLDSON: I do.

HANSEN: Yeah. So page 6, line 3 through 6. That's the part I think you were addressing, right? Applicants, scope of practice. The regulatory entity of that profession shall serve as a technical committee?

AMY REYNOLDSON: Yeah.

HANSEN: Does regulatory entity mean the licensing board, or does that mean like the professional board or--

AMY REYNOLDSON: That's their professional licensing board. So for the optometrists it would be the Board of Optometry.

HANSEN: OK.

AMY REYNOLDSON: For LMHP, it would be the Mental Health Board. For--

HANSEN: I mean-- so I was trying to see, because you mentioned like it's going to be really tough for optometrists--

AMY REYNOLDSON: Opticians.

HANSEN: Opticians. OK. Oh, OK.

AMY REYNOLDSON: Opticians.

HANSEN: I missed that. OK. You're right.

AMY REYNOLDSON: Yeah.

HANSEN: And then the part you were talking about just below that then, you shall consult with the applicant group and opponents. Is that the part then you were addressing the second part like you didn't get a

chance to discuss it with-- OK. So would this then-- is that a good thing?

AMY REYNOLDSON: Absolutely.

HANSEN: OK. Fine.

AMY REYNOLDSON: And that was some of our feedback that we gave the department. When they have an applicant reach out and submit an application, part of their expectations with the applicant group needs to be if you're going to bring an application through the 407, you need to reach out to all interested parties, even those who might be opposed, and have a, have a conversation. We welcome it. And actually, quite frankly, athletic trainers, physician assistants, medical nutrition therapy. Occupational therapy is a great example. We had some concerns with some of the language, we worked through it. We were able to find a compromise and find a path forward. So of the 12 that had successful outcomes, they weren't successful when they first, when we first read them over, we had some concerns and we, we were willing to sit down and do the work before those applications were submitted or even during. We're happy to do that. But you got to give everybody a chance. So I do like that language in, in the bill here. But that is a recommendation, a strong recommendation that we asked the department to consider.

HANSEN: And the shortened time frame, you're OK with that part too?

AMY REYNOLDSON: Yes.

HANSEN: Shortening the time. OK, just making sure. Cool.

AMY REYNOLDSON: Yeah. There's no need to draw them out. I, I think that was a staffing issue quite honestly.

HANSEN: Thanks.

FREDRICKSON: Other questions from the committee? I have one. So you know what-- I, I heard your-- one concern you proposed was kind of a potential conflict of interest, it sounded like you in other words, if you were having something being reviewed by a peer or a colleague or something along those lines. I also kind of can appreciate or understand the other side of that argument of having someone from that board, for example, kind of be in the space to be able to provide some expertise. Do you have any-- can you elaborate a bit more on your thinking with that or your thoughts around that?

AMY REYNOLDSON: I, I would love it if all of the licensing entities had the, the green light from the department, from the Attorney General's office, for them to engage in the 407 applications. It's not that way. So with Doctor Vandervoort, I mean, he was heavily engaged in the most recent 407 for the optometrists. We couldn't get Board of Medicine there. They were told no. So we've got some very strong inconsistencies on expectations of their role as a licensing board. And I think it needs to be a one size fits all, and I think it needs to be engaged. Otherwise we're going to bring forward bills to the Legislature that don't have that proper insight. I think there's a lot to be said about having Dr. Vandervoort involved. But also, I would love to have somebody from the Board of Medicine. And I would love to have somebody from the PA committee when we had the PA one going on. But that wasn't the case. And so I just think there needs to be some consistencies with that. That also was brought forward to the department.

FREDRICKSON: Thank you. Other questions? Seeing none, thank you for being here.

AMY REYNOLDSON: You're welcome. Thank you.

FREDRICKSON: Other opponents to LB436. Good evening.

NICK PAYNE: Good evening. I've been here quite a while, so. I think you guys have a couple of bills after this, so. Good evening, Vice Chair and members of the committee. My name is Dr. Nick Payne, N-i-c-k P-a-y-n-e, and I am the executive director of the Nebraska Chiropractic Physicians Association. I'd like to thank you guys for giving us the opportunity to speak today on LB46, or LB436. We respectfully ask the committee to hold LB436 in committee and let the department continue down the road that it is currently working on. As we've heard today, the most recent TRC process worked well. One example is not a change in the process, but I think it's a very important concept to understand that the changes are happening. The Nebraska Chiropractic Physicians Association has worked closely with all the stakeholders. We've been at all the meetings with all of the health care providers, we were at the coalition with the NMA, we've had conversations with DHHS, we've attended the interim committee hearings. There's a lot of collaboration that's going on today, and I think it's very positive. I think that it's helping health care move forward in a very positive direction, and, and that collaboration is resulting in action that's impacting the 407 process today. One of the things that has occurred as well is the Board of Health had the

subcommittee that explored this and made those recommendations to the department. Some of those are in the process and have been implemented, I think two weeks ago, I got the new finalized policy and procedure manual, which many stakeholders had the opportunity to provide feedback on. I think it's a great improvement in the process, but part of that recommendation was that the boards, the licensing boards should be involved in the process. But does that mean they should be the TRC? That's, that's the question. But the involvement definitely should be there. From the perspective of the NCPA, we think that there's great work going on. We think there's great collaboration and given more time and continuing on the path that we're on, we believe the department is going to continue with the collaboration of stakeholders, continuing to work together, continue to improve the 407 process, bringing to you a well-balanced and information decision concept that has all stakeholders' input and hopefully allows you to evaluate and make your decision on how we move forward. So with that, we just urge the committee to continue to, to support the continued evolution of the process with stakeholder collaboration and the department in building upon the progress that's already been made. Thank you very much, and I'll answer any questions.

FREDRICKSON: Thank you for your testimony. Questions fro the committee. Senator Hansen.

HANSEN: Finally, six years, I get the chiropractic association here. I really don't have any problems, I just--

NICK PAYNE: All right.

FREDRICKSON: I was going to text you, I was like this here, these are your people.

HANSEN: Yeah. Just to clarify, though.

NICK PAYNE: Yes.

HANSEN: It's not so much you're against the entirety of the bill, you're just looking to say, hey, wait, hold off a little bit, let's see what the amendments going to bring. So maybe we can make a more holistic approach to the, you know, looking at the 407 process.

NICK PAYNE: Correct. Exactly. So there's many good pieces of the bill. And we think that there's also-- there, there's good collaboration that's occurring now outside of the bill. The department is making

positive improvements. And we want to see those continue with that large collaborative group.

HANSEN: Awesome. OK. Thank you.

FREDRICKSON: Other questions? Seeing none. Thanks for being here.

NICK PAYNE: Thank you very much.

FREDRICKSON: Any other opponents for LB436? Seeing none, we'll move on to the neutral capacity for LB436.

KENT ROGERT: Good evening, Senator Fredrickson, members of Health and Human Services Committee. My name is Kent Rogert, K-e-n-t R-o-g-e-r-t, and I'm here today in a neutral capacity on LB436 on behalf of the dental hygienists of Nebraska. I'm handing out an amendment that fixes one of the previous testifiers' opposition points. This would say that if you are a profession that doesn't regulate yourself solely, then you get to keep the 407 process the way it is today. And tha-- so that would-- that's the way the, the hygienists are regulated by the Board of Dentistry, which have more dentists than hygienists on it. And they, they don't figure they'd fair too well in any technical challenge through their board. So this would say they would just keep the way it is. So I'm happy to answer any questions.

FREDRICKSON: Questions?

KENT ROGERT: And thank you, thank you for being here this evening.

FREDRICKSON: Questions from the committee? Seeing none, thanks for being here. Anyone else in the neutral capacity? Welcome back.

CHARITY MENEFEE: Thank you. Good afternoon, Senator Fredrickson and the, the members of the Health and Human Services Committee. My name is Charity Menefee, C-h-a-r-i-t-y M-e-n-e-f-e-e, and I'm the director of the Division of Public Health of the Department of Health and Human Services. I am here solely to answer questions, because we have the same question or comments and concerns that we had previously. So you do not need to hear my testimony again, but I wanted to make myself available if there's any additional questions that have popped up.

FREDRICKSON: Great. Thank you. Any questions from the committee? Senator Hansen.

HANSEN: Thank you. From the-- from your perspective, is there any issue with the makeup of the Technical Review Board right now? Are you looking to add or subtract anybody from it?

CHARITY MENEFEE: So the way that it works right now is three members that are from a professional body, three public members, ideally, and then the Board of Health member. We have been working to recruit new members and we have expanded that pool, so sometimes that had been a challenge, to be frank about it. But I think that that's improving. And then what we would be recommending in the, the amendment that we were proposing is to get to the point I think that Senator Riepe's bill was trying to get to was to have as non-voting members the-- include the folks from the universities, from the public health perspective, to be able to provide their guidance and input with evidence-based and access to care questions and things of that nature.

HANSEN: OK. So like so somebody from maybe like UNMC or Creighton?

CHARITY MENEFEE: Yes. From the public health side.

HANSEN: OK.

CHARITY MENEFEE: Yes, sir.

HANSEN: Do, do you think that might kind of hinder-- like one of the biggest concerns I think a lot of people have with the 407 process is the overreliance on physicians, like what Senator Riepe even mentioned during his opening, about being-- their involvement on the 407 process?

CHARITY MENEFEE: Well, first of all, there-- we did not recommend that they be voting members to provide their input, but that-- I do understand that they could have influence. In my head, I wasn't even thinking that it would necessarily be a doctor always, that there's folks that work in those programs that aren't practicing physicians that have a lot of input on, and a lot of knowledge base on what access to care looks like in Nebraska. They're from the public health side that aren't MDs. So that's also a path forward for that.

HANSEN: All right. Thanks.

FREDRICKSON: Other questions? Can you-- I have one question. So there was some testimony that sort of shared that the department has been responsive to feedback or has been in shift. Can you speak at all

towards what the department might have, might be kind of tweaking or changing about their, their side of things?

HANSEN: Yes. So from the earlier testimony, we, we do have new staffing on board that is bringing new perspective and reviewing everything. We have overhauled the, the procedures manual, as you've heard already, based on all the feedback that we've received, really trying to incorporate what we were hearing from multiple stakeholder groups on where there needed to be changes. Because the current criteria language is very confusing, and you've heard about that a lot today, we have also completed a companion document that really just puts that in plain language, like, here's the question you're answering. This is what a yes means, this is what a no means to very clearly try to alleviate those concerns right now. We would support the, the groups that you've heard about today, the, the language that they came up with to be able to clarify in statute those questions. But in the meantime, that's been one of our fixes as well. We've also sped up the process for the technical review committee meetings and are doing those more frequently. I will say, though, because those are public meetings that we are trying to be cognizant of people having to travel in and, and what that looks like. So the reason the current one, the current one, was completed in three meetings, because we are also asking folks to reach out to all stakeholder groups in advance so that's speeding up the process once it officially enters it, and I think that'll continue. But also we, we completed it in three processes, but the hearing and the final meeting, we're trying to be considerate of people having to travel from the western part of the state coming in for that. So there's-- we're aligning that with the Board of Health meeting they're already going to be in-- coming to. so that's been the only delay there. That would be my only concern on the timing. I think that we have it down now would be when those types of things happen.

FREDRICKSON: Great. Thank you. Other questions from the committee? Seeing none. Thank you for being here.

CHARITY MENEFEE: Thanks.

FREDRICKSON: Are there any other testifiers in the neutral capacity? Seeing none, Senator Hardin, you are welcome to close. While we wait for Senator Hardin, we did have online comments for LB436. 46 proponents, 3 opponents, and 0 in the neutral capacity. Senator Hardin.

HARDIN: Thank you. We're in agreement that bias is a bad thing. Ironically, that is an issue that is leveled in both directions simultaneously, which is part of what makes this a thorny issue. A reminder, big picture, the 407 is not a requirement or mandate. It never has been since 1985. It's never been a required thing. It's good that in 2023 and beyond, recent outcomes have been better. I'm glad that shortened outcomes are something we hold in common, 6 versus 12 months. We, the people in Nebraska need help from a group of medical professionals on potential quality of life and death matters. Few or no other committees deal with this weight of life and death, of consideration of those kinds of things more than this one does. Again, it's not that we don't need all of these professionals and this process. To the contrary, we need their A-game every time. Not some of the time. And not just the last time. I believe there is an amendment we can bring that will improve this bill. I also believe that people in Nebraska will hold us accountable for the needed improvements and immediately. And if we do not see consistent improvement, we this committee will have no choice but to ponder a more robust response in the coming years. We have a chance to make some significant improvements now. Thank you.

FREDRICKSON: Thank you, Senator Hardin. Questions from the committee? Seeing none. That will end our hearing on LB436.

HARDIN: We're going to start in just a moment. Senator Riepe.

RIEPE: Yes.

HARDIN: Would you mind leading?

RIEPE: Why, are you running off?

HARDIN: I'm up.

RIEPE: Oh. You're up. Well, OK.

MEYER: One stop shop here.

RIEPE: How many seconds shall we give, give him to get up there?

HARDIN: I'm sprinting now.

RIEPE: Chairman Hardin, we-- welcome. And we would invite you to go ahead and open on LB569.

HARDIN: Thank you, Senator Riepe. Good afternoon, fellow senators of the Health and Human Services Committee. I'm Senator Brian Hardin. For the record, that is B-r-i-a-n H-a-r-d-i-n and I represent the Banner, Kimball, and Scotts Bluff counties of the 48th Legislative District in western Nebraska. I'm here to introduce LB569. LB569 is a committee bill with a single and specific intent: to require the Board of Emergency Medical Services to submit an annual report to the Legislature containing aggregate data on emergency medical services in Nebraska. This aggregated data shall consist of the following: call volume, the number of EMS calls received by each type of first responder, caregiver level of care, regional response times, patient demographics, complaint nature, provider impressions, patient dispositions, number of licensed providers, comparative data with other states or national regions. The purpose of this report is to provide policymakers and interested parties at every level with timely and useful information that can be used to optimize emergency medical services in Nebraska. Emergency medical services are a critical component of public safety and health care. Every day, our EMS providers respond to life threatening emergencies, ensuring that Nebraskans receive immediate and effective medical care when they need it most. However, to maintain and improve the quality of these services, we must have a comprehensive understanding of how our EMS system is performing. This legislation mandates a thorough review of our EMS system at least once every five years, along with an annual report to the Legislature. This report will provide critical data, and with this information we can assess the efficiency of our system, iden-- identify areas for improvement and allocate resources where they're most needed. By requiring this level of oversight and transparency, we're assuring that Nebraska continues to provide high quality emergency medical care to all residents. This initiative will support our first responders, strengthen our health care infrastructure, and ultimately save lives. I'd like to acknowledge that LB376 that we heard yesterday removes this report. We will work with DHHS and EMS representatives on this issue. Following me today will be EMS experts that can answer any technical questions you may have. However, if you have any really easy ones, really, really, really, three "really-reallies," easy ones, I can answer those.

RIEPE: Thank you. Are there questions from the committee? I have a question.

HARDIN: OK.

RIEPE: It looks like an annual report. Just roughly looking at fiscal note, it's a $1 million report, this. For-- and my follow-up question on that would be is there existing software that's out there in the profession, that-- and maybe we'll hear more about that later.

HARDIN: That's a great question. And it is. It's a seven figure experience at the moment, but that's what we're looking at is the cost of not doing it being exponentially higher than the cost of doing it.

RIEPE: Good response. Are there any other questions? Thank you, sir. I assume that, that you're staying.

HARDIN: I'm staying.

RIEPE: That's the routine answer.

HARDIN: Thanks.

RIEPE: We will te-- now take proponents.

FREDRICKSON: I'm back now.

RIEPE: Do you want to take it?

FREDRICKSON: I'll take it.

RIEPE: Take it.

HARDIN: It's like a hot potato.

FREDRICKSON: It is a hot potato. Welcome.

MICHEAL DWYER: I believe it's good evening.

FREDRICKSON: It is good evening, yes.

MICHEAL DWYER: Good evening, Chairman Riepe and members of the Health and Human Services Committee. My name is Micheal Dwyer, M-i-c-h-e-a-l D-w-y-e-r, and I appreciate the opportunity to testify in support of LB569. Thank you to the entire HHS Committee for introducing this important bill to provide basic, readily available data on one of the most important state-sponsored, state-regulated, volunteer served, front line medical services in Nebraska. I am a 40-year veteran of volunteer fire and EMS with nearly 2,800 calls on my resume, author of the fourth version of The Future of EMS in Nebraska, a member of the Nebraska State Volunteer Firefighters Legislative Committee, and

co-chair of the Nebraska EMS Task Force. As members of this committee know, pre-hospital emergency services have been, and continue to be, under significant stress, particularly in rural areas, since the 1960s. The dedicated volunteers of Nebraska's rural communities have held this system together with, quite literally, blood, sweat and tears. Our state of Nebraska has watched while call volumes and educational requirements increase, while the number of people willing to sacrifice so much for so little continues to decrease. Since 2016, the state of Nebraska has required electronic patient care records to be submitted within 24 hours of the EMS call, and for good reason. These provide quick and consistent patient records that everyone up and down the EMS system wants. A little sidebar. Typically, when I was doing reports, it'd take me about an hour to run the call and about an hour to complete the report. This is the first step in evidence-based medicine. The pre-hospital EMS community has honored this requirement in the hope that we would get good, actionable data from which we will be able to make informed decisions about patient care. That has not been the case. Despite repeated requests from myself, the EMS Board, at least two senators and the state's own EMS assessment, providers like me rarely see a return on the information we are required to submit. The data is there, we simply need basic reporting on the fundamentals of what we're doing, who's doing it, and how long it takes to provide the care. We're not asking for personal information. We're not asking any individual EMS providers or agencies to do anything that they're not already doing. We are just asking for basic operational data. I've handed out excerpts of the National EMS Information Systems 2023 Annual Report and the Iowa's 2023 annual EMS assessment as samples. I've also submitted the full reports to your offices electronically. These reports are based on the same patient care records that I referenced earlier that everybody has to input. On the surface, LB569 is a simple, straightforward bill that should have no fiscal note, (I will come back to that in a moment), that amends the system's statute to require a report from the Nebraska Board of EMS annually with data. However, LB569 also represents-- and Chair, with your permission, I'll continue just to cover the fiscal note.

FREDRICKSON: Yes you can.

MICHEAL DWYER: Oh, sorry.

FREDRICKSON: You can continue.

MICHEAL DWYER: Is that OK?

FREDRICKSON: Yes.

RIEPE: He outranks me, so.

MICHEAL DWYER: However, LB569 also represents a long game of tug of war in the arena of public safety in a community that is under serious stress, with the same staffing and funding shortages that everyone else is suffering with. To the fiscal. In my opinion, there should not be a fiscal note on LB569 for these reasons. The data is required for volunteers to be entered every time a patient is seen by EMS, but we're not getting anything out of it in return for that. In 2024, LB1108 gave $1.27 million for the new software, and an additional person in the department to do-- to update the software so that they can do reporting. So if the fiscal is to, to allocate that money, if you will, great. If it's additional money, then I object to that. Three-- I have something in my response that went away, I'll continue. In 2022, Minnesota did a 27 page EMS workforce study for $960, including printing and mailing. Three-- four, I spoke to ImageTrend, who's the company that handles the software called Elite that all of this data goes into. My question was, how is, how is this going to work? Can we actually get the data? And I got to tell you that Michael in tech support got a little short with me. Well, yeah, I just did a report. What-- I don't know what you're asking. So he's certainly indicated to me that the information is there. Now, to be fair-- and I'm way over my time, so cut me off here. To be fair, part of what LB1108 did was give the, the agency the ability to upgrade the software that they hadn't been able to do for a long time because they got it-- as I understand, they got it free and then they couldn't, but they couldn't upgrade. So part of what LB1108 did is give them the ability to upgrade that, which also includes the ability to do some more reports. So I think the functionality piece of this is coming, but I would continue to make the case that there should not be a fiscal on this. Last thing I'll say is the relation. This has helped to build a better relationship with the department. I see some, some light at the end of the tunnel and some hope with that. We have much tougher issues to deal with going forward in terms of funding and structure and staffing, and this is the first little sort of baby step. And if we can sort of grease the skids a little bit with this, I have hope and optimism that we'll be able to do that. With that, I'll shut up and take any even hard questions. Senator.

FREDRICKSON: Questions from the committee. Senator Meyer.

MEYER: Thank you, Vice Chair. And just for clarification, I think you just addressed the fiscal note. $20,000 per dis-- dispatch center, the cost to establish [INAUDIBLE] to 65 dispatch centers across the state. I would assume that's already in place, quite frankly.

MICHEAL DWYER: It is. And I saw that and I, I think it's somebody either in fiscal or in the agency just-- and there was a lot of confusion about what this-- originally the bill had the number of telephone calls that we needed. We don't really need EMS calls. But back to your question. I think they, they assumed that they had to go out to the PSAPs, which is typically a sheriff's office, to try to get those response times, which in my world is really, really important for a lot of reasons. But I know from having entered that data myself that the data is in there. We put down, I-- don't quote me on the numbers exactly, but I think it's nine different times. What time the call come to the PSAP? What time were we dispatched? We'll time did we arrive at the station? Or time did the rig actually leave? What was the arrival on scene? Typically, we put down some kind of an arrival at patient in case there's a distance there. And then how long did we stay on scene? How much time did it take to get to the hospital? And what had we actually done?

MEYER: It just appears that they assume you're starting from scratch. And from my personal viewpoint, I doubt that's the case, and I-- and so I agree with your observation on the probability is there is no fiscal note on this.

MICHEAL DWYER: Thank you. And I know that that-- they had a $1.3 million of the total was just for that. So if that goes away then I think that we, we've made our case.

MEYER: Thank you.

FREDRICKSON: Other questions? Senator Hansen.

HANSEN: Thank you. I also agree with your assessment on the fiscal note. But I think right now there's a war on reports, you know? Like we, you know, we're, we're trying to get rid of seems like, which I don't totally disagree with, a lot of unnecessary reporting that's done that, you know, Departments then have to invest a lot of time and effort into collecting and doing all that kind of stuff. However, I don't feel like that's the case with this. And also, I think there is some purpose and benefit to having reports on trends, growing trends on something we're gonna have to look at as a Legislature, and

concerns that we do have in the future. And EMS is one of them. That's a huge one, especially in rural areas of Nebraska. So this is information I think we actually do need. I mean, just like I saw on the bill that was to eliminate a bunch of our reports, some of, a lot of those, many of those did look like, hey, look, we don't use this anymore, nobody's looking at it. A lot, a lot of us do here as legislators, and I think the department does as well. So this might be death by fiscal note, maybe. You know, they're like, we don't like this report, so we're gonna put a one point something million fiscal note on it.

MICHEAL DWYER: Well and there, there's, there's that.

HANSEN: So.

MICHEAL DWYER: And I appreciate, Senator, my senator, what you said. We go a tiny little bit farther. There's a couple of pieces in there that I think, both as a member of the EMS task force, but also as a provider, that are really important to look at. One is response times, and specifically the amount of time between the time of the call, the time the pager goes off or your app lights up, and the time that the rig leaves the station. That gap in there, there's a certain amount of time just to drive to the fire hall in the volunteer world. But part of the time is you're sitting there waiting for a full crew. And if that's four or five minutes, man, that's awesome in a volunteer world. If it gets up to eight, nine, ten or twelve, that tells you something, not about individual departments, let me be clear with that. But if you have-- if you see those times as much, much larger, particularly in regions, that tells you a lot about the, the quality of that region. And quite honestly, if you're on the other end of that call, if you're the guy that's got part of his arm cut off or you got chest pains or something, that time is really important. So I, I think that's important. The last thing I would mention is the other piece of the data that's a little bit, in fairness to the agency, a little bit harder to find. And that's how many active providers we have. So we have, I don't have the exact number, but I think it's 5,918 active EMS-- excuse me, EMS, licensed EMS providers in the state. Anecdotally, most departments will tell you that, yeah, we got 20 people on the department, but there's only really 5 or 6 of us actually show up for calls. The Minnesota study that I referenced compared licensed providers with the providers that actually appeared somewhere on a patient care report, and it was 49%. So a number of senators have said how many EMTs do you need, Micheal? And I can't tell you that because I don't know how many we have. But if you take

that 5,900, divide it by 49%, and then spread it out over most of the rural counties, that is, that's not a pretty picture.

MEYER: If I may add one other thing that, Mr. Vice chair. There's a-- to some, some extent, there's a perception in the, in the community that when they call 911 that that rescue unit, that fire truck goes out the door right now.

MICHEAL DWYER: Yup.

MEYER: And if you can be within three and a half, four minutes for any type of response, there is a lag time there. And so I have an appreciation of what you're saying. And, and so the public generally are very pleased with their emergency response, but perhaps be a realistic idea of how long it actually takes.

MICHEAL DWYER: Yes. And I will tell you a lot of the conversation, sort of off mic, if you will, in the EMS task force is, is education. We, we have to do a better job of explaining to Nebraskans, particularly in rural areas that this is the EMS system and this is how it works. Specific to your question, I'm chairman of the planning commission in little Arlington, and I guarantee you, as, as our community grows and people are thinking about moving into Arlington, the last thing they're thinking about is what their fire and EMS response is like. They assume because there's a fire hall sitting there and on [INAUDIBLE] day they saw a truck there, that we're just sitting there waiting to go fight fires and save people. And obviously, that's just not the case. So we have some, some educational work to do and optimistic about that.

MEYER: Thank you.

FREDRICKSON: Senator Riepe.

RIEPE: Thank you, Chairman. I want to echo what Senator Hansen pointed out, the importance of having some statistical information going forward, because I think the EMS is going to be one of the key, key things, particularly in rural markets, without information, we're shooting in the dark. My, my piece would be on the information would not only be a profile maybe on age, so that we know whether we have an aging population of volunteers or where they're at, if they're all concentrated in Arlington versus the one here or one over there that's different. But that's-- we need some real serious, helpful information when we get down to this.

MICHEAL DWYER: Yeah. And I would, with permission, I would just briefly add a couple of things. One of the things that it's important to the community is that it's-- that this is, is not anecdotal data. This isn't just some figures that are sort of painted to go a certain direction. This is literally data. This is, these are just numbers. One of the things I mentioned in my written that I just scratched because of time, is there's a number of people here some-- people that run a businesses, people that run health care, certainly Senator Hansen has their own businesses. Can you imagine running those businesses and never looking at a financial statement? That's what we're trying to do in EMS. And this is sort of akin. We're not looking at financial numbers, I don't mean to imply that, but this is akin to a business looking at financial numbers. In our business, I looked at them every week. That's not practical in EMS, of course, but, but we at the very least, we should be looking at these. And to Senator Hansen's, I think, point that we should begin to be looking at trends. And that's one of the things I really liked about the Iowa report, because they were looking historically, I think, seven, eight years back on the number of EMT numbers. I will only say that I get the sense anecdotally that we're starting to recover a little bit from the bottom that in the volunteer world that we hit during, towards the end of COVID, when ever-- everywhere just burned out. I spent two, two and a half hours or so in Chambers, Nebraska last Sunday and just talking to how it's going. And they kind of said, well, it's, we, we hit bottom about two years ago and but we're kind of clawing back here, we got some new people and they're coming in and they're going through classes. So I get the sense that, that it's improving. But, but again we don't have any data to support that.

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

FREDRICKSON: Thank you. Are there any, any other questions? Seeing none. Thank you for being here.

MICHEAL DWYER: Thank you very much for this.

FREDRICKSON: Next proponent?

JERRY STILMOCK: Mr. Vice Chairperson, members. My name is Jerry Stilmock, J-e-r-r-y S-t-i-l-m-o-c-k, testifying on behalf of my clients, Nebraska State Volunteer Firefighters Association, Nebraska Fire Chiefs Association. Support the efforts of the committee in signing on to the legislation. Thank you. You've heard it all afternoon, particularly with certified midwives. The rural areas, what

do you do? And as frontline providers of EMS across the state, we need help. And we think this would be one way to obtain it. We're, we're under the-- I'm under the understanding that the department is going to get quite a bit of information of what's contained in the request that appears in LB569. So I'll let committee staff and your, your chairperson and communication with Mr. Dwyer and the department. But it was my understanding that a lot of this information is willing to be provided without having to wrestle with this fiscal note. Folks in Nebraska get it for free. Plain and simple. Volunteers are out there to serve. You know, there's a pat on the back every once in a while, show up at the fundraisers they do. But if you don't get it for free, you either do without or you pay for it. And we know that side of the coin, because you wrestle with it every day, you campaigned on it. Property taxes. And cities, villages, fire protection districts, somehow, somewhere there would be, you know, the charge. There's several communities that ran out of volunteers. Some significant communities. Wahoo, Nebraska City, McCook. The-- those communities simply-- Cass County as a whole. They didn't go completely, but they have a supplemental paid crew that comes in and helps across the county. Those are the communities that could no longer recruit, retain volunteers. And as you recognize, Senators, around the, around your table, it, it's, it's, it's a dire situation in some communities. Yeah, chambers may have the answer for their community, but I can tell you, a host of others that are struggling dearly, some significant communities, 2,000, 3,000 people in population. They don't move, people don't move there checking, what about EMS? Is somebody going to be there when the call goes out? We believe this would be a way to help-- we in the, in the relation to this legislation and the information the department we understand is going to provide, will provide some framework. You know how difficult it this-- the senator asked me the question, after years and years and years of serving the volunteers in this capacity at the Capitol, well, how many volunteer EMTs are there out there? I don't know. Why? No data. Senators, thank you for your time today, this afternoon, and I appreciate your willingness to stay on this evening. Thank you.

FREDRICKSON: Thank you for you testimony.

JERRY STILMOCK: Mr. Vice Chair.

FREDRICKSON: Any questions from the committee? Seeing none. Thank you for being here.

JERRY STILMOCK: Thank you for your courtesy. Good evening.

FREDRICKSON: Any other proponents? Seeing none. Moving on to opponents for LB569. Seeing none. Anyone here to testify in the neutral capacity? Seeing none, Senator Hardin, you're welcome to close. While you come up, we did have online comments, 1 proponent, 0 opponents and 1 in the neutral capacity for LB569.

HARDIN: Thank you. I think this is one of those reports that was not tried and found to be, you know, a needless report. I'm all for getting rid of needless reports, and I congratulate the department on getting rid of a whole bunch of those. Based on how this one was essentially untried, I would have kicked this one to the curb too. And so. But given the fact that we still need that data, we still need this report, except now we need to execute on it. And so that's, that's our concern here, right? It, it doesn't work to say that we just need more. We none of us can stand that when we hear that. How much more do you need? This isn't enough, we need more. We need to measure that. And this is one way to do that. So the medical desert is not infinite and it doesn't get to be. And this is one way that we're going to measure that. Thanks.

FREDRICKSON: Great. Thank you. Any questions for the committee? Seeing none, that will end our hearing on LB569.

HARDIN: We are up to LB570. And I was feeling underlawyered until this moment. And now, Senator Cavanaugh, you're here.

J. CAVANAUGH: Good evening, Chair Hardin. Don't worry, I only have a 45 minute open. Good, good evening. Chair Hardin and members of the Health and Human Services Committee. My name is Senator John Cavanaugh, J-o-h-n C-a-v-a-n-a-u-g-h, and I represent the 9th Legislative District in midtown Omaha. I'm here to introduce LB570, which intends to provide additional funding for nursing scholarships through the Department of Health and Human Services. The scholarship program was initially established by the Legislature in 2021 using American Rescue Plan Act funds. The description in this bill mirrors the language used in 2021, but I have received feedback that expand-- that the expanded definition from 2024, which doubles the potential scholarship amount and allows for additional BSN students to receive funding as well, is more appropriate. If the committee moves forward with LB570, I would welcome an amendment to expand eligibility. Over the interim, I had a number of conversations with stakeholders about nursing shortages in Nebraska and the need to continue funding for scholarship programs. I'll let those behind me speak in more detail, and I recognize that $5 million represents a significant sum during

our present budget situation. I'm open to working with the Committee on finding an alternative funding source if one is available, but I believe addressing our nursing shortage by investing in scholarships for nursing students is important. And so basically what-- how I came into this situation was I had a number of constituents who were worried about nursing shortages, specifically in long-term care facilities. And so during the interim, I met with some folks at nursing schools, long-term care providers, hospitals. And I actually had the opportunity to go visit the nursing program at Northeast Community College, and just trying to figure out how we can get more folks into nursing. I represent a number of nursing schools in my district, and, you know, a lot of them don't have capacity for more students. But there are a number of other programs that have more capacity if they could find more students. So this bill came from a place of trying to find a way to get more folks into nursing, specifically into two-year programs for, for long-term care facilities. But obviously there's a, a broad need for more nursing, and that's probably what you're going to hear behind me. So with that, I would ask for your favorable consideration of this bill and be happy to take any questions.

HARDIN: Sorry. I'm getting bothered by people here and asking about this.

J. CAVANAUGH: They're asking-- they think I talked too long.

HARDIN: They did. No, they didn't do that. Questions? Senator Riepe.

RIEPE: Chairman. Thank you for being here at this late hour. My question is, is there a-- maybe in here, is there cap on how much each student could obtain?

J. CAVANAUGH: That's a good question. I don't think there's specifically a cap. I think it's-- I'm just looking at it. Enrolled in the nursing program. I, I mean, my guess--

RIEPE: I see something here, it says, I'm sorry, on--

J. CAVANAUGH: On page--

RIEPE: --page 2 on the top it says, shall award scholarships of $2,500 per semester to student nurses, to student who qualify. So it looks like it's $2,500 a semester.

J. CAVANAUGH: Right.

RIEPE: OK. Thank you.

J. CAVANAUGH: So for $5 million, you get a lot of nurses.

RIEPE: Hopefully.

HARDIN: Senator Hansen.

HANSEN: Thanks. Wa-- thank you, Chairman. Was, was this used before, or was all the funds used previously? Because we used ARPA funds for it. Never mind, it was. Someone's shaking their head behind you.

J. CAVANAUGH: Oh, great.

HANSEN: So--

J. CAVANAUGH: I'm going to say yes, then, for the record.

HARDIN: So what happens if you give them money and they don't come back, and they don't work?

J. CAVANAUGH: That's a good question. So, and actually, I've had a few conversations with folks about different mechanisms, about how-- loan, loan forgiveness is kind of a tough category. And so this is a scholarship with an obligation. You can do it as a loan forgiveness program would be another option. I just sort of mirrored the language that had already been for nursing, but I've had a few conversations about maybe there'd be other mechanisms that would be more effective at delivery, delivery mechanisms. My point was really to say we should be giving scho-- giving money to encourage people to do nursing, and then encourage them to go into nursing in Nebraska. And so I'm not married to this particular mechanism of a scholarship with an obligation, but maybe a loan forgiveness over a number of years of service.

HANSEN: Yeah, I think we just heard a bill with psychologists with that I believe, where they-- but that wasn't, that wasn't a scholarship program, it was more like you come, we're going to pretty much pay you if you're staying in Nebraska. And if you don't, you have to repay it within a certain amount of time.

J. CAVANAUGH: That's the premise of this TV show, Northern Exposure.

HANSEN: I wish-- I never watched that.

J. CAVANAUGH: It's a late night, but it's a great show.

HARDIN: Senator Riepe.

RIEPE: Thank you. We had a conversation this morning. I think we talked a little bit about this was specifically directed towards those that would work in nursing homes.

J. CAVANAUGH: Yes. So that's-- that was my.

RIEPE: I don't see that in the language.

J. CAVANAUGH: It's-- that's not necessarily in the language. We had some real trouble trying to shoehorn it in. But I've also had a lot of feedback since then that maybe there's a broader desire for just more nursing in general. And so maybe not so specific. And that's kind of where the conversation is at. I came at this from the-- my intention of trying to get more nursing into-- folks to go into nursing, to be in long-term care facilities. But I think you'll hear from folks that there's a desire for generally we have a nursing shortage, and that this scholarship that was previously afforded to folks, maybe it's just in our best interest to re-up it more broadly.

RIEPE: Because I think Senator Hughes had one, because I know it was my priority last session was for the hospital association, it was for a major nursing recruitment with not a whole lot of stipulations about nursing homes or--

J. CAVANAUGH: Yeah.

RIEPE: --or doctor's offices or anything else.

J. CAVANAUGH: I don't remember that bill, I'm sorry.

RIEPE: And in some ways, I would almost be inclined to, to direct them away from physicians' offices. You know, they, they, because the hours are better it's more easy to recruit. You got to go for the tough one. You almost have to go for the night shift at the local hospital or nursing home.

J. CAVANAUGH: Yeah, and--

RIEPE: I mean, $2,500 a month. It's not chicken feed [INAUDIBLE].

J. CAVANAUGH: But $2,500 the per semester.

RIEPE: Pardon?

J. CAVANAUGH: Per semester.

RIEPE: Oh, well yeah, per, so.

J. CAVANAUGH: Three months, four months.

RIEPE: So it could be $5,000 a year, wouldn't it?

J. CAVANAUGH: Yeah.

RIEPE: That's pretty good.

HARDIN: Senator Meyer.

MEYER: Thank you, Mr. Chair. Just an observation. I appreciate what you're trying to do here, Senator Cavanaugh. And once again, if we would want to specifically encourage some to go to long-term care facilities, nursing homes, or whatever, there can perhaps be some additional incentives tied to that. I, I think the scholarship's a good program. But there could be some other incentives after the fact, after-- once they get their nursing degree. And I'm sure you'd be amenable to something along those lines.

J. CAVANAUGH: I'm open to all suggestions, and I just wanted to make sure that we're trying to find-- get more folks into nursing.

MEYER: Sure. Thank you.

HARDIN: Other questions? Will you stay with us?

J. CAVANAUGH: Depends on how late it goes. No. Yes.

HARDIN: Proponents. Welcome.

MARY DISHMAN: Welcome. Thank you for having us. My name is Mary Dishman, M-a-r-y D-i-s-h-m-a-n. I'm the Director of Undergraduate Nursing at Clarkson College in Omaha. My comments really today reflect the support of the Council of Independent Nebraska Colleges, which the organization is compromised [SIC] of 13 independent post-secondary institutions in the state of Nebraska. LB570 was created a scholarship for health care, which will award $2,500 per semester to students who are enrolled in a program which will lead to an associate degree, diploma or certificate in nursing, or an accelerated Bachelors of Science program in nursing. We do applaud these efforts and support

students obtaining degrees or certificates in these areas. But what is missing from this Legislature is inclusion of a Bachelors of Science degree, or BSN, in Nebraska. The private, non and-- nonprofit institutions graduate more than 50% of health care degrees, including BSNs. 80% of graduates in Nebraska are BSN prepared. Collectively, our students pass NCLEX with a 94% or higher. Clarkson, we run about 95, 98%, making them highly employable and skilled in the area of nursing. Clarkson College happens to be one of the oldest nursing programs in the state of Nebraska. We were started by Bishop and Mrs. Robert Clarkson in 1888. We did transition from a diploma of nursing to a baccalaureate program in 1984. 80%-- 87% of our students are from the state of Nebraska, and 90% of our graduates will go on and stay in Nebraska to work, contributing to the health care workforce of our state. Research has shown that hospitals that have a higher percentage of BSN prepared nursing staff can reduce patient mortality by 30%, and reduce the rate of failure to rescue by 12%. For these reasons, Clarkson College and the Council of Independent Nursing Colleges ask that LB570 include BSN degrees. The scholarship funds included in this Legislature will assist all students who are seeking a career in health care. Thank you.

HARDIN: Thank you. Questions? Senate Ballard.

BALLARD: Thank you, Chair. Thank you. Thanks for being here this evening. Are these scholarships? Are they-- do they attract students, or is it more of a, is it more of a sweetener for students that are already going to enroll in a nursing program?

MARY DISHMAN: It does both.

BALLARD: OK.

MARY DISHMAN: It's-- it will attract students to come into the nursing programs to get their BSN. But also it helps the ones that are already actually are in the programs to help offset some of the cost.

BALLARD: OK. And ballpark what is tuition for a nursing program?

MARY DISHMAN: Depends. For independent colleges, it runs about $12,000, $15,000 a semester.

BALLARD: Thank you.

HARDIN: Other questions? Senator Riepe.

RIEPE: I thought the world of Mrs. Jacks, who was at Clarkson, and I and Edna Fagan, and their diploma programs were exceptional. My question gets to be is, is our money best spent on spending money on BSNs, or should we be spending money on two year associate nurses. Somehow or another we need some mix, but we might get a better payback by trying to recruit more associate levels.

MARY DISHMAN: Right in and associate--

RIEPE: Especially in nursing homes, I would say, but--

MARY DISHMAN: Abs-- absolutely. But-- absolutely. And I think there should be a mix of associate degree nurses and BSN prepared. But the research does show, and this is from the American Association of College of Nursing, that patient outcomes are better when you have a more robust staff that has BSN prepared nurses on the units. Now the gap does close as that ADN nurse is on that unit longer. And a lot of that is, is associated with the other courses that are offered in our-- that are part of our BSN curriculum, like evidence-based practice leadership that prepares our students, plus with their preceptorship at the very end where they spent 180 hours with one-on-one with a nurse at the end of their program, where they learn a lot of these skills, and a lot of that thinking skills are clinical judgment.

RIEPE: Given the idea of added students, do you also have faculty and do you have clinical sites? Because particularly in mental health it's historically been a challenge to get a clinical site.

MARY DISHMAN: Actually, at Clarkson, we've been very fortunate because of our educational partnership with Nebraska Medicine. I am fully staffed with faculty right now. I have 26 full time faculty. Only have-- only in the need of maybe three to four adjunct faculty to do some clinicals for me every semester. And so clinical sites have --mental health, we have a good relationship with Community Alliance, and our students do a lot more community type basis for their mental health, for the majority of our patients with mental health are at. So they do a few days in the inpatient, but mostly they do outpatient.

RIEPE: Ok. Thank you very much. Thank you, Chairman.

HARDIN: Senator Hansen.

HANSEN: Thank you. So you're proposing everyone who has a ba-- a ba-- who gets a bachelor of science gets the $2,500 per semester?

MARY DISHMAN: Correct.

HANSEN: So, like, starting, like, as a freshman I'm going to major in some-- I don't know what you major in. Or how does that work then?

MARY DISHMAN: So for our students, they, they apply to the nursing program and they come straight into our nursing program.

HANSEN: OK, so they start in the nursing program.

MARY DISHMAN: Correct. And it could be whether they're doing their general education courses or where they start their first nursing course.

HANSEN: So once they get their Bachelor of Science, could then they decide they don't want to do nursing, they can go into like lab assistant or technician or something else.?

MARY DISHMAN: They'd have to go on to get a different certificate or degree.

HANSEN: Would they still get the $2,500 a semester?

MARY DISHMAN: They could, if that's-- I know they could.

HANSEN: OK. Because if that's your intent, maybe we might have some language in the bill that says if you don't continue in nursing after that, after getting your bachelors, you have to pay it back.

MARY DISHMAN: Right.

HANSEN: There's no point in doing it, then.

MARY DISHMAN: Right. And I will say that we have very few students that do not go on and take NCLEX and work as a nurse. Like I said, 90% of our students stay in Nebraska upon graduation.

HANSEN: OK, cool. Thanks.

HARDIN: Senator Riepe.

RIEPE: Chairman, thank you. This sounds like a little hardball question, but I'd like to have your assurance that when the scholarship of $2,500 per semester goes in, that the tuition doesn't go up a corresponding $2,500, so that we're fundamentally giving a scholarship to Clarkson. The second question I would have is, and I

had this before us, Creighton at one time came to me and he wanted one, I said, I won't do it for Creighton specific, I'll do it for nursing. Because then you throw the net out there bigger for any educators as opposed to one per-- because one will get you ten. And the minute if we do something that's a specific Clarkson scholarship program, we're going to end up with a lineup like, like a truck stop outside the door. So I'm more-- I'd like to be generic on it, but--

MARY DISHMAN: Right. And I agree that it should be across the board, across the state for students in the BSN.

RIEPE: Well, that's generous on your part, thank you.

HARDIN: Other questions? Senator Fredrickson.

FREDRICKSON: No.

HARDIN: Oh, OK. Very good. I saw that twitch of that finger.

FREDRICKSON: I'm just very engaged.

HARDIN: All right. Thank you. Appreciate you being here.

MARY DISHMAN: No, thank you for having me.

HARDIN: Proponents LB570. Welcome.

MINDY BARNA: Good evening. So, just like Mary, I am also with the Council of Independent Colleges in Nebraska, and Nebraska Methodist College. I'm Mindy Barna, M-i-n-d-y B-a-r-n-a, and I'm the Dean of Nursing at NMC. I also agree that the $2,500 per semester for students who are enrolled in a program leading to the associate degree, diploma, or certificate in nursing, or an accelerated BSN in nursing degree is a great opportunity for our students, and will bring in more students, but it's still missing the Bachelor of Science in Nursing degrees. Nebraska Methodist College does recognize the critical role that all nurses play in strengthening health care across Nebraska. And so in response to the growing demand for nurses, we're also expanding our offerings by launching a licensed practical nursing program this fall. Additionally, in 2024 179 of our graduates took the NCLEX exam, making NMC the second largest contributor of new nurses in the state, following only UNMC. The majority of our nursing graduates are traditional BSN students, making up 78% of our nursing graduates in 2023 and 74% in '24. These graduates represent a vital segment of Nebraska's future nursing workforce. Ensuring their inclusion in this

scholarship opportunity will provide essential support, ultimately strengthening Nebraska's healthcare system. And so, for those reasons, NMC and the Council of Independent Nebraska Colleges ask that LB570 include BSN degrees.

HARDIN: Thank you. Questions?

HANSEN: Quick question.

HARDIN: Senator Hansen.

HANSEN: Thank you, Chair. Does Methodist or any other colleges you know encourage students to stay in Nebraska? Are you doing anything like, anything proactively as a college to say, look, we're going to do this to help out Nebraska, whatever, I don't know. I'm saying we're giving out $2,500 scholarships to encourage students to go your college. I don't know if there's anything you're also doing likewise to say, we're encouraging you to stay in Nebraska. You know--

MINDY BARNA: So--

HANSEN: --it is for everyone.

MINDY BARNA: It is. Not necessarily, no, but I believe that bill does require them to work for two years in Nebraska.

HANSEN: The bill does--

MINDY BARNA: So--

HANSEN: I'm curious to know what you do as a college.

MINDY BARNA: As a college, I would say their clinical experiences are here, their preceptorships are here. So I think that that entices them usually to stay.

HANSEN: OK.

MINDY BARNA: You know, they enjoy their experience while they're here, so--

HANSEN: That makes sense.

MINDY BARNA: More likely.

HARDIN: Other questions. Senator Riepe.

RIEPE: And I have a follow up question. Do you have a hardship exit on this thing that for some reason they have a, you know, family member that can't stay for, for the two or three or years, or they have a spouse that flies off in the Air Force or-- then do they have to pay it back?

MINDY BARNA: I would assume that they would, yes.

RIEPE: OK. So you get an IOU from them. But a follow-up question--

MINDY BARNA: I mean I think something would have to be included, yes.

RIEPE: Yeah, otherwise--

MINDY BARNA: Some teeth. Yes.

RIEPE: And yet, you notice in here in your college you have a diploma program, right? Is that-- that's not in nursing.

MINDY BARNA: Oh, we're opening an LPN program. It's a certificate program. So one year LPNs primarily will work in long-term care. Nebraska Methodist Health System has an acute care for the elderly floor that they'll work on.

RIEPE: Yeah. What, what, what's, what's the average tuition per semester for going to nursing school?

MINDY BARNA: It ranges about $12,000 to $15,000 per year. For our LPN program it'll be about $12,000 for the entire program. That's a discounted program because it's one year.

RIEPE: A little bit, probably, less than, say, Wesleyan here in Lincoln or whatever, but--

MINDY BARNA: Yeah.

RIEPE: I forget there was some place, the, the tuition was $90,000, not for nursing. It was some other ni-- I, I, I think the shock of it made me forget it. Thank you, Chairman.

HARDIN: Senator Quick.

QUICK: Yeah. Thank you, Chairman. My question, and I probably should have asked the last, last testifier too, but like your student make-up. Is it from all over Nebraska or mostly from, like, maybe the Omaha area or metropolitan?

MINDY BARNA: We get students from all over Nebraska. I would say the majority are still from the Omaha metro area, but we do get students from all over Nebraska.

QUICK: OK. And how much like are-- how many, like for class size? What is your class size for each year?

MINDY BARNA: We typically graduate about 80 students twice a year.

QUICK: All right. Thank you.

MINDY BARNA: Yeah.

HARDIN: Senator Meyer.

MEYER: Thank you, Chairman Hardin. Do you have a waiting list to get on?

MINDY BARNA: We do not.

MEYER: You know what? My, my daughter actually wanted to go to Methodist. Couldn't get in. I was just curious. Because there weren't enough slots for her, quite frankly, and went on UNMC, and now she's a nurse practitioner through Creighton, ended up getting her degree through Creighton.

MINDY BARNA: We all used to have waiting lists.

QUICK: So at, at one time we did have, we did have a waiting list for people to get into the nursing profession. Now we're a position where you're trying to recruit students. And, and I'm just, just pointing that out that at one time, maybe at that time we should have expanded the program so we could take everybody that wanted to come in, quite frankly. Now we're suffering some of the consequences of it with not having enough people to fill, fill positions. So not your fault. Not, not blaming you, but I was just curious on the, on the waiting list side, if we had more applicants than what we had positions or slots in the, in the, in the classes. So--

MINDY BARNA: Yeah.

QUICK: Thank you for that.

HARDIN: Additional questions? Thank you for being here.

MINDY BARNA: Thank you.

HARDIN: Proponents, LB570. Welcome back.

LINDA HARDY: Thank you. Last time I let a-- went a little rogue off my testimony. So this time I'm going to carefully read what I wrote for you. My name is Doctor Linda Hardy, spelled L-i-n-d-a H-a-r-d-y. I'm a registered nurse with a PhD in nursing education, and I will add that the CNE letters down below stand for Certified Nurse Educator through the National League for Nursing. So education has been my thing for the last many years. I'm the current president of the Nebraska Nurses Association. I'm speaking on behalf of the NNA with the endorsement of our Legislative Advocacy and Representation Committee. The NNA wishes to express support of LB570. We are strongly in favor of providing scholarships for nursing students. Having said that, we believe that there are opportunities for improvement in this bill, and I-- that I would like to share with the committee. So number one, current tuition for the 75 hour certified nurse assistant or certified nurse aid, some are called aids, some are called assistant, range from $380 to $540. When I left two days ago, Bryan College of Health Sciences charges $500 for this course. Often, employers cover this tuition with an agreement that the CNA will work in their facility for a certain amount of time. The course is rarely offered as a semester course. It would be helpful to state coverage of the tuition for the CNA course rather than specify $2,500 per semester. Number two, the scholarship should be extended to traditional Bachelor of Science in Nursing students. Although the intent seems to be to provide support to increase the nursing workforce as quickly as possible, supporting this category of nursing student is still valuable. These students will augment the nursing workforce, albeit over a longer period of time for entry into the workforce. The bill should stipulate $1,250 per quarter, or $2,500 per semester. Many licensed practical nurse and associate degree RN programs are housed in community colleges. Often these programs are set up with quarters rather than semesters. The NNA is the professional organization that represents over 29,000 RN's licensed in Nebraska. long-term care facilities rely heavily on LPNs and CNAs. And I've been the DON of a long-term care facility in Wahoo, Nebraska back in the '90s, but I rarely had all of the CNAs and all the LPNs that I needed. All the nurses, period. We are well aware of the shortage of nurses across our state, and strongly advocate for financial assistance for students to support an increase in the number of RN's, LPNs, as well as CNAs available to care for the citizens of Nebraska. This bill has potential to increase the number of health care providers across our state. We respectfully ask the committee to consider these suggestions and move LB570 forward. I will add one more

comment, because the bill does list diploma. There are no diploma programs left in Nebraska.

HARDIN: OK.

LINDA HARDY: There, there were-- they were three year type programs housed in a hospital. I'm a Bryan grad from a diploma program.

HARDIN: OK. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. Do you have something for before you were awarded, say, $2,500 a semester. It's almost a probability of success. Almost like universities and colleges, although some of them walk away from ACT scores, or-- I'm not saying they take an ACT., but you have to have something that says, if we give you $2,500, there's a high probability you'll be successful as opposed to failing, because maybe it's chemistry, maybe it's whatever. And so I'm just trying to hedge on my bet. I want some, some-- 80% are going to be successful at it.I don't want a 50/50 deal. You see what I'm saying?

LINDA HARDY: Yeah, I do. So, many scholarships that are awarded-- I, I taught for many years at another university here in Lincoln. And the scholarships, to keep them you have to keep a certain grade point average.

RIEPE: Yeah, but they're in by that time.

LINDA HARDY: Well, they're in the program, but they may be dismissed from the program. And you're not going to-- at least I don't think you should still give them this scholarship if they're, if they're dismissed from the nursing program.

RIEPE: If they, if they're halfway through, can you claw back the $2,500?

LINDA HARDY: Well, I don't know. Is there a way-- I don't know the answer to that. Is there a way to put that into how the, the scholarship is administered?

RIEPE: We can put anything in there, just ask the attorneys in the room, you know, where you're--

LINDA HARDY: See? He's saying, yes, there's a way to do that. And the paying back piece, yeah. I had to be a nurse educator. I had a scholarship, I had to teach for, I think it was three years, teach

full time in a nursing program for three years, or I had to start paying that scholarship back.

RIEPE: And you have to teach at a specific--

LINDA HARDY: It didn't, at--

RIEPE: At Bryan. No, I didn't teach at Bryan.

RIEPE: You could have taught any place?

LINDA HARDY: In Nebraska.

RIEPE: In Nebraska, OK. OK. Very interesting. Thank you.

HARDIN: Other questions? Senator Quick.

QUICK: Yeah. Yeah. Thank you, Chairman. And so I guess I'm liking this part. I mean, you're suggesting that through the community colleges that they would also qualify for those scholarships because I know we have a lot of nurses that had graduated through-- at Grand Island to that--

LINDA HARDY: Absolutely. My niece did.

QUICK: OK.

LINDA HARDY: Yeah. The main thing that I'm saying here is extend it to-- you could call it a four year BSN, because typically that's about how long it takes, if you're doing like at Nebraska Wesleyan. I don't have my other colleagues here, but most of, most of the pre-licensure BSN programs where you start from scratch, you graduate in four years with a Bachelor of Science in nursing, you take NCLEX, hopefully pass NCLEX, and have your nursing license. Associate degree, often, I don't know if I can say always, but often are in community colleges. It's a two year degree. Sometimes those nurses, and I'm not saying we should do that here, but sometimes those nurses come back to school and get a BSN. That's where I first started teaching, was in an RN to BSN program. So they had an associate degree, and then they finished to get a Bachelor of Science degree. Because, as a previous testifier said, there's good research that shows patient outcomes improve when you have a mix that has a certain number of BSN nurses.

QUICK: Yeah, and I know that like the LPNs are sometimes they're school nurses, they become-- work in nursing homes. So this would still qualify them to receive that scholarship.

LINDA HARDY: Ab-- absolutely. All I was trying to say here was because the bill says $2,500 per semester, that doesn't work well if it's a community college that's on a quarter system. And some are still. I know some have switched to a semester system, but some community colleges still are on a quarter, quarter system.

QUICK: And I do know some of them go on to Kearny or wherever to get their BSNs to become a registered nurse.

LINDA HARDY: Yep. As did my niece eventually. Yeah.

QUICK: Thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. I'm a real believer in supply and demand. How many of your schools of nursing could double their enrollment?

LINDA HARDY: Double?

RIEPE: Yeah. Let's go for the moon.

LINDA HARDY: Did you see my-- did you see me gulp when you said double?

RIEPE: Shoot for the moon.

LINDA HARDY: Well, I'll--

RIEPE: Well, over a 20%.

LINDA HARDY: --tell you what. There's-- I don't know the answer. I will tell you one of the issues. There is a bit-- one of my colleagues that testified said she had all the faculty she needed. When I ran a nursing program, I had all the faculty I needed, then I didn't, then I did, then I didn't. It kind of fluctuated. A lot of nursing faculty are my age, and I can tell you I'm old enough that I have retired from full time. I still teach as an adjunct, but-- So just like, you know, baby boomers aging, a lot of nursing faculty are close to my age. So we need faculty to double how many students we can teach.

RIEPE: And space.

LINDA HARDY: And space.

RIEPE: But if before you hang it up, I would hope that you would be able to get AI to be able to train all of these nurses.

LINDA HARDY: Well, I'm a, I'm, I'm, I'm, I'm this much scared of AI, but. And actually, Oregon has a bill before their legislature to say that a nurse must be a human being.

RIEPE: Oh I've known some, I've known some nuns who were nurses, and--

LINDA HARDY: OK.

RIEPE: --they weren't necessarily.

LINDA HARDY: When I first read that. When I first read that, I thought, what? But that-- some are advertising that you can use AI to be a nurse, to be your nurse.

QUICK: Senator Riepe, even the page enjoyed that one.

LINDA HARDY: That was a good one.

HARDIN: Any other questions? Thanks for being here.

LINDA HARDY: Thank you.

HARDIN: Proponents, LB570. Opponents, LB570. Neutral folk, LB570. Look, Senator Cavanaugh stayed.

J. CAVANAUGH: It was too interesting.

HARDIN: We have 16 proponents online, 0 opponents, and 3 in the neutral.

J. CAVANAUGH: Thank you, Mr. Chair, and Senator Riepe, there must be a back story there.

RIEPE: Years.

J. CAVANAUGH: I'd love to hear it. So, I mean, there's obviously, I think there's a lot of great points raised. I appreciate everybody who came and testified, and I appreciate the online comments. And like I said, I came to this from a specific perspective. And obviously there's much more need and desire. The threshold question is, do we want to make a commitment to investing in scholarships for, for

nurses. I think just rea-- looking through this, we have a two year commitment. If we're going to expand it to a four year, four years worth of scholarship, I feel like the commitment was commensurate with the amount of scholarship. So we might want to increase the commitment as well. But, you know, the technical questions about whether up to $2,500 to cover those other things that cost less than that, of course. That's actually one of the comments that came from the DHHS. And I, I was looking through this. I don't think I've ever seen this before where DHHS came in neutral, and they actually suggested that we increase the scholarship amount to $5,000, which I've never seen the department come in and tell me that I wasn't spending enough money. So I must be on to something here. They also suggested that we should expand it to BSNs. I'm of course in favor of that. Whatever gets us the most people invested and interested in this. And to Senator Riepe's question about doubling, in my kind of, you know, visiting with folks about this, one of the problems they have is that it is prohibitive to basically expand their capacity. And so this is just, honestly, this is a smaller thing. We need to be doing bigger things. But this is a small thing to get more people into nursing. And Senator Quick, I came at this of, of course, my initial approach was to get into community college nursing programs. So I'm happy to expand it. The more, the more the merrier. I've been in the-- had enough experience in the health care industry or whatever, been a patient or-- that I know the nurses are the ones doing the real work, and that's what I want, to make sure we have enough of them. No offense to doctors, but nurses are the ones that are doing, that have done all the real work for me. But yeah, so the question is, do we-- are we willing to make a commitment and move this bill forward? I think that all of the issues that have been raised or concerns are addressable very easily. We just need to, you know, kind of tinker with it a little bit to make sure that we have assurances in place that folks are actually going to follow through. And Senator Riepe, the hardship one I hadn't thought about. But that is, that's something that we probably should contemplate. If somebody goes into nursing and then their spouse gets transferred from the base or something like that is a real scenario. So I'm happy to take any other questions. Oh, and Northern Exposure takes place in Alaska. I didn't want anybody, for the record, to think that it was in, in, in, in Nebraska. It's not in Nebraska, it's Alaska. But it is about the same idea.

HARDIN: Questions? Senator Hansen.

HANSEN: Some of the recommendations that were made, made for the administration or anybody else, [INAUDIBLE] any mentions of staffing agencies at all?

J. CAVANAUGH: Not that I recall, but I can look through--

HANSEN: I was just kind of curious if they're working for a staffing agency after they graduate or not.

J. CAVANAUGH: Yeah. Well, and again, I'm not trying to narrow it, but my intention was specifically I was thinking rural, I was thinking high need industries. And I think that there's a conversation to be had about putting those sorts of constraints and say, maybe you get a bigger scholarship or you get less repayment time, some kind of incentive that shifts it in favor of going into some of these more high need areas as opposed to-- you know, midtown Omaha is great, but-- and I think I would love to have more nurses there, but we do have more need in other places, and maybe there's some--

HANSEN: I agree. And also a different source of funding as opposed to General Funds? Have you explored that at all?

J. CAVANAUGH: I haven't, but if there's a suggestion, I'm willing to look at it.

HARDIN: Other questions? Seeing none, thank you.

J. CAVANAUGH: Thank you.

HARDIN: This concludes our hearing for LB570, and after hearing this for today.