HARDIN: We're going to go ahead and start, and when they come in, we will all boo them when they walk in the door. Is that agreeable to everyone? Good morning and welcome to the Health and Human Services Committee. My name is Senator Brian Hardin and I represent the 48th District, and that's the real west in Banner, Kimball, and Scottsbluff counties. And I serve as Vice Chair of Health and Human Services Committee. I'd like to invite the members of the committee to introduce themselves, starting on my left with Senator Machaela Cavanaugh.

M. CAVANAUGH: Senator Machaela Cavanaugh, District 6, that's central Omaha, Douglas County.

RIEPE: Merv Riepe, Legislative District 12, which is part of Omaha, Millard, and the little town of Ralston.

HARDIN: Also assisting the committee, is our legal counsel, Benson Wallace, research analyst Bryson Bartels, and our committee clerk, Christina Campbell. A few notes about our policies and procedures. Please turn off or silence your cell phones, and that includes me. And we will be hearing one interim study this morning, along with two presentations. On each of the tables, near the doors to the hearing room, you will find green testifier sheets. If you're planning to testify today, please fill out one and hand it to Christina when you come up to testify. This will help us keep an accurate record of the hearing. If you're not testifying at the microphone, but want to go on the record as having a position on what's being heard today, there are yellow sign-in sheets at the entrance where you may leave your name and other pertinent information. Also, I would note if you are not testifying but have an online position comment to submit, the Legislature's policy is that all comments for the record must be received by the committee by 8 a.m. the day of the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits, we would ask if you do have any handouts that you please bring ten copies and give them to Christina. We use a light system for testifying. Each testifier will have five minutes to testify depending on the number of testifiers. Five minutes it is. When you begin, the light will be green. When the light turns yellow, that means you have one minute left. When the light turns red, that's when Christina hits the eject button and you go flying through the top of the Capitol. That's not true. But we'll ask you to wrap up your

final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone, and then please spell both your first and last name. That's the easy part to forget. The hearing will begin with the introducers opening statement. Interim studies are not proposed legislation. Therefore, we will not have opponents and proponents. Each testifier will come before the committee for the purpose of informing, after which the introducer will then be given the opportunity to make closing statements if they wish to do so. On a side note, the reading of testimony that is not your own is not allowed unless previously approved. We have a strict no prop policy in this committee. With that, we will begin today's hearing with LR338. And welcome, Senator Riepe.

RIEPE: First of all, thank you all for being here.

HARDIN: Good morning.

RIEPE: Good morning.

HARDIN: What do you have for us today?

RIEPE: Well, we're going to talk about rural health. And we're not going to solve all those problems, but we're going to talk about it, and hopefully we can stimulate even greater interest and try to look at some of the inequities in some of our system. First of all, I want to thank you, Chairman Hardin and Senator Cavanaugh, I also-- for affording us this opportunity to talk about this particular very important rural health care in Nebraska, al-- along with its challenges, the opportunity for innovations, and the opportunities it will have. I also wanted to point out for those who are testifying is a written report will be created from this hearing and distributed to all senators in hopes that we find and will take action to improve Nebraska's health care system and its inequities. I just-- I wanted to make sure that those that have been kind enough to show up today to testify are not playing to an empty house of senators, as many of our senators, one of them's on a honeymoon, and another one is unable to be here today. And so that's kind of the way it works a little bit during the quote unquote recess that we, we share. I do want to thank all those that are here today to share their knowledge, their experience, and their perspective on opportunities that might result in greater health care access and affordability in Nebraska's rural communities. Presenters will include Dr. Jed Hansen of the Nebraska

Rural Health Association, Shane Farritor with the creative Virtual Incision, which is, for those of you who may not know, is a Lincoln robotic surgical technology firm. Dr. Libby Crockett, who is a general and high risk ObGyn with a Grand Island clinic, will talk to us a little bit. And she has a relationship with many of the rural physicians who are doing maternal and infant care. Mr. Marty Fattig, who I call the dean of Nebraska's hospital administrators and CEO of the hospital in Auburn, Nebraska. He's also on the Nebraska Rural Health Advisory Committee and has been for some time. Marty's Hospital, one of the things I'm particularly interested in, I've known Marty for a very long period of time, is that his hospital sponsors a hospital based emergency rescue squad system. And in my thinking that might be a model as we want to look at to try to how do we resolve some of the emergency care, which is obviously a very critical and important thing in rural Nebraska given farm and farm accidents and, and distances, if you will. He also, if he chooses, he might talk about the financial challenges in rural health delivery. We also with us today will have Dr. Gerald Luckey, a David City primary care physician, and Dr. Kyle Meyer, a primary care physician from the University of Nebraska Med Center. The presenters will address rural health care disparities in Nebraska, technological innovation in health care, in rural health care, maternal care and maternal care deserts, critical access hospitals, emergency medical services, and the impact of Medicare, and now challenges with Medicare Advantage policies and procedures that are creating a financial distress for our many rural critical access hospitals. I also want to publicly thank my gifted legislative aide, Gerald Fraas for his ability and commitment to this project. He has done a lot of heavy lifting. We will also be sharing this morning with two re-- results, and those are one of physicians and one of nurse practitioners as to why they do not or do elect to practice in rural Nebraska. So with that, Mr. Chairman and committee members, I conclude and would entertain any questions you might have of me before we go forward.

HARDIN: Thank you. Any questions? I think we're excited to hear what this is all about.

RIEPE: Well, we're excited as well.

HARDIN: Yeah.

RIEPE: We, we have so much to learn and sometimes the rural aspect gets kind of left behind. So we need to just focus and, and trying to make a better go of it. But with that, thank you very much.

HARDIN: Thank you.

RIEPE: I will be around for closing.

HARDIN: OK. Dr. Jed Hansen.

JED HANSEN: I'll both try to remember to spell my name and not get ejected from the seats.

HARDIN: That's entirely up to Christina.

JED HANSEN: Good morning, Senators, and thank you for the opportunity to speak today about rural health care in Nebraska. My name's Jed Hansen, J-e-d H-a-n-s-e-n, and I think that makes just the second or third time I've actually spelled my name, [INAUDIBLE], so thank you for the reminder on that. And I serve as executive director with Nebraska's Rural Health Association. Nebraska's rural health care infrastructure is both vast and diverse. We're home to 62 critical access hospitals, one rural emergency hospital, nine rural regional hospitals, and about 130 rural health clinics, making this the fifth largest rural state by number of hospitals. These, these facilities form a vital safety net for communities across our state, each operating within unique payment structures. When describing Nebraska's rural health care system, I think in threes. In the east, we see more traditional rural care, established communities with a relatively-- with relative density of critical access hospitals and clinics supported by tertiary systems in Lincoln and Omaha. As we move along the I-80 corridor, the density decreases somewhat and the support is through our rural regional hospitals that support larger catchment spaces, areas like Kearney, Grand Island, Scottsbluff, and North Platte. And finally, in our frontier areas that Senator Hardin is very familiar with, those in the west and north central regions with fewer than six people per square miles, access challenges are stark, and residents often are required to drive over an hour to see a provider, or EMS service response times can be dangerously long. Despite these challenges, Nebraska's rural hospitals are resilient as its people, thanks to strong leadership, and policies like the passage of LB1087 that happened last year. However, sustaining these-- this resilience

requires thoughtful, flexible policies to ensure fair reimbursement for primary care, emergency services, and EMS transportation. Currently, about 40 of our critical access hospitals operate at a financial loss. Within that, about 6 to 10 of those are at risk for closure. As we work together to strengthen rural health care. We should consider a tiered approach to services as a potential solution, a tiered system that could better align reimbursement and infrastructure investment with specific needs to communities. Some examples of a tier one service would be foundational care like primary care, emergency services and EMS, telehealth, preventative screenings and outpatient mental health. Tier two services would enhance regional capacity, supporting critical needs like maternal care, general surgery, specialty clinics, cardiac care, oncology, and acute mental health. And then finally, tier three services addressing high acute and specialized care, including advanced surgical services, dialysis, and inpatient rehabilitation. By embracing a system like this, we can ensure that care is tailored to meet local needs while building stronger regional networks that, that complement rather than compete with one another. As this committee considers solutions, some areas that we could consider in bolstering essential services, that tier one for primary care, EMS and mental health, would be like Medicaid's 1115 waiver program. This is a program that has traditionally been underutilized by the state of Nebraska, and something that does provide that potential to draw additional federal funds to our state. Providing payment flexibility, support regional services like general surgery, maternal care and acute mental health crisis are going to be needed. And then we need to look at where we're currently at and protect services and programs like 340B, looking at harmful white bagging processes and predatory PBM practices, all of which erode our health care system. There is reason for optimism. Nebraska's rural communities are deeply committed to their health and well-being, and by investing in fair reimbursement models, infrastructure, and workforce initiatives, we can empower these communities to thrive. So thank you for your time and your commitment today to rural health care. And together we can build a healthier Nebraska for all.

HARDIN: Thank you, Dr. Hansen. Questions. Why, Senator Cavanaugh

M. CAVANAUGH: Thank you. Thank you for being here. I said I can ask enough questions for a full committee so you won't feel short shifted today. So I was, I was trying to take some notes here on the different tiers, and then you mentioned the 1115 waiver program. So what, what

would that waiver, if we applied for a waiver, because that's the Medicaid program. So there's Medicaid dollars that we could be drawing down that we're not currently drawing down for these hospitals?

JED HANSEN: Potentially. So the 1115 waiver program allows for innovation models. And with that, you can pull down for a certain time period additional Medicaid dollars to support the, the restructuring of those innovation models.

M. CAVANAUGH: OK. So--

JED HANSEN: It's--

M. CAVANAUGH: --it's not necessarily tied to individual patients, then.

JED HANSEN: Correct. It would be. Yeah. You would be setting forth a program that would, that would better align patient outcomes with, with current delivery systems.

JED HANSEN: OK.

JED HANSEN: The nice--

M. CAVANAUGH: I wasn't, I wasn't aware that that was an option, so that's cool.

JED HANSEN: Yeah. Yeah. And the nice thing about those 1115 waiver programs, they do require state DHHS support, which I think this committee can probably bolster a little bit of that when needed. And-- but it, it also is flexible enough that we can look at areas like mental health, we can look at areas like maternal care. So they're not so rigid that you can only look at addressing a single need within a community or within a state.

M. CAVANAUGH: And so this, this three tiered approach, that's not the current model.

JED HANSEN: It, it isn't. And the current model is a little bit more fractured than that. We really-- we currently, our payment systems are structured so that we can have, we have regional hospitals, critical access hospitals, and then now this new rural emergency hospital model. And we're potent-- there's potential inefficiencies in that

current model in that we're reimbursing things that just may not fit at a community level, but could be very beneficial from a regional level. And we just need to start thinking outside the box in how we're addressing what are those essential services. And those are things like primary care, health screenings, emergency services, EMS, that really every, every community and every individual should have access to. And then maybe a little bit more controversial, but that tier two and looking regionally are things like maternal care. And when I'm talking maternal care, I'm not saying that you shouldn't have the ability to have that care locally, but what are those regional approaches that we can do and how can we support payment reform or other policies to be able to make sure that we have the right resources in place. I-- talking with a number of rural physicians that are family practice, OB trained, and there are some really scary births that take place. And it's not that they don't want to help in their community, it's that they are often asking themselves, am I the-- am I the best one to be able to deliver care in this community? So I think just looking at some of those other areas. And then that tier three are-- looking at our regional PPS hospitals like Great Plains, Faith Regional, Regional West, etc., and what are the services that they can support, things like advanced oncology treatments, rehab, looking at Madonna and how they can support our rural communities and build those tier systems up. So really looking at what can we do at each level to make sure that we're maximizing the dollars that are being spent to provide the greatest amount of good.

M. CAVANAUGH: And you mentioned critical access hospitals that are closing or have closed?

JED HANSEN: We-- in the state since 2010, we've had two critical access hospitals that have closed.

M. CAVANAUGH: Where were those located?

JED HANSEN: Those were in Tilden and Oakland. Tilden was 2010, and Oakland was in '21. We do have-- of our 62 critical access hospitals, we really have a, a third of those, that upper third that are running very robust services, they're very healthy financially, and some of that is just the size of the community. It's just a great model for those communities. And we have a middle tier that great leadership teams in place, but maybe that community or that catchment space that they're looking at, there are just changes. And while they're not

financially fragile today, with, with changing winds and policy, they could become fragile, or just as the population ages. And then we have a lower third that really are fragile. And of that lower third, about a third to half of those, I would say, are in imminent financial fragility, meaning that if some-- if you have a change in leadership or if a physician leaves the community or whatever, if there isn't swift action to take place, there could be a closure there. One of the areas that we're looking to address that is with the rural emergency hospital model, and it's something that's been implemented in the community of Friend. And that was a-- it's been a fascinating kind of just case study to look at, at what they've been, been able to accomplish there. That was a hospital that really for over a decade struggled, and struggled mightily. And the community really, really got behind them. There was some, some community events, they were able to realign that model. Some of the work that this committee did, we, were an early stage in passage of the rural emergency hospital model to align state perspectives. So that's something that will continue to evolve, and will get, will be a potential solution and could fit into that tiered approach.

M. CAVANAUGH: Thank you.

JED HANSEN: Yeah.

HANSEN: Senator Riepe.

RIEPE: OK. OK, thank you, Chairman. My question is on 1115 waiver. The state still has a financial obligation for like, what, 10% of the costs? It's not a major cost to the state, if we very well could receive one of those 1115 waivers.

JED HANSEN: That is correct. So there is still some of the the Medicaid financial obligation that the state would, would bear. But we would potentially access some additional federal funds to be able to offset some of those expenses.

RIEPE: I have a second question if I may, Mr. Chairman, I, I want to follow up question on the Friend Nebraska. This-- because I believe it has one bed, it's a holding bed. Is that correct?

JED HANSEN: The-- that's a, that's a great question. They do have more than one bed.

RIEPE: Oh they do?

JED HANSEN: They do. So the way rural emergency hospitals are allowed to operate is that they're required to have an emergency department. It kind of makes it sort of--

RIEPE: 14/7?

JED HANSEN: 24/7, yep. And they're held to the same operational standards as a critical access hospital would be for that emergency department.

RIEPE: OK.

JED HANSEN: Things that they're not able to do, they're not able to participate in the 340B prescription drug program, and then they're not able to maintain inpatient beds. But they can still maintain observational beds, so you can keep a patient there. Let's say that someone has, they come in with, with an infection and you're wanting to run antibiotics for that patient. They're, they're allowed to stay in the community. And it's just the type, the type of bed that has been switched over.

RIEPE: You said emergency departments, now for the staffing on that, does that have to be an M.D. or a D.O, or can a clinical nurse practitioner be the only provider in that emergency department?

JED HANSEN: There are physician requirements, both for the rural emergency hospital and for critical access hospital, that that physician does need to be available.

RIEPE: I needs a physician.

JED HANSEN: Yeah, but there-- but nurse practitioners and physician assistants are able to be the primary staff member for those emergency. But that-- and that's the same for the rural emergency model and critical access.

RIEPE: In your opinion, is the Friend hospital now off the critical list?

JED HANSEN: They're not off the critical list, but they are moving in that direction. They, they were going to close if we didn't, if we

didn't convert them over. And I think that they have a lot of potential to, to thrive at this point.

RIEPE: OK. Thank you, Mr. Chairman.

HANSEN: Senator Hardin.

HARDIN: Do we have examples from other states of a multi-tiered approach, and how is it working in those other states?

JED HANSEN: Yeah, Pennsylvania is a, a really interesting case study. They have something called the Pennsylvania model, and they brought all of their payers to the table, including both state and private, and they worked towards a global payment model. So these hospitals were receiving funds on the front end of the of the payment cycle instead of on the back end. And it really shifted how these hospitals were able to operate. So it was, you know, we have all this great data on you increased transportation, if you do some of these preventative services that it decrease costs, it increases the mortality and health of a community. And it allowed those hospitals to access those funds and then to create tiered programs in how that best serves the community. It's been running for about five years now, and they're looking to continue to push towards this tiered, toward this tiered model in greater, in greater ways.

HARDIN: Great. Thank you.

JED HANSEN: Yeah.

WALZ: Could I just--

HANSEN: Senator Walz.

WALZ: Hi, how are you?

HANSEN: Well, I'm good, thank you.

WALZ: Thanks for coming. This is very interesting. I just want to ask one more question off of his.

JED HANSEN: Yeah.

WALZ: So that Pennsylvania model is a matter of if you provide it, you get paid. Not after you provide it, you get paid. Is that what you're trying to--

JED HANSEN: Correct. Essentially, what they're-- what is happening is that they're taking the pool, the [INAUDIBLE] for each of these payer systems, and then they're providing a forward payment to the hospitals. And so the hospitals then, the onus is on them to decrease costs by creating healthier communities. And if they're able to decrease costs, then they make more money. Now, not all hospitals in Pennsylvania are, are a part of this model because there is risk with it. But it can be something that it can limit the upward exposure for, for payers and then provide greater potential for, for stable profits for hospitals, all while hopefully aligning the-- kind of that, that public health component of, of care in the community.

WALZ: Awesome. Thank you.

HANSEN: Senator Hardin.

HARDIN: Jumping off of what she just said. In Pennsylvania, would they, for example, take that group of six to ten hospitals that we have that are in a rough spot here in Nebraska? Is that where their program is focused, or is it more broad?

HANSEN: Great question. It's more broad, so-- and I would anticipate that the healthier our hospitals are, they're probably more apt to jump initially into this type of a model, just because they would be-- there would be less risk. Or they're-- you're taking on greater risk for greater profit potential. And so with-- you have, when you have a struggling hospital, their appetite for risk is probably going to be a little bit lower.

HARDIN: And a strange follow up question. You may or may not know this one. Is that an insurable risk for those hospitals? Or for those--

JED HANSEN: I don't know, I don't know the answer to that one. I would have to give you some follow up on that, too. And I can I can reach out to the to the Pennsylvania--

HARDIN: Or an insurable risk for those payers. Maybe. Curious. Insurance wag, sorry.

JED HANSEN: Yeah. Yeah. From a payer standpoint, they're really looking at capping what their costs are. So the risk is, the risk is lower there. Now they've created a tighter window, window for profitability from a payer standpoint, but they have removed risk off of the table for themselves.

HARDIN: Thank you.

HANSEN: All right. Seeing no other questions.

JED HANSEN: Yeah.

HANSEN: I've got to give a shout out to my hometown, or not my hometown, where all my family's at, Tilden, you mentioned Tilden, Nebraska, so I-- you never hear that, so far.

JED HANSEN: They-- and they still do have a clinic up there, just-- yeah.

HANSEN: Yeah. Yeah.

JED HANSEN: Yeah, yeah. Great community.

HANSEN: Seeing no other questions, thank you for coming. Appreciate it.

JED HANSEN: Yeah. Thank you, Senators.

HANSEN: All right. We'll take our next invited testifier. Shane Farritor? I'm pretty sure I said that wrong.

SHANE FARRITOR: Thank you very much.

HANSEN: Welcome.

SHANE FARRITOR: My name is Shane Farritor, S-h-a-n-e F-a-r-r-i-t-o-r. I'd like to invite the Senat-- or thank the Senator for the invitation, and the committee for the time. I play a couple roles. I am a faculty at the University of Nebraska in mechanical engineering where I do robotics research. And as part of that role, I co-founded a company called Virtual Incision way back in 2006. It's grown quite a bit, and we now have about 70 total employees, about 40 of them here in southwest Lincoln, where we make small robots that are used for surgery. So very happy to create both engineering and manufacturing

jobs. We do engineering and manufacturing here in Lincoln. Happy to create those jobs right here. We've got some really, really bright people, a very talented team. I grew up in a little town called Ravenna. And of course, rural health care is really important to us. I was sitting back there and thought I had surgery in Grand Island, Nebraska, and it's hard to believe my father had surgery in Broken Bow. That's an even greater stretch. So looking back on that, that's, that's a little bit strange. But I want to tell you a little bit about Virtual Incision. Again, we make small robots that are used for general surgery. So surgery on soft tissue in your abdomen. So it's not knee replacements or anything like that, it's soft tissue surgery. We have a very innovative and different approach to this in that our robot is hand-held, it's about as-- the size of your forearm. There are other robots out there that are sold for surgery, but they are all big robots that reach in from the outside. So they're nine feet tall, literally, they weigh about 2,000 pounds. They're very expensive. And we're trying to simplify that. They're not just expensive in terms of capital equipment, but also in terms of the support staff required to use them. They're a great technology, but they are, they are-- have limitations, including expense. So we're trying to simplify that. We're trying to make small robots that go inside the body for surgery rather than big robots on the outside. And that's a very special approach. I think we're the only ones in the world that are making this type of robots. This-- earlier this year, in February, we were cleared by the FDA for colorectal procedures. And so that's obviously a huge milestone for us and our company. We're installed in two hospitals and we've done about, I don't know, maybe 50 surgeries on people so far. We're kind of just getting started, but very excited about the path of the company and where we're going. So one of the things we're working on is what we call remote surgery, where the surgeon and the patient are in different locations. So this is pre-clinical work. We're not doing surgery on people yet. But we have demonstrated this, again, an area where I think we're world class, and the fact that we have such a small robot lends itself to remote surgery. When I was doing research on this at the university, we were sponsored by both the Army and NASA because both those organizations want to do surgery in crazy places. The Army wants to do surgery in ambulances immediately after injury. And NASA, of course, wants to do surgery in crazy places, too. And you may have seen we flew our robot on the International Space Station earlier this year in February, we had surgeons in Lincoln, Nebraska, operating a device to do simulated

surgical tasks on the International Space Station. Our robot spent 91 days in space, so that was exciting. But we've also done several other pre-clinical demonstrations between Lincoln and Chicago. We did seven procedures with four surgeons. That's the first time ever, I think, in the history of the world where we did surgery in two directions. We had patients in Chicago and surgeons in Chicago, and patients in Lincoln and surgeons in Lincoln. Again pre-clinical, but we did back and forth like that. And then we recently, about a month ago, completed 22 procedures between Santa Barbara and Chicago with four surgeons. So that was another great demonstration. So there's lots of reasons to explore remote surgery. One is efficiency. Surgeons talk about, you know, can one surgeon sit in a room and do surgery in three different patients in three different rooms? Can they not have to drive across town to other hospitals? Sometimes you have to travel between hospitals, and that's an inefficient use of surgeon time. But the use case that I'm very interested in is rural critical access hospitals. So we're going to do a special demonstration actually coming up on this Monday, good timing here. We're, we're going to do a surgery between Lincoln and Columbus, Nebraska, the critical access hospital in Columbus. You can imagine a patient in one of these rural areas who has a colorectal, colorectal cancer, and needs surgery to correct that problem before it spreads. Often what happens now is generally there's a general surgeon in those communities. However, if it's a complicated case, they'll send them to Lincoln or Omaha to see a colorectal surgeon, a specialist in this type of surgery. Our idea is that if that patient could stay in that community, the local general surgeon could provide support. They could, you know, see the patient up to surgery. They could make the initial incision, manage anesthesia, assist the remote surgeon, But then that colorectal surgeon could dial in from another community, from Lincoln or Omaha. Then you could allow that family to stay home, which is obviously a big deal. It's hard for a family to-- in that situation, period. But then it's even harder to have them come to Lincoln, stay for a week or something when their loved one's having surgery. It would also be beneficial, I think, for those critical access hospitals to be able to capture the revenue associated with these procedures, because they're some of the best reimbursing procedures in the hospital, and that can be important for these local hospitals as well. So I've been pushing this because I want to demonstrate this remote surgery. But I think remote surgery is something that's coming. I think it has lots of use cases. Again, I think the entire continent of Africa could benefit

from remote, minimally invasive surgery. But I-- but the use case that is very interesting to me is this ability to help rural communities have greater health equity, have better access to specialists, you know, and just better access to health care in a more conducive manner to healing, which is staying home and, and being around your community and the people who you love. So this is something we're pushing. It's hard to believe, but I think this is an area where Lincoln, Nebraska is leading the world. I think we're doing the best. There's some, some places in China that are doing remote surgery, but they obviously have a different health care system and a very different regulatory environment. But I think Virtual Incision is leading the world in remote surgery. I think if you ask anyone across the country, we've come up first right off the top of their list. So this is something I want to push and something we want to enable Nebraska, I think Nebraska can lead in this area. So with that, I thank the committee for their time.

HANSEN: All right. Well, thank you and thank you for all you do, and staying in Nebraska, too. We appreciate that. Any questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman. I'd like to get your opinion because one of the things that we are looking at going into the 2025 session is regulations and trying to say which ones need to stay and which ones need to go. Do you have regulations that you believe are excessive?

SHANE FARRITOR: Well, it's a tough position for me to evaluate or discuss such things. We are obviously in a very highly regulated industry and environment, which I think is largely appropriate. Our application to the FDA, I've often mentioned, was I believe, 35,000 pages. So it was a significant amount of work to prepare for that. I'm very happy that we have advanced through that milestone. If we talk about remote surgery, this is a brand new area and it will require cooperation with the Food and Drug Administration as well as state lic-- state issues there. Licensing of doctors is generally a state issue. And if you're licensed in this hospital or you, you know, how does that carry over into having privileges at other hospitals? So there's a lot of things to work on beyond the technical aspects.

RIEPE: I have a follow up quick-- this is a little off of the Nebraska rural, but--

SHANE FARRITOR: Yeah.

RIEPE: I was a Navy corpsman at one time, and if you're out to sea, very often times hospital corpsmen will do appendectomies. So I could see this--

SHANE FARRITOR: Yeah we're looking at--

RIEPE: We were probably not the most qualified people to be doing surgery out there.

SHANE FARRITOR: We're looking at--

RIEPE: Minor as it might be.

SHANE FARRITOR: Yeah, we're looking at several use applications. The Navy is one interesting one. Appendectomy on a submarine without having to resurface? Right?

RIEPE: Exactly.

SHANE FARRITOR: If you can prevent things like that, that's, that's a big deal.

RIEPE: Especially if you're small enough that it's not going to take up half the sub.

SHANE FARRITOR: Yes. Trauma is a very difficult and very different problem than we work on, but it's an area where I'm interested as well. So if you're in a car accident in Thedford, you know, you're an hour and a half from a hospital, you're an hour and a half, longer than that to get to a surgeon. Things can get pretty dicey in those situations. And if you could provide-- and our device is very small, if, if even paramedics could, could provide some assistance, then a remote surgeon could dial in and, and give important care very early in the process. And I think that can be important. So there's, there's a lot out there. And we think our device enables some of these interesting use cases.

HANSEN: Senator Hardin.

HARDIN: Thank you for what you do. This is-- we don't always get to hear exciting things that are forward leaning, and this certainly is

the paradigm of that. What's next for you? What are the next challenges that you're facing in order for us to see reality here?

SHANE FARRITOR: Well, several things. We're going to expand our indications, which involves, again, a regulatory process to be cleared in other areas of surgery. We are just beginning a trial, a clinical trial. Actually, we did five-- we did some cases in, in Europe to begin a trial in hysterectomy, benign gynecology procedures. So we have a plan to expand the procedures where our device can be used. And then I think there's some question about how remote surgery might roll into that. As a private company, we have to prioritize what we're working on. And, you know, I would like remote surgery to be a big part of that, again because I really believe in the impact it can have on rural health equity and all kinds of, of, again, use cases. So I hope we can keep pushing remote surgery forward.

HARDIN: Thank you.

HANSEN: Senator Walz.

WALZ: I am just blown away about-- so when you said we have tiny robots, this is how much I know about it. I really seriously thought it was like just a little--

SHANE FARRITOR: Little person?

WALZ: Right. Robot. That's amazing. Can you-- I just am curious about the success rate that you've had so far on your vir-- virtual surgeries.

SHANE FARRITOR: On the surgeries themselves?

WALZ: Yeah.

SHANE FARRITOR: Well, personally, I'm very pleased with the outcomes. You know, one of-- the most important thing in, in our jobs at Virtual Incision is to take good care of patients who entrust themselves to, to our care. A lot of that is-- almost all of that is the quality of surgeons we have been working with. But patient care is at the top of our, our list, so I'm, I'm very excited about where we've been and where we're going with, with taking good care of our patients.

WALZ: Well, I see it as a big benefit for rural, rural health care. And, you know, I also, as you were talking, thought about people who are confined in nursing homes, and how it's tough for them to go anywhere to have surgery, let alone, you know, travel miles and miles. So I, I would see that as a big benefit for people in nursing homes as well. So thank you. That was very, very interesting.

HANSEN: I think I one question--

SHANE FARRITOR: Sure.

HANSEN: And you seem like the right guy to ask. In your opinion, what's the-- with the emergence of A.I., I know they use it, they're starting to use it diagnostically, right? To, you know, di--

SHANE FARRITOR: Yes.

HANSEN: With imaging, you know. What about surgery and something that you do, and in the future? Where do you see that landing? I'm kind of curious about your viewpoint.

SHANE FARRITOR: Well, it's a, it's an excellent question. And honestly, I don't think anyone really knows, A.I. in general, where it's going or specifically with respect to surgery. But in surgery, I think about this a lot, and I think about-- I think there will be stages, obviously. And so we will have some-- very soon we'll have some neural networks running on our system that are doing observational machine learning, or observational artificial intelligence. They're just watching what the surgeon is doing and they're drawing conclusions based on what's happening. They're not intervening with the surgery at all. They're using artificial intelligence to observe and support in a sort of a passive way. So I think that will be the first stage of this process. And then it will become a little bit more active as you go. So one of the things I'm excited about is nonsurgical tasks. So there are moments in a surgery where you have to do something that's not exactly surgery, I-- this is a silly example, but as you do suturing, you pass a needle through and you grab it with your left hand, and now your job is to take it, put in your right hand so you're ready to do another suture. That act of passing it through from your left hand to your right hand is something that you could potentially automate. That's-- you're not performing surgery at that moment, but there's still kind of a tedious task that

could be done well by a computer using artificial intelligence. So I see that kind of as the second tier, you know, simple nonsurgical tasks. And I think it'll get more and more advanced. I always also talk about an analogy with if you have a remote control car, your kid has a car, they're making every decision about the car. Go fast, go slow, turn right, turn left. If they want to drive it through the door over here, they've got to make every decision about that. It's not that way with a horse, right? You kick the horse, it makes all the decisions about how not to run in the fence. It doesn't fall over. It does-- it makes a lot of low level decisions on your behalf that you don't have to think about. And I think that will-- I think surgery will eventually, after a lot of time, kind of get to that area where the surgeon, the surgeon is saying, I want you to dissect along this plane. I want you to roll back this section of tissue, and, and the device will make some of those decisions. I always say good surgery is about judgment. And I think it will be a long time before that judgment is placed in the hands of artificial intelligence. But I think there's a lot of things A.I. can do to support. I don't know if that makes sense.

HANSEN: It does. A long time when we're talking about A.I.--

SHANE FARRITOR: Don't mention [INAUDIBLE] mentioned kicking horses, by the way, but that's the way it works.

HANSEN: That's all right. We kick the horse down the road, yeah. So any other questions from the committee? All right. Thank you very much. Appreciate it. Thanks for coming. All right. Next, invited testifier, Dr. Libby Crockett.

LIBBY CROCKETT: Good morning.

HANSEN: Welcome.

LIBBY CROCKETT: I am Dr. Libby, L-i-b-b-y, Crockett, C-r-o-c-k-t-t-- C-r-o-c-k-e-t-t. Wow, I can't even spell my own name today. It's a great start to the day. I am an obstetrician and gynecologist who has been practicing in Grand Island for the past eight and a half years, and I have been practicing obstetrics and gynecology in Nebraska since I started my OB/GYN residency about 15 years ago. I'm here to bring the perspective about rural health care in the context of maternal health care deserts. In the state of Nebraska, it's recognized that

about 50%, I think the March of Dimes quote says about 50% of Nebraska counties are maternal health care deserts. And that just simply means that the proximity for pregnant people in those areas to access obstetrical care is very limited. And obviously, in the context of today, we're talking about rural areas, but that can be in urban areas too. So I want to make sure that that gets noted. But I do appreciate the recognition by Nebraska senators for the need to address the growing issue of maternal health care deserts in Nebraska. It very much affects my patients. Grand Island itself is an urban location, but because of our central location in the state, and because we have seen a very rapid decline in the number of surrounding community hospitals that provide obstetrical and neonatal care, we do see a significant number of obstetrical patients from more rural areas, and it's not uncommon that we are caring for women in our practice who live between 1 to 2 hours away from our clinic and the local hospitals where we deliver. So today I want to-- this is obviously a huge topic with many facets, but I want to provide like a little bit of the physician's perspective on this issue. Obviously, there's time limitations and I can't go into the whole thing, but just one of the major factors, I think, is that the delivery of health care is now far more complicated than it has ever been in the past in all aspects. But the poorer baseline health of patients today really does make delivering any type of medical, medical care more challenging. And having spoken with several family medicine doctors that are friends of mine, I believe that this is also one of the many reasons we are seeing less and less family medicine providers providing OB care. And it's just because of demands for their skills to be high in all other aspects of medicine like trauma, cardiology, neurology, gerontology, and pediatrics has grown. Like the demands on their knowledge has also grown with time. And it just means that it's really hard for them to take on the growing patient acuity demands of delivering obstetrical care as well. Since I started my OB/GYN residency in 2009, the general health of the population of reproductive aged women has declined pretty significantly. We are now seeing a very high percentage of our patients, like pregnant people with chronic health conditions, which when I started it was just a small percentage. And it's just-- now it's just seems to be the norm. Chronic hypertension, obesity, diabetes, these are all major risk factors for pregnant-- pregnancy complications, and also complications in birth and for their neonates. And additionally, we have really started seeing much higher rates of congenital birth defects over the last several years in our practice.

And it's far more than any of us can ever remember seeing before in our practices. We are lucky. Our practice, as well as the practice in Kearney have been fortunate to partner with Nebraska Medicine Maternal Fetal Medicine Program, and maternal fetal medicine physicians are OB/GYNs who are fellowship trained in just specialty of high risk obstetrics. So when the program first started, before I moved to Grand Island, they came out with their team of nursing and ultrasound techs once a month to see patients. And then over the years it increased to be twice a month and now it's weekly. That's just in Grand Island. And then there are additional clinics that have been increasing in Kearney as well. And it's not uncommon that there are no spots to get patients in, and we have to still send people to Omaha for that care. But these, these trends just underscore the need for higher levels of obstetrical care by highly trained licensed and qualified individuals available to patients across the state to be able to actually recognize these complicated conditions that they exist early in pregnancy and to manage these people's pregnancy care appropriately. It is also really important that as legislators work on the problem of maternal care deserts in Nebraska, that they understand the importance of creating sustainable systems. Obstetrical care is highly stressful to provide, and primary obstetrical providers need to be supported by a team of skilled nursing, surgical, anesthesia, and pediatric staff, and to be financially reimbursed appropriately. In preparation for this hearing today, I reached out to the one of the family medicine physicians in O'Neill, where they have a well-established, high quality family medicine run program. And when I asked about why their prac-- their practice works, he indicated that successful and competent programs need to have a number of highly trained providers, which helps ensure good care, but also really prevents burnout. And when they have appropriate coverage so that they can focus on just doing obstetrics and they're not trying to run an emergency room and with multiple traumas and strokes and manage a labor patient and possibly a complicated neonate with problems, too. So geographical location also helps in as being in a more central area that reduces drive time for a number of individuals. And he also emphasized that support from hospital systems is a key and that very early recruitment, like in high school and college, of potential future physicians was key to sustainability. I think it's also critical to acknowledge that supporting or allowing poorly trained providers such as lay midwives will not solve this issue. Proposed care solutions that do not address or acknowledge that complications can arise

quickly and unexpectedly fall short of providing safe, effective care. These complications are managed most effectively when the care is led by someone who is highly trained and supported. Maternal care deserts in Nebraska is a very complex topic, and I realize there are no easy solutions currently. But I think that when senators seek to better understand the complexity of the problems that have contributed to the situation that we're facing now for maternal care, as you all are doing today, we can work toward a more sustainable and high quality solution. So thank you.

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

RIEPE: Thank you, Chairman. I'd like to have you share with us your thoughts about the role of midwives.

LIBBY CROCKETT: Yeah. So I think it's really important to designate that the-- that term is thrown around loosely, but it kind of means two very different things. So there are certified nurse midwives who are well-trained and have a very clear and important role in the delivery of high quality obstetrical care when they're supported in a system, right? That they have access to other consulting services like obstetricians or maternal fetal medicine doctors who can then perform the higher level of care procedures like operative vaginal deliveries, like with forceps or vacuum, or pretty significant perineal lacerations that can happen with obstetrics, or significant hemorrhage, or critical care situations, or C-sections. There is also the term midwife gets placed on individuals who are lay midwives I guess would be the best way to describe, where they don't have-- they're not licensed. They may or may not have had formal training in any way, but it's not recognized or regulated. And they, they work as a contract. Like a patient, they provide care and the patient pays them cash for this care. I recently had a patient that didn't have insurance, and so she was seeking this care out from that person. But this person, this patient got hospitalized because of a pneumonia in the middle of her pregnancy, and that's how I ended up seeing her. And there were a lot of things. She was well into her 40s. She likely had diabetes. She had to be counseled about a lot of the options about just normal antenatal interventions to assess for other health care, like health issues. And she had no idea what preeclampsia was when I brought it up for her, which she was really high risk of getting. And ultimately, she ended up-- she, she ended up delivering at home. But

she called into the office, my office, 13 hours, 14 hours later, and wanted to be seen because she had been delivered the night before and had a tear on her bottom that the midwife couldn't repair, which is just a really normal basic part of being able to provide obstetrical care. And when lacerations happen, if they are delayed, then sometimes we can't close them right away. And you have to let them heal by secondary intent, which may not be as ideal for structure and function later on. And so I was nervous about that. But when she came in, I was able to repair it for her in the office. But, you know, I didn't have the same anesthesia options or, you know, comfort care items that I would have available to her if we'd been on labor and delivery.

RIEPE: OK. Excuse me, could a tear be taken care of by remotely, by Virtual Incisions?

LIBBY CROCKETT: You know, I, I, I could see how a robot could do a perineal laceration. I'm not sure the technology is there yet to be able to remove a-- deliver a fetus via C-section, just because of the maneuvers that need to be present to do that. But maybe someday. Probably not in my lifetime, but maybe someday.

RIEPE: Everything's possible I guess.

LIBBY CROCKETT: Right. right. But I mean, he's talking about colorectal surgery, and a fourth degree repair is colorectal surgery.

RIEPE: OK. Thank you for being here.

HANSEN: Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here. So I, I have three children, all delivered by midwives in a hospital setting. They're nurse practitioners. And so hearing talking about the non nurse practitioner, I'm assuming midwifery. Is this-- I didn't even know that this was a, a thing in Nebraska that people were doing. I mean, I guess I shouldn't be completely surprised, but is there any medical training or is this--

LIBBY CROCKETT: There's no formal medical training.

M. CAVANAUGH: So is it more similar to like a doula?

LIBBY CROCKETT: I, I mean, I haven't-- I don't-- from what I'm seeing is that the, you know, what I know is what I've seen from co-- you know, patients that have come in with complications. And in general, they seem to be, the movement is people that have either like trained with other people doing this without a formal medical education, and then billing their services directly as cash payments to patients. I mean, I'm not seeing the uncomplicated things that are going without problem. I just see the major problems that come to me. And over the years I've seen a few things.

M. CAVANAUGH: So like the preeclampsia issue, they don't necessarily-- well they wouldn't have access to give them the screening for diabetes.

LIBBY CROCKETT: I'm-- I don't know what their-- yeah, this patient that I was taking care of had not had any labs done to screen for diabetes. She had her sister's glucometer, and so she knew about diabetes herself because of the family history and had been checking her own. But it was on her own volition and not part of recommended medical care.

M. CAVANAUGH: So, I'm not really sure how that can be addressed, but obviously there's a need for maternal care. Do you have thoughts on how we could more intentionally build up, sort of, practice.

LIBBY CROCKETT: Yeah, it's hard. I mean, I think, I think the fact that there aren't, you know, close geographical proximity places for people to get care opens the door for people to seek care through lay midwives for sure, which is really unfortunate. It's hard with obstetrical care, the nature of it. You know, it's not like orthopedics, where someone could fly into a rural area, see 30 people in a day, and then set up their surgeries for two weeks later, and come in with a team. I mean, it just-- the, the timetable is on a rolling basis. And so people's due dates and the and the points when complications come up are either unpredictable or not able to put them in the cohort together. I think it is, you know, also important that because of obstetrics getting more complicated, it's harder to maintain your skills. And so volume is really important. And I-- you know, I think that hit home when I talked to the physician on, you know, you know, they've managed to increase their volume over the years and they feel they're doing a good job up there. But I think looking at ways to work with, you know, outside of the box, is there

are ways to create obstetrical teams that could be employed in different places? What would that look like for funding? What would that look like for training? Is it possible? Is it possible-- you know, I think there is a lot of, you know, ability to, to create if you have people. So like in my practice, we cover two hospitals. And when that happens, then we need more people in town to be able to do everything safely. So we have only-- until we had a sixth person this year, we weren't able to even go do clinics in surrounding communities. But now we have-- we can go to Aurora and Central City. Because we have enough people, we feel like we can, we can cover the work that's happening in Grand Island while that person is seeing patients out of town, right? So I think it's just an understanding that this is going to require more people who are physician level trained, and certified nurse midwife trained, to be in communities, and creating better incentives to recruit, and also retain. I think, you know, it's-- when I look around at the people that stay in these areas or that are high quality, because sometimes we get people in, and they don't stay very long, and they may not, they may not be as high quality as other providers. It's people that grew up outstate in Nebraska, to be really honest, or married somebody in outstate Nebraska, or came to Nebraska and fell in love with it, and they're like, we're here. But it's not the people that are like, I just need a job. And so I do think many peo-- many of those like myself, made that decision many years before we were actually in medical school. And I think looking at those people much earlier on, I think first support is important.

M. CAVANAUGH: It, it seems like in a lot of the different health care desert areas that nurse practitioners are being utilized more, do you think that that's a good route to go down? I know the training obviously is not the same as a doctor, but is that working as part of a medical team? Do you think it's easier?

LIBBY CROCKETT: It's a, it's a great question. And there's certain-- certainly a role for nurse practitioners and PAs to work in medicine. From what I'm seeing is that we have really lost the incentive to retain high quality skilled career floor nurses in the hospital. And I don't know what that looks like. I don't work in hospital administration or-- and I very-- and most of them are women. So it is really important to me that women have opportunities to advance their careers. And I don't know how to reconcile this, but what I'm seeing is that a lot of people are going into nursing and doing floor nursing

for just a few years, so they're not having these 20 year experiences on the floor. Like when I started as a resident, like, I mean this-- that the skilled nursing of those nurses, I mean, you can't, you can't get it without all those years that they've done it on the floor, and we're losing it. And so it's, it's a lot of very young, very green nurses that just don't have quite the same history of experience. And then they move pretty quickly into graduate school programs, and then they're moving into clinical roles. And so we're, we're losing the shortage of people because of that access. And then I think a lot of those people were probably people who probably could have gone to medical school and had that higher level training, but they weren't supported. Like totally smart enough, right? But they weren't supported in the right ways up front to know that that was a viable career option for them. They were scared. They were told that you can't have a family, or whatever the situation is, right? And that goes also, you know, that pulls in child care issues in central Nebraska. That's all, that's all part of this. You can't pull them apart. And so I think that that's-- it's, it's like this whole systems wide issue, if that makes sense. And I certainly think, you know, they have an important role, but they can't be left out like-- they just can't be hung up. They can't be the only solution. Like the evidence is pretty clear that physician led health care teams have the best outcomes, right? And that doesn't mean no nurse practitioners. It just means that they have access to be able to have appropriate mentoring and support as they practice.

M. CAVANAUGH: OK. Thank you.

HANSEN: Senator Riepe.

RIEPE: Thank you, Chairman. Two things I wanted to point out. I, I think we hit the one answer that probably maybe solves rural health care, and that is marriage is the key to rural health care. Is that--

LIBBY CROCKETT: Marriage?

Unidentified: Marry a farmer.

LIBBY CROCKETT: Marry a farmer.

RIEPE: That's right. So I guess that was a smart aleck question on my part.

LIBBY CROCKETT: Well I didn't marry into it. I grew up out there.

RIEPE: And then you recruited your husband?

LIBBY CROCKETT: He grew up-- he grew up out there, too.

RIEPE: Oh, OK. OK. OK. Well, that's, that's good, that's very-- The one thing that I saw, and I would ask you to react to this, because in your testimony, you talked about you have a relationship with the Med Center with more high risk mothers, diabetics, forty years old, yada, yada, yada. And then the link is you also talked about you have then a link with rural, others. So it seems like this critical almost peer review support. You know, I, I have this issue, tell me. Because my own experience is solo practice is not a good place to be. And I don't know that it's much of it's going on anymore, but--

LIBBY CROCKETT: It's surprising, there are some practices that do. But I think it's just-- there's always people who can-- there's always that individual that will say, I can do this, and they'll charge through. But it's not a sustainable solution long term in the big picture, if that makes sense.

RIEPE: You'd better be married, right, to be able to pull that one off. The other one I-- a question if I can, Mr. Chairman, is on these certified midwives. Are they all required to have that formal relationship with a maternal OB/GYN?

LIBBY CROCKETT: And I believe they're--

RIEPE: Required?

LIBBY CROCKETT: required to have a practice partnership. They can actually practice independently in the state of Nebraska, I'm not-- it's been a while--

RIEPE: It's not a formal contract.

LIBBY CROCKETT: --looked at the licensure on this, or-- because I used to supervise midwives at the Med Center, but I haven't since I've been to Grand Island, so I haven't paid attention to that in years, so years. But I believe-- so some-- so somebody can correct me on that. But they have to have a relationship with a provider. But I think they can-- usually the recommendation that they need somebody who can

accept a patient for a cesarean section or an operative delivery. But I don't know what the actual legal requirements are on that.

RIEPE: The other thing, if I may, just as on a comment. I've, I've been in the hospital business long enought-- I lived through the time when we had nurses who were incredibly bright. And all of a sudden the opportunity opened up, as it should have. They were going to medical school at that point in time, they were going to law school, they were getting MBAs, and all of a sudden that tremendous resource was--

LIBBY CROCKETT: Yeah. We haven't--

RIEPE: --was void.

LIBBY CROCKETT: --opened up the opportunity for floor nursing to be really encouraged for younger men to go into. I think that that's-- you know, you, you see-- so I see more and more in some specialties, not typically OB/GYN, but not to-- I mean it's still a very highly prominently a female specialty. And so when you open up other career options for women, you know, it was always just nursing and teaching and maybe some other. But when, you know, tech is big, and they can go to medical school, and they can do, you know, an infinite number of other careers, of course, your, your job pool is declined.

RIEPE: Yeah. Thank you Mr. Chairman.

HANSEN: Let's have one quick question.

LIBBY CROCKETT: Yeah.

HANSEN: The example you gave of the non-certified nurse midwife. Seemed like a successful interaction between you two with the patient getting where they needed to be, the delivery seeming to be, not appropriate, but successful as well. And so in, in your, in your opinion, you know, as unconventional as it might be from a medical perspective, but you think in your opinion it would be a good idea, though, for those non certified nurse midwives, ones who are delivering at home to be certified or have some kind of formal training then?

LIBBY CROCKETT: I think that anybody delivering-- providing medical care should have formal training, and ha-- be like appropriately licensed.

HANSEN: OK.

LIBBY CROCKETT: I-- there is an incredible amount of luck sometimes that goes into this. And I always-- I, I don't-- I appreciate when every time when I know how bad something can go, and it goes smoothly. I am-- I'm not chalking that up to my skills. I'm chalking that up to we got very lucky. And so I also know what I can competently manage when we're not so lucky, when things don't go correctly, when-- for a myriad of reasons. And that's, that's the issue, is that in Nebraska the ability to facilitate transfer of care of patients to a hospital system is not the same as it is in Europe. You know, there are good studies out of the Netherlands where home births-- it looks great, but it's attended by licensed, well trained providers, and they have the infrastructure in their area to be able to get people quickly to a higher level of medical care. And I would also venture to guess the health of that population is probably different than what we're seeing in our population. And so I think you-- when we see those sorts of studies, you can't compare it to Nebraska because we just have a very different system. There was zero communication between that midwife and me. I actually do not even know her name becau-- I know it was a woman, but I don't know her name because the patient told me she had been expressly directed to not disclose that.

HANSEN: OK. From a personal opinion, do you view birth as a medical procedure?

LIBBY CROCKETT: I think because of the general health changing over time, there is a requirement for many births to have medical interventions. I do think that there are many people who are able to have low-- you know, that are low risk and have normal, healthy deliveries. But I think because of in Nebraska, the way our health systems are set up and geographical location, they still need to deliver in places of close proximity to acute care centers so that-- because you have minutes when a problem arises, you have minutes. And so if people can't recognize a problem early on because honestly, like with a hemorrhage, a lot of times you have to be on it before the ho-- before you even got into the blood [INAUDIBLE], you have to be intervening. And I even remember a conversation on a hospital thing

where they said, well the doctors are ordering medications for postpartum hemorrhage before we've even hit the diagnosis of postpartum hemorrhage. I'm like, you bet we are. I'm recognizing that the act of bleeding is happening, and I'm trying to prevent, number one, getting to a hemorrhage, and number two, preventing if that hemorrhage is occurring from being catastrophic. Even if people don't die. I mean, obviously, that seems like a pretty important marker. You know, an ICU stay. Any time separated from their baby, another-- you know, a blood transfusion. All of those levels of intervention create a harder time to recover, decreased time with their baby, increase hospital stays, and more, you know, more conditions like postpartum depression or higher rates of not being able to breastfeed. And so I think coming to it medically is really important to keep it low intervention, if that makes sense.

HANSEN: OK. Yeah. Well, I appreciate your perspective. Thank you very much. All right. Seeing no other questions. Thank you for coming. Appreciate it. All right. Next, Marty Fattig from the Nemaha County Hospital. Welcome.

MARTY FATTIG: Well, thank you, and good morning, Senator Hansen and members of the Health and Human Services Committee. My name is Marty Fattig, M-a-r-t-y, F as in Frank, a-t-t-i-g, and I am the CEO of Nemaha County Hospital in Auburn, Nebraska. I'm here at the request of Senator Riepe to share experiences I've had in my long career as a health care provider and administrator in several different communities across Nebraska. I am also, as was stated earlier, the Chairman of the Rural Health Advisory Commission, but I am not speaking on their behalf today. I have not been authorized to do that, to speak for them. So my comments are my own. I think that we realize that there are many issues related to the provision of emergency medical services across the state, including 911 responses as well as transfers from one acute care hospital to another. We had a prob-- a problem with getting a timely response from providers of transfer services in our area. So we have created a solution to at least part of that problem. Two of the local volunteer EMS providers in our county have become advanced life support licensed. The hospital has hired a team of paramedics, one of which is in our facility at all times. If we need to make a transfer, and none of the for profit services are available, we call one of the local services. They bring their ambulance. We provide the paramedic and the transfer is made. We do not charge the local EMS squad for the use of the paramedic,

allowing the local EMS squad to bill for the ALS transfer and retain the revenue, which improves their financial viability. We have had this model in place for a little over a year and it's worked quite well. When the paramedics are not making an EMS run, they provide excellent care in our emergency department in the hospital. If you visit with the leadership of any health care organization in the state, you will find the number one issue that is impacting them is lack of staff. This is a problem that has been increasing in intensity for a number of years, but it finally came to a head during the Covid 19 pandemic. Many providers simply left the profession during this time because of the stress and strain of caring for patients during this uncertain time. Many providers, especially nurses, were at or near retirement age, and they saw this as a good time to get out. We saw the same thing happen in our organization. We took this as an opportunity to invest in changing the culture of the organization to one where people want to work and never leave. We also want to be able to attract providers from other hospitals because of the culture we have established. We still struggle with staffing but to a lesser degree than we did before investing in this culture. In fact, we have had agency nurses enjoy working in our facility so much that they have decided to quit traveling and work for us full time. There are other issues impacting the viability of rural hospitals across the state of Nebraska, such as Medicare, Medicare Advantage, prior authorization, Medicaid, 340B, increased regulatory requirements, rural emergency hospitals, and others. I could talk about these for hours, but I would rather spend time talking about the issues that you are interested in by responding to your questions. The future of the state depends on maintaining the viability of rural hospitals across the state, and the solutions will vary from community to community. I am of the opinion that strong rural hospitals depend on vibrant rural communities and vice versa. Anything that helps the economic growth of the rural community will help the hospital. And anything that helps the hospital will have an economic impact on that rural community. Thanks for your interest in rural health care, and I'm more than ready to answer your questions if I am able to do so.

HANSEN: Well, thanks for making it here.

MARTY FATTIG: Thank you.

HANSEN: Let's see if there are any questions from the committee at all. Senator Riepe.

RIEPE: Thank you, Chairman. Good to see you again. Thank you for being here very much. Does the county provide any financial support on your rescues effort?

MARTY FATTIG: They do not.

RIEPE: They do not.

MARTY FATTIG: They do not.

RIEPE: OK. So it-- then it becomes somewhat of a subsidy for the hospital, if you will?

MARTY FATTIG: The providing of the paramedic is the-- is a, is a subsidy, yes. Well, it's a, it's quite a cost that we employ those paramedics. But we but we realize the importance of it in the grand scheme of things, in the delivery of health care.

RIEPE: I guess that goes, I guess, to my next question is, can this serve as a model to other critical access hospitals across the state? And when you said significant cost, that puts it in jeopardy just with that statement alone, I guess.

MARTY FATTIG: It does. There are some ways that you can recoup part of that cost of having paramedics in your hospital through the Medicare cost report. I won't get into a discussion of that because that is a complicated thing that could really get us down a rabbit hole. And I don't think any of us want to go there. But we recoup a certain percentage of, of their salary for when they're working in the hospital. When they are out of the hospital, on an ambulance run, those-- the cost of those services are not covered by it.

RIEPE: So you keep very strict records, it sounds like.

MARTY FATTIG: Yeah, you have to. You have to do time studies and make sure that when, when people check out, you know, of, of whether they're working in the emergency department or outside the facility on an ambulance run.

RIEPE: Do you have an auxiliary in your hospital?

MARTY FATTIG: You know, we do not. We had one and I think they all got too old.

RIEPE: That happens.

MARTY FATTIG: And young, and young women are busy. And, you know, it's a different mindset that young people don't volunteer like the older ones did. And, and it's something that we haven't pursued at this time. Probably to-- we probably should. That's probably something we have been negligent in doing.

RIEPE: Ok. Thank you, Mr. Chairman.

HANSEN: Senator Walz.

WALZ: Thank you. Thanks for coming today. You know, you mentioned something in your testimony that said I'm of the opinion that strong rural hospitals depend on vibrant local communities and vice versa. So I got to thinking, how much involvement, or is there a lot of involvement with health care systems in economic development when it comes up to the local level and the state level? And do you feel that that's a viable or a good collaborative effort, or should it be more?

MARTY FATTIG: I, I-- thank you for the question. And yes, everywhere that I have seen strong rural hospitals with strong rural leadership, those people are involved in economic development at the community level, doing everything they can to attract those people to their community. What really kills a lot of rural hospitals, especially in western Nebraska, is depopulation.

WALZ: Yeah.

MARTY FATTIG: There's just nobody there to take care of anymore. So, you know, that's important. The other thing that I will state that I didn't put in my testimony that I have never seen a strong rural hospital without a really strong medical staff. You have to have good doctors. I have not yet admitted a patient to the hospital ever, and never will. But the doctors do. And so that's very important as well. But economic development is so interlinked between the hospital and, and, and the rural community. In fact, I have seen rural communities that have-- that had a hospital that wasn't a, a county hospital that would help refurbish homes in the community so that staff had a place to stay. You know, we can't do that as a county hospital. But if you

are a private corporation, absolutely. And they, they do it and they have been very successful at it in various communities.

WALZ: Thank you.

HANSEN: Senator Riepe.

RIEPE: I thank you, Chairman. I'm Curious George. I'd like to-- Tell me a little bit about like, what-- do you as a-- the hospital in your community find that at times you have patients that might come there from the nursing home, but there's no place to move them out to. So at that point in time, I assume you can put that in on your Medicare cost report. But do they in fact or-- I see you saying no.

MARTY FATTIG: Yeah it's, it's, it's a slippery slope.

RIEPE: And Medicare Advantage plans are probably not interested in that at all.

MARTY FATTIG: They're not and that's the problem. You know you get these patients that come to your hospital, and, and Medicare Advantage will not pay the long term care facility for taking care of them because they require too much care. You know, they're, they're at that level. And so, you know, the Medicare Advantage plan won't pay. And of course, the family doesn't have any funds. And so the patient sits in your facility for several days. This is something the Hospital Association's been working on for a number of years and trying to get some, some relief for that, for this problem. It, It's a-- it is really critical, especially with the decrease in nursing homes in the state of Nebraska than has really happened in recent years.

RIEPE: All of it seems to be interlocked, you know, across the board.

MARTY FATTIG: You know, it is. It really is. You know, and I think the medical, I think the maternity deserts are all interlocked with this as well. I think the decrease in population is, is why some of those doctors in rural communities don't take care of-- do-- don't do maternity care anymore. The number of young women in their communities has decreased to the point that these physicians don't feel like they can maintain their skills, and they do not want to do-- have a bad outcome for, for a number of reasons. But when you have a bad outcome

in a rural community, everybody knows about it. And it, it's a, it's-- it just compounds the problem.

RIEPE: As an observation, because you talked about the critical importance, which we all agree with, physicians are a pivotal role here. What's-- without necessarily statistics, what's your observation about the aging of physicians across the state?

MARTY FATTIG: It's a real problem. It's a, it's a problem. And, and, you know, a physician, aging of physicians, aging of dentists is a real problem across the state. Aging of pharmacists in rural communities is a huge issue across the state. All these things are interlinked and tend to make, you know, a vibrant medical community happen, and that is to have all the pieces of the puzzle, you know, on the table and without it, we're in trouble.

RIEPE: OK. Thank you, Mr. Chairman.

HANSEN: I, I had a question-- Oh.. Sorry. Go ahead, Senator Cavanaugh.

M. CAVANAUGH: That's OK.

HANSEN: Just making sure I get it right. OK.

M. CAVANAUGH: So the aging we're hearing, this is kind of a lot, the aging of the physicians. But I, I don't know if this is true or not, but has the enrollment in medical school gone down? Is it just that we we still have people entering the health care field, but they're not coming to these communities any longer?

MARTY FATTIG: Yeah. The, the, the rural communities are not attractive to very many people other than rural people. As, as a member of the Rural Health Advisory Commission, we, you know, we have, we have loan repayment programs that we will help pay off the student loans of a physician if they come to a state designated medically underserved area. And we've been really successful in, in maintaining those people in rural Nebraska. But if you look at the resumes of those people that apply for that program, a lot of those are rural people in the first place. You know, there are some people in a federal program that come to these rural communities and stay three years and, and they split for the city. But, but the people that grew up rural tend to stay. And the way we have the loan repayments program structured, it behooves the local community to make sure this new physician fits in and

becomes a part of the community, and is, and is well accepted there. And I think that's part of the success of the program.

M. CAVANAUGH: So when you have physicians come to the community that don't stay, is there any sort of evaluation as to why they didn't want to stay in the community?

MARTY FATTIG: There is, but it's generally-- they generally give you pretty vague answers. You know, my wife wants to be near the shopping mall, you know?

M. CAVANAUGH: Yeah. OK. I, I just-- I have-- well, you probably know them, because there's not that many, but my aunt and uncle are physicians out in Hooker County.

MARTY FATTIG: Oh, good.

M. CAVANAUGH: And they are very much a part of the aging population, because I believe they are in their 70s now. And so I, I see firsthand this problem and they have had to shut down the nursing home there. And, and now they-- my aunt is retired and my uncle's still working in North Platte part time. But, you know, that's-- they've been it for decades, and so--

MARTY FATTIG: Well, I grew up in Wallace, and then 35 miles north of North Platte on a ranch, so, I'm very aware of those areas.

M. CAVANAUGH: Yes. And he, he did, my uncle did what the other doctor was suggesting. He married a woman from Omaha and brought her to the rural community.

RIEPE: Marriage.

M. CAVANAUGH: They-- yeah, marriage. And they met at UNMC, so.

MARTY FATTIG: We try to do that with our nurses, get them, get them going out with a farmer so, because they can't move ground. So they're going to stay if we get them married to a farmer.

M. CAVANAUGH: That's right. Well, thank you very much.

MARTY FATTIG: Certainly.

HANSEN: I'm going to brag about my district for a second. Because I, I, I've done a couple of tours of the Franciscan Hospital in West Point.

MARTY FATTIG: They're wonderful.

HANSEN: And they seem like they have a good relationship, when you're talking about that public private partnership and the relationship they have with the community and a strong, vibrant community, I think they've done a really good job, I think from my perspective. Maybe I'm wrong, but about being able to provide quality health care in a smaller kind of setting, either because they were forced to because other areas were closing, or they just took up the mantle and did it themselves. But I think they've done a really good job.

MARTY FATTIG: I've known, I've known the, the CEO administrators from, from West Point for a number of years. And, you know, when Ron was there, Briggs, he was, he was absolutely wonderful and a, and a community asset, even if he wouldn't have been a hospital leader. And, you know, and Tyler's has carried that, that on. He sees the value in that. So, yes, they've done a great job.

HANSEN: And, and from your-- in your opinion, do you think one of the other reasons maybe why some physicians aren't in rural areas or willing to see maybe a limited amount of patients is maybe because of malpractice insurance, or tort reform?

MARTY FATTIG: That's always an issue. That's always an issue.

HANSEN: Because that's a pretty big cost sometimes, and you know, if they're unable to afford that, I know that might be a reason why they go to a more centralized location.

MARTY FATTIG: It is. We are, you know, we are fortunate in Nebraska to have a cap, which helps. But it's still-- malpractice insurance is a, is a huge problem. That is not why Auburn physicians chose to not practice, not do maternity care any longer. But it, I mean it certainly weighs heavily on the profession overall.

HANSEN: Sure. OK. And, and, and one more thing. This may be my last time as Chair of HHS, so I have no problem talking about two or three

hours on Medicare cost analysis on it. But the rest of the committee might not appreciate that, so I'll hold off. Senator Riepe.

RIEPE: I have a question. Many times in more rural markets your payer mix is very critical to the hospital business. So oftentimes those with better insurance and more financial resources are more inclined to travel to maybe to Kearney, or to some bigger market. Do you see that, not just at your hospital, is that part of the problem, too? Because a lot of times the people with poorer insurance or no insurance don't have that luxury or opportunity.

MARTY FATTIG: You know, I find that as-- thank you for that question, by the way, because that's very important. There is a lot of outmigration from any rural community. You know, the, the, the grocery store in Lincoln has better produce than the grocery store in Auburn. And, and, you know, and the restaurant in, in Omaha is much better than the restaurant in, in West Point. And there's always this feeling that the bigger one's better. And that's why it is so important for rural hospitals to to market themselves and, you know, and show that they are every bit as good, if not better, as long as they stay within their scope of practice. They got to tend to what they're good at and not try and venture off into something where they'll get in trouble. But as long as they tend to take care of what they're good at, they're every bit as good as, as a big hospital at taking care of, of those patients. And probably better because we know them personally. You know, we go to church with them, we see them in the grocery store. And, and, you know, they're their personal friends. I mean, we, we, we give them personalized care.

RIEPE: In the past, primary care practitioners at one time became more-- they gave up, in my opinion, too much. They ended up being triage centers. And all of a sudden, I think, training programs are now going back and trying to do more-- have them do more, and maybe we'll hear something about that, too, but even to the point of doing deliveries and, and doing other things that they are more engaged in, not just simply sending patients to specialists. I also would ask, now we're building up Kearney. I hate to pick on one town here, but to be this hub of what I call little U.N. Med Center. Now, is that an advantage, or is that drawing off business from more rural hospitals? So is it-- or maybe it's both. Some, some advantage to it, but it also has some disadvantages.

MARTY FATTIG: I think it depends-- a great question. I think it depends on which hat you're wearing. You know, if you're looking at education, I think having educational programs available in rural areas, and Kearney is about as, as-- I mean, that was a big city when I was growing up. But, but, you know, having people educated in rural Nebraska is far better than having moving them all to Omaha. You know, there's statistics that show that most people, you know, practice, continue their practice within about 78-- 70 to 100 miles of where they got their last education. So if they're educated in Omaha, you know, they'll probably prac-- they have a-- tend to practice in Omaha. And if they, if they're educated in Omaha and marry an Omaha girl--

RIEPE: Or boy.

MARTY FATTIG: Yeah, a big, big chance that they're going to stay in Omaha. But if we can get them in western Nebraska, even for, you know, a short period of time and show them what it's all about. The quality of life is, is what we have to offer. And that's, that's very important, especially if we can help pay off their student loan.

RIEPE: Yeah. Good point. Thank you, Mr. Chairman.

HANSEN: All right. Seeing no other questions, thank you for coming.

MARTY FATTIG: Thank you. Appreciate it.

HANSEN: Thank you.

MARTY FATTIG: And I appreciate your interest in rural health care. It is so, to me, so refreshing to see urban centers interested in rural health care. I appreciate that very much.

HANSEN: Thank you.

RIEPE: Thank you.

HANSEN: All right, Dr. Gerald Luckey with NMA. Welcome.

GERALD LUCKEY: Thank you. Chair Hansen and members of the committee, thanks for having us. My name is Gerald Luckey, G-e-r-a-l-d L-u-c-k-e-y. I'm a retired family physician from David City, and a member of the Nebraska Medical Association's primary Care Deserts Task Force. I'm testifying today on behalf of the Nebraska Medical

Association, which represents approximately 3,000 physicians, residents, and medical students in Nebraska. And we'd like to thank Senator Riepe, who's been a friend of medicine for many years, for introducing this study, and for a strong interest in the issue in rural health care. NMA shares Senator Riepe's concerns about access to quality care in all areas of Nebraska. In February of 2024, the NMA Board of Directors formed a Primary Care Deserts Task Force based on a resolution brought forward by Dr. Todd Pancratz, who was a former NMA president, and current OBGYN physician in Hastings and Grand Island. At that time, Dr. Pancratz had determined that his practice was providing maternal care to patients from 58 counties, some of which I believe are also in Kansas. This statistic from one practice highlights the shortage of primary and maternal care providers in parts of Nebraska. Now, the aggregate data paints a similarly starting picture, and the aggregate data that we're talking about here is from the Centers for Public Affairs Research, done by UNO and funded by UNMC. Between 2017 and 2023, Nebraska lost 57 primary care physicians, including 41 family medicine doctors. The state of Nebraska has designated all counties except Douglas and Lancaster as shortage areas for at least one type of primary care specialty. We define primary care as family medicine, pediatrics, general internal medicine, and obstetrics, OB/GYN. For example, 25 out of 93 counties are designated shortage areas for family physicians. Aside from Scottsbluff and Dawes Counties, most western and central Nebraska counties either have no primary care physicians, or have a low number of primary care physicians relative to hosp-- relative to population size. As a reminder, Dawes County would include Lexington and the Gothenburg and Cozad. While the total number of physicians in Nebraska had is projected to increase 19% by 2030, the total number of primary care physicians is projected to decrease by 9% during that same time interval. In Nebraska, 51% of counties are defined as maternity care deserts. A maternity care desert is any county without a hospital or birth center offering obstetric care, or without any obstetrician providers. And I think Dr. Crockett addressed that. 15.9% of women have no birthing hospital within 30 minutes. And the problem is getting worse. In 2017, Nebraska had 54 birthing facilities. By January of '24, that number had shrunk to 46. Seven Critical Access hospitals have discontinued OB services since 2020. Fewer than half the counties in Nebraska have maternity services available. When it comes to maternal care, we know that decreased access results in delayed prenatal care, which means delay in pregnancy induced

hypertension, gestational diabetes, drug use, drug misuse I should say, mental health issues, alcohol, tobacco use, increased pregnancy related hospitalizations and the like. Consequently, beyond the effects of the mother, this results in premature births, premature births being that prior to 37 weeks. Pre-- prematurity is the number one cause of infant mortality. The goal of the NMA Primary Care Deserts Task Force is to better understand the underlying issues that have led to care deserts in our state, and to identify strategies to address the problem. We began the process earlier this year by identifying and meeting with stakeholders, and we want all the stakeholders involved in this effort. To date, we've had meetings with UNMC and Creighton Medical schools, the Nebraska Academy of Family Physicians, College of Public Health, Nebraska Hospital Association, and the state's chief medical officer, Dr. Tim Tesmer.

HANSEN: Dr. Luckey?

GERALD LUCKEY: Yes.

HANSEN: Sorry, the red light went off. So we'll wrap up our thoughts--

GERALD LUCKEY: OK.

HANSEN: --just briefly. I know you've got quite a bit left here, so--

GERALD LUCKEY: I'm sorry. Solutions. Collaboration. The concept of a maternal care team in rural areas. Let, let's say, let's say Hebron and Geneva, a maternal care team to, to deal with those two hospitals. The new one. Improve data collection. Enhance reimbursement. Most, most people feel that physicians aren't under reimbursed, but, but enhance reimbursement for doing obstetrical care. We need to promote family medicine in our medical students, family medicine and primary care. And then working-- we're looking at potentially a one year family, or one year obstetrics fellowship in obstetrics for family medicine residents after completing their residency. Whether this is feasible or not, there's a lot going into this. Now the final thing would be to recruit from rural. We know that rural people go into rural. And then I would also add train for rural. So basically the, the problem here is multifactorial, the solutions are multifactorial. We don't have all the answers, but we're trying to find them. Thank you.

HANSEN: Thank you. And thanks for providing some of those recommendations. It's nice to see them actual listed out, and, and good clear recommendations as opposed to, you know, we hope this will happen and this-- can you do this for us? So it's nice to see that written out.

GERALD LUCKEY: Well, I concur with a lot of what Dr. Crockett has said here. And then a lot of this testimony has been, I think, very, very helpful.

HANSEN: Thank you. Any questions in the committee? Senator Riepe.

RIEPE: Thank you for being here. I want to follow up a little bit. You talked like, it sounded like one additional year of training.

RIEPE: Yes.

RIEPE: And I assume that to make that happen, it's going to take some money because--

GERALD LUCKEY: Not very much. We wouldn't necessarily get graduate, graduate medical education funds for that because it doesn't result in a board certification in obstetrics. And in talking with the dean at the Medical Center, he thought that that would be workable without those additional funds, and we, we don't need to into that now, but it-- I would say--

RIEPE: Thank you. I, I appreciate that thought. Thank you, Chairman.

HANSEN: Yes. Any other questions from the committee? Seeing none, thank you for coming. Appreciate it. All right. Last but not least, Dr. Jeff Meyer with UNMC. We saved the best for last.

KYLE MEYER: You'd better wait before you submit that declaration. One small correction. Chairperson Hansen, Senator Riepe, thank you and members of the committee, thank you for inviting me. It's actually Kyle Meyer. There was a little confusion in the transcription, so K-y-l-e M-e-y-e-r. I have the privilege of serving as a dean and an assistant vice chancellor for Healthcare Workforce Development at UNMC, and I'm here to testify today on behalf of UNMC and the University system.

HANSEN: Thank you.

KYLE MEYER: Thank you. My comments will-- we've had some wonderful discussion about health care systems, delivery models. My comments will focus largely on workforce preparation, particularly pre, pre licensure. The new Douglas A. Kristensen Rural Health Education Complex on the UNK campus has been a transformative investment in our state's health care future. The second building is set to open in early 2026, and then the complex will provide over 150,000 square feet of exemplary learning space for eight allied health professions: nursing, medicine, pharmacy, and public health. UNMC projects the enrollment in those two facilities to reach 750 learners across those five colleges by 2030. That expansion was supported by the state and built upon the success of the first health science education complex, which opened in 2015. In just ten years, that complex has achieved a combined annual enrollment of 355 students in multiple nursing and allied health programs, and produced 863 graduates. That's just over 6% of all of the UNMC graduates for the same time period. Despite this early success, challenges and disparities remain, as we've heard today, in creating a sustainable rural health care workforce. In 2023, 83% of our health practitioners were concentrated in metropolitan areas, serving approximately 65% of our population. Conversely, 35% of the population relied on just 17% of health professionals. To address this disparity and continue to build a sustainable rural health care workforce across all of the professions, UNMC proposes several key strategies. I've listed them for you in the testimony in no particular order, but I'll review them briefly. Inform and inspire students throughout early primary and secondary education about health care careers through collaborative outreach with UNMC, area health education centers, UNL extension offices, and community hospitals and schools. Continue to develop and deploy the free online health science e-learning modules known as uBEATS for students in grades six through twelve. Just this year alone, there are 35,000 students engaged in those e-learning modules nationwide. Expand pathway programs and enhance scholarship and loan repayment, particularly given what we know will be the decline in high school graduates over the coming decades. Expand the preceptor network through our rural communities by implementing innovative incentives such as continuing education credits and tax benefits. Implement community based recruitment strategies, some of my colleagues have spoken about that today, that focus on increasing the number of residency position, and placing

entire health care teams rather than individual professionals or providers in selected areas. Actively monitor regional workforce data and wages to maintain our ability to recruit and retain skilled health care professionals and limit domestic migration of the workforce that we train here in Nebraska. Continue to strengthen infrastructure to support education, professional development in rural areas, including broadband, affordable housing and transportation. And we appreciate and ask the continued investment in the over $2 billion health care facility at UNMC in Omaha, known as Project Health. That public-private partnership between UNMC, Nebraska Medicine, the philanthropic community will help build the state's health care workforce through class size and residency expansion and clinical training for specialty areas not available in rural communities. UNMC is committed to partnering with the legislature and our health care systems in rural communities to implement these strategies and ensure that the Kristensen complex reaches its full potential as a catalyst for the development and sustainability of a rural health care workforce. Thank you for the opportunity and thank you for doing this study.

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

WALZ: I just have a quick question. I was wondering, and I didn't hear about this Building Excellence in Academics Through STEM, and that's pretty cool. Is that-- are those credits? Do kids get credits for those curr-- OK [INAUDIBLE].

KYLE MEYER: It's a partnership between UNMC and UNO. [INAUDIBLE] if you read the whole UB title, it's part of that. UNO and UNMC Building Excellence. So your comment but-- so that is a partnership. The health science teachers from the high schools can access that information and then use that in their courses and curriculum. So it is both science content, and it is also exposure to health-- there are modules about exposing students to health care careers, different across the different kind of health care career.

WALZ: OK, great. Thank you.

KYLE MEYER: Very exciting, you're welcome.

WALZ: That is.

HANSEN: Senator Hardin.

HARDIN: We appreciate the partnership with UNMC in Scottsbluff. And you all get to have the finest view anywhere in Nebraska from the new conference room window from that second floor building, so-- But we're very excited about your involvement there. Thank you.

KYLE MEYER: May I-- you didn't ask, but may I just extrapolate a moment, because Senator Riepe asked something about that earlier. The focus is in Kearney, based on the long standing relationship between UNK in the, in the early building and the second building. But it is certainly not the intent. That is the hub and the critical mass for educating students. But as you know, the College of Nursing has five different divisions, one being in Scottsbluff across the state. And certainly the goal of this expansion is to increase the preceptor network so that we are using all of the rural communities across the state to train all of these different students. So if you don't mind me using that opening, just to comment on Senator Reipe's earlier remark.

HARDIN: That's wonderful. And if I can just kind of jump on that. Would you be willing to prognosticate for us? We've been hearing for the course of the last year, two years we're looking at a shortage of RNs of about 5,400 come January 1st, 2025. So we have just a few days left to make all of that up, it sounds like. Can you tell us a little bit about what that looks like from your perspective for those RNs for Nebraska leaning into 2025?

KYLE MEYER: I'm not the dean of the College of Nursing, I'll preface by saying, so I'll speak on their behalf. But one of the things that nursing has done, I cannot tell you this how the gap is short-- if the gap has closed. I do know that the College of Nursing has increased their enrollment. They are actually going to two times a year enrollment for their BSN program. So it used to be, you know, a typical August start date. Beginning this year, they're going to enroll a second class in January. So they will have rolling admissions two times a year as opposed to one, in part to, to address that. And they are expanding their work and their number of students in Kearney as are Allied Health-- Nursing and Allied Health have been in Kearney for a number of years, since 2015. Medicine will be there beginning in

2026, college of Medicine. Pharmacy will start fall of '25. So there are efforts underway. You're welcome.

HANSEN: In your opinion, how has the RHOP program worked?

KYLE MEYER: I think--

HANSEN: Successfully?

KYLE MEYER: Yeah, I think so. I would say that's true. in fact if I have some-- I had some data in front of me. I have a little bit of data about the RHOP program. I won't belabor, but the answer is that I have several answers for you. I think it has worked well for the reasons that have gone before. We've recruit students from rural communities. We've expanded the number of state colleges involved. You may recall when it started in the early '90s, it was Chadron State only. Wayne State was added in 2008, Peru in 2015, if my memory serves me. So we are now partnering with the state colleges across the system. University of Nebraska Kearney has entered a model, a similar program, a mirror program, Kearney--

HANSEN: Kearney HOP?

KYLE MEYER: Lots of HOPs. Yeah, everybody's got a HOP. And so I think that there's been about 860ish, if my memory serves me. I may have that written down here. Hold on one second, I'll look. Since 1992, 842 HOP graduates across the ten entry level health professions and two residency programs. What I don't know is medicine added something they call you UHOP, with UNO about five years ago. So there haven't been a whole lot of graduates. So I don't know how many that 862 might be those urban students. Not that many. 360 of those students, that's about 43%, are serving in Nebraska. So I'd say that I think that the program has been successful. The-- and the, and the state colleges and UNMC have partnered to do some good things in terms of-- you know, those students identify themselves out of high school and make a selection for their profession. And, you know, how many things can change between when you're 17 or 18 and when you-- so they have done some, some good work in terms of addressing strategies at the undergraduate level for alternates to making sure that those positions stay filled. And those students are often then educated to the lots of the prior discussion, in rural communities. They come from rural

communities, and then much of their clinical education for the experiential learning is done in rural communities.

HANSEN: That seems to have been, been a common theme among the testifiers is that if somebody comes from a rural setting, they're much more likely to return to a rural setting--

KYLE MEYER: Typ, yeah.

HANSEN: --when they do graduate, which I think is a whole, you know, the reason for the RHOP program, I think, is to get those kind of students into health care settings.

KYLE MEYER: Could not agree more. And the expansion to Kearney to have a, you know, whether you believe Kearney's a big city or not, but at least in the central part of the state, so that we can have more of a hub there to access our rural communities. We are working diligently, trying to increase the number of preceptors, hospital based systems, provi-- private practice providers so that we can move the-- all students who have the experiential part through rural communities. And think about, like my view of the, of the experiential learning for all health care students in rural communities is to think about it in the ways that some other folks have talked, smaller private practice, small community practice opportunities, critical access hospitals in larger communities, regional medical centers, right? So that they can see the differences in care there, but also the delivery models, but still within the continuity of our rural system.

HANSEN: If I can ask you kind of an odd question, I should have asked Dr. Luckey this before and I apologize.

KYLE MEYER: I'll ask Dr. Luckey.

HANSEN: This, this, this, yeah. This is I think in his testimony, one of the stats he brought up is that that we will see increase in physicians in the state of Nebraska, but that we might expect a decrease in primary care physicians. And I'm assuming those are more kind of specialty physicians that we're talking about, where like we're talking about physicians as a whole, like more of a specialty?

KYLE MEYER: Increasing in number, correct?

HANSEN: Yes. Yeah, I would assume so. Why is that? Is it because of our overreliance on, I think Senator Riepe even touched on this earlier about our overreliance on specialty physicians to refer somebody to as opposed to primary care physicians. Is that an insurance thing, or is that just the way the direction of health care has been over the years?

KYLE MEYER: I'll give you my understa-- I, I am not a physician, so Dr. Luckey or any of my colleagues can respond. One of the-- one reason is medical school debt. You don't make as much money as a primary care physician as perhaps you would make in a specialty area. And so depending on the volume or the level of debt, it's obviously choice, you know, lifestyle, location. But there is something I have read and heard about that is an issue for getting people to go into primary care is if they have su-- you know, substantial debt to repay, you don't make as much money.

HANSEN: OK. That makes sense. Yeah.

KYLE MEYER: Doctor Luckey, I don't think, is it a---

GERALD LUCKEY: I-- you know, there there's many factors. Work life balance.

KYLE MEYER: Certainly.

GERALD LUCKEY: Administrative [INAUDIBLE]. Keeping, keeping on top of a wide range of things, you know, their comprehensiveness versus a partial [INAUDIBLE]. And, and I don't think we have a culture that promotes primary care and family medicine in medical schools, I think we need to change that culture.

KYLE MEYER: With the breath-- with the responsibility--

HANSEN: Even though that may not be in the transcripts, because we couldn't hear with the microphones, I agree. So. All right. OK. Any other questions from the committee? Senator Hardin.

HARDIN: A comment. This last year, I was approached by a neurologist from that other university in Omaha, at Creighton, and they brought up an interesting challenge that's going on across Nebraska. And I thought I might just lay this at your feet and we can listen to your wisdom on it. And I've been trying to help them through the department

and so forth. The challenge is we have a rut in the road where we train students in specialties from other parts of the world. It's a visa related question. So they come in, they complete it. And we have a real shortage, in my opinion, of J-1 visas in Nebraska. By my own guess, from my own organization that I'm CEO of, we tend to do a lot of work with businesses and so forth. If in fact visas were related to numeric supply and were commensurate to that, Nebraska should probably have between 1,700 and 1,800 J-1 visas a year. We literally process about 299. That has everything to do with someone who's trained as a neurologist, and we sure train them in Nebraska, at UNMC and at Creighton. But whether it's neurology or any other kind of ology, they tend to leave us because then their status changes from a visa perspective and they go trotting off to some other state that has a wider funnel capacity for accepting more of those J-1 visas. So what I'm doing is just a simple plea out there to the educational world and wherever else we can. We've literally reached in to the Secretary of state federally to try and get some help on these allocations to see what we might do. But wondered if you all might have seen some of the same kinds of challenges where we certainly can train these wonderful folks from wherever they may come, and they might stay in rural Nebraska. For example. Mel McNea did a wonderful job of-- in Scottsbluff of bringing the first neurologist west of Grand Island, I think, in more than 15 years or something like that. And so-- and that was a person from another country. And so we were able to claw them back, if you will. And so I wondered if you have seen the same type of thing where we train them and lose them to other states. I understand that Iowa actually has gobbled up a number of our neurologists, which could be cause for border war, I'm just saying that, and what happened a week ago on Friday. But anyway, I wanted to get your thoughts on that.

KYLE MEYER: I might, I might have more thoughts on the football game than on that topic, Senator, I'm sorry. I know very little about that. I, I-- in terms of accepting international students, I, I, I don't know the answer. If there-- if those individuals, are you're speaking about graduate medical education, or bringing foreign trained physicians--

HANSEN: Tends to be those who are graduating, whose then status changes from an educational visa over to now being professionals who

can stay in the country. And just wondered if you had seen anything related to that at UNMC.

KYLE MEYER: I'm sure there is. I have not. I apologize that I cannot comment. I can do some more legwork and get back to you, though. I'm happy to do that.

HANSEN: It might be--

KYLE MEYER: Or at least investigate on my own.

HANSEN: It might be a way of retaining more of what we can call a Nebraska product.

KYLE MEYER: Appreciate that. Thank you.

HANSEN: Seeing no other questions, thank you very much.

KYLE MEYER: You're welcome. Thank you.

HANSEN: And we will welcome Senator Riepe back up to close.

RIEPE: Thank you, Chairman Hansen. I very much appreciate on a cold day of you showing up, and all the committee members showing up with staff as well, along with all of our testifiers. I truly do appreciate, and I think it was very informative, if you will. I also want to again thank Gerald Fraas for, Fraas for all of his work, hard work on this. He deserves a lot of credit and I want to make sure he gets that. I think one of the things that we didn't talk about is deserts is in dental care, and particularly for children. It's a major issue in this state. And I know the dental school here has 60 slots, and they can't expand without further structure development because they would lose their accreditation. So it's a Catch 22, if you will. I also would like to, to say, you know, on a personal note, I have extreme interest in scope of practice. I think we need to take a hard look at it. I intend to do that, whether that will result in legislation or not. But I think it's a long overdue evaluation of it, at least because in some cases, what works for urban in the scope does not work, or it could be maybe be more effective out of state. Ophthalmology and optometry become one of the primary hot issues, if you will, between the urban and rural. I would also like to say that I think the only way that we're going to solve this is much like they say, eating an elephant. You-- to do that, you have to take it one

bite at a time. So this is not going to be an overnight cure. We've been at it a long time, and we're going to be at it for into the future for some time, too. But-- and hopefully we can learn from other states and other communities, and within our state learning from what Marty is able to do and maybe take that to other communities, if you will, and that we will have the ability and the willpower to, to find financing that it takes for some Medicaid at times or other programs. I also would like to acknowledge that-- or share the, the written report of the-- we're putting this together, and that will be distributed to all of you and to all of the senators, not just those here on the committee. And we will also make it a point that all of the people that have testified today, to give them a copy, I'm sure they're looking for some exciting reading. And so we'll make sure that they have that. If there are others here that did not testify who would like to have a copy of that, if you would give us your name, we will make sure that we put that in an envelope and put the stamp on it and get it to you. And with it again, thank you, sir. Thank you very much. And all the committee members and for everyone that's been here this morning, I appreciate it very much. Thank you. Any questions?

HANSEN: Thank you.

RIEPE: Thank you.

HANSEN: Senator Walz and myself might know a little bit about pediatric dentistry--

WALZ: Yeah.

HANSEN: --and our frustrations with that, but. Seeing no questions, thank you, Senator Riepe, and that'll close our hearing today for LR338.