HARDIN: Welcome to the Health and Human Services Committee. I'm Senator Brian Hardin, representing Legislative District 48, and I serve as chair of the committee. The committee will take up the bills-- just kidding. We're going to take up the gubernatorial appointments in the order posted. Did you all get a post in terms of what order you're to be in? I'm seeing a shake of the nod of the head. OK, good, because I would feel terrible if we all looked at each other in a little bit. As you're planning to testify today, please come up and-- what we need to have you do is make sure, whether you've got in your script or not, spell your name, first and last, OK? Because that just helps us to make sure that we transcribe it correctly into the record. And then, give us your testimony in terms of your-- what, what you're trying to do in this process, with these appointments. Then, what's going to happen is these people up here might ask you questions. They'll be really hard ones. OK? I'll ask the easy ones. And so anyway, there, there may be questions; there may not. And so, if you see people coming and going, that's part of our process because we have to go, and we are still presenting bills. Today we're doing appointments, but other committees are still doing bills, and we're the ones that are presenting those bills. So, when you see people come and go, it's not that you're not important; you are. They're just having to be somewhere else to do the same type of thing. And so, when you do come up, hopefully you've got a dozen copies of your testimony. And hand that to the page, they'll pass them out. If you don't happen to have that, hand it to the page, beg them, "pretty please," and maybe they can go make you some copies. OK? And so, pass those around. I would like to introduce some of my friends to you. Can I do that? Senator Riepe is over here, and each of them will introduce themselves.

RIEPE: Thank you, Chairman. I'm Merv Riepe. I represent Omaha, the Millard district, and the city of Ralston.

HANSEN: I'm Ben Hansen. I represent District 16, which is Washington, Burt, Cuming and parts of Stanton County.

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

MEYER: Glen Meyer, I represent District 17; that'd be Dakota, Thurston, Wayne and the southern part of Dixon County.

HARDIN: Also assisting us today, to my left is our legal counsel, John Duggar. To my far left is Barb Dorn; she's our committee clerk. Our

pages today are Sydney Cochran and Tate Smith. They're from UNL, and they really despise it when I tell them to get up and say something, so I'm going to go easy on them today and not require them to do that. But with all of that, may we ask-- we're up to the State Board of Health, and I believe Bertch is up first.

BARB DORN: You want to start at the bottom of the list?

HARDIN: Oh, I'm sorry. Where are we going?

BARB DORN: You do it however you want.

HARDIN: Well, I don't see a Lindau on the list.

BARB DORN: Oh.

HARDIN: That list does not have that. I'll pull this one out. I pulled it out here. Thanks.

BARB DORN: Yes. And these, with the-- they submitted their testimony for you to read.

HARDIN: OK. The blue ones are?

BARB DORN: Yes.

HARDIN: OK.

BARB DORN: So--

HARDIN: Let's go to--

BARB DORN: One, two, three, four, five, six are here.

HARDIN: Let's, let's go to Kimberly, then.

BARB DORN: OK.

HARDIN: Kimberly Stuhmer? We'll do the readings later. Welcome.

KIMBERLY STUHMER: Hello. I'm Kimberly Stuhmer, K-i-m-b-e-r-l-y S-t-u-h-m-e-r. I am a registered nurse as well as a licensed massage therapist, and then I also have an associate's degree in surgical technology. I have mainly ever been employed with rural health care. The reason I applied to be on the Board of Health was because rural health care is pretty important to me. I-- we lived in a very rural area for a long time, and then I kind of realized it's really hard to

access rural care sometimes. And so, I know it's way easier for people in Lincoln and Omaha to come and be on boards such as the Board of Health, so I thought I would like to bring a perspective of, of ruralness to the, to the board. Yeah. I just, I just really appreciate rural health care challenges. I know that what works for rural doesn't necessarily work for urban, and vice versa, so. That's kind of-- that's all I have, I guess.

HARDIN: OK. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. My question is, we talk a lot in this committee in particular about health care deserts, and more of those in more "rumal"-- rural areas. And I always like to talk to people that actually practiced and or lived in those areas. Do you have ideas of how we might eliminate-- probably beyond paying Medicaid more, which we don't have, but-- do you have any ideas about some organizational pieces out there? And I don't have the answer.

KIMBERLY STUHMER: Right. I-- organizational pieces, no. I think that we need to rely more on community support. And when you get rural, sometimes it's really hard population-wise to support those kinds of areas. But I feel like if you have buy-in from your community, you have way more support.

RIEPE: Do you have a good rescue squad? I mean, I'm-- is it volunteers?

KIMBERLY STUHMER: I think a lot-- I, I don't know. I mean, it varies a lot by community to community. I know there are some that-- who have gone to contracted companies because they don't have community buy-in or community support, or even community funds.

RIEPE: I'm an urban senator, but I appreciate your commitment and interest to rural. Thank you, Chairman.

HARDIN: Other questions? Senator Meyer.

MEYER: Thank you, Chair. Hospitals in Polk, Nebraska?

KIMBERLY STUHMER: No, sir.

MEYER: No-- and--

KIMBERLY STUHMER: Well, Polk, Polk, Nebraska would be at Polk County, which-- the closest would be in Osceola.

MEYER: OK.

KIMBERLY STUHMER: So-- but I, I spent time at the Ord-- well, the Ord hospital, and then Broken Bow. I was in Seward for a short time as well, so.

MEYER: Would you happen to know a nurse practitioner by the name of Jenna Hilk-- Hilker?

KIMBERLY STUHMER: The name sounds familiar. Probably know.

MEYER: She's out of the Ord hospital also.

KIMBERLY STUHMER: OK.

MEYER: And my youngest daughter.

KIMBERLY STUHMER: OK. Yeah, It's been a couple of years since I've been up there, but--

MEYER: Oh, OK.

KIMBERLY STUHMER: Yeah.

MEYER: Well, you were like two ships passing in the night, I think.

KIMBERLY STUHMER: Probably so, yeah.

MEYER: But anyway. Thank you.

KIMBERLY STUHMER: Yes.

HARDIN: You're in Polk now?

KIMBERLY STUHMER: Correct.

HARDIN: OK. And so, kind of give us your impression of what is it like? Are there enough RNs? If there aren't enough RNs within the hospital, or within the-- you've got friends in the nursing home world and so on and so forth.

KIMBERLY STUHMER: Sure.

HARDIN: Give us your perspective on what you're seeing in the rural areas.

KIMBERLY STUHMER: I think that probably people get out of nursing school and they want a high-paying job, so they probably concentrate mostly in Lincoln, Omaha, Grand Island, North Platte; bigger, bigger communities, just because they can pay more. A lot of nursing--

HARDIN: On that note--

KIMBERLY STUHMER: Yeah.

HARDIN: --can you give us kind of a sense of what that is? I believe you--

KIMBERLY STUHMER: Yeah.

HARDIN: --when you say they pay more. What are opportunities paying in Polk, Broken Bow, Seward versus what are they paying in Lincoln?

KIMBERLY STUHMER: I don't know specific numbers.

HARDIN: OK.

KIMBERLY STUHMER: When I first became a nurse, I made $18 an hour.

HARDIN: OK.

KIMBERLY STUHMER: I know a lot of-- the last nurse, when I was hiring a nurse, I believe we offered her, like, $30 an hour.

HARDIN: OK.

KIMBERLY STUHMER: That was for a home health and hospice department. But, you know, it's-- I think it varies greatly also, because a lot of nurses are coming out of nursing school and they're going into a specialty type of situation, either for ICU or labor and delivery. When you're, when you're a critical-access hospital nurse, you have to do everything. You're med surg, you're labor and delivery, you're-- if, if they're fortunate enough to have a labor and delivery. But I feel like some nurses don't want that, and maybe that is a challenge as far as, you know, I don't want to go be a labor and delivery nurse; I want to just do ICU or similar.

HARDIN: On that note, do you guys deliver babies?

KIMBERLY STUHMER: Aurora used to.

HARDIN: OK.

KIMBERLY STUHMER: It's, it's really a challenge for physicians to-- or, for hospitals to find physicians to deliver babies in a rural setting.

HARDIN: OK. Just curious. This is not your area, but where, where do people from Polk go if they want to have their baby in a hospital? What's the closest opportunity?

KIMBERLY STUHMER: So, Polk County, Osceola does deliver babies still.

HARDIN: Osceola does. OK.

KIMBERLY STUHMER: Otherwise, when I worked up at Ord, there was nobody in Ord that delivered babies, so they would have to go to Broken Bow, which is about an hour away.

HARDIN: OK. I see

KIMBERLY STUHMER: So. I mean, it varies greatly. You get out into really western Nebraska and you have a-- probably driving two hours to find someone, yeah.

HARDIN: Senator Meyer.

MEYER: Thank you, Chair. From your perspective, what do we need to-- what do we need to do as a, as a Legislature or, or as a medical community, as communities out in-- our underserved communities, to attract nurses, or to attract doctors? What-- we, we have a, a program whereby we can pay down a portion of student, student loans, but what else do we need to do, from your perspective, to attract people into our underserved communities?

KIMBERLY STUHMER: Honestly, I think you really have to reconstruct the whole nursing system and make it more attractive to a workforce. I think younger people coming in to, to a nursing situation are way different than somebody in their 50s or 60s who have been there. They expect to be able to have a better hours, I guess. When you're working three- or four-hour shifts at a time, that's, that's-- or three or four 12-hour shifts at a time, I feel like that's really a difficult situation. But largely, I think, aside from reconstructing the whole entire workload and, and system for nurses, I feel like getting community buy-in is really going to be important. You know, you're, you're probably not going to have somebody who's grown up in Lincoln go to nursing school and want to go out to Sidney, Nebraska to be a nurse. So, I feel like promoting that in the high schools, promoting that, promoting community college buy-in, getting into youth

organizations or schools to try and show you what the benefits of being a nurse are. And physicians and PAs, and--

MEYER: I wouldn't want to put any pressure on you, but you-- could you draw a structure and a framework for us so that we can rubber-stamp, and, and so that we can, you know-- I'm sure we'd be very [INAUDIBLE].

KIMBERLY STUHMER: Sure. I could have that this afternoon.

MEYER: I'm sure we'd be very, very receptive of any type of blueprint to where we could--

KIMBERLY STUHMER: Right.

MEYER: --generate more-- deliver health care in our rural communities much better, so.

KIMBERLY STUHMER: Yeah.

MEYER: Thank, thank you. I appreciate it.

KIMBERLY STUHMER: You're welcome.

HARDIN: Other questions? Seeing none. Thank you.

KIMBERLY STUHMER: All right. Thank you, everybody.

HARDIN: There were no online proponents, opponents, or those in the neutral, and this concludes our hearing for Mrs. Stuhmer. Next up, J. Paul Cook. State Board of Health. Welcome.

J. PAUL COOK: Thank you. Good afternoon. Paul Cook, family physician, Omaha. Private practice. I have-- I was appointed a year ago to fill out the term of Doctor Tesmer, who was on the Board of Health and then became the CMO for the state of Nebraska. And now, this round is just-- is confirmation for reappointment for a full term. Father of four, grandfather of ten, and in private practice in primary care. Yeah.

HARDIN: Very good. Senator Fredrickson?

FREDRICKSON: Thank you, Chair Hardin. Thank you for, for being here, and for your willingness to serve the state in this capacity. Can you-- so, you-- you've had some experience, obviously, with your appointment. Can you maybe share with the committee a little bit about how that experience has been for you, and, and kind of what you envision for the-- for your experience on there moving forward?

J. PAUL COOK: Yeah. Last year was mostly confusing. I wasn't sure what was the role of the board, or of a board member. Now, I feel that I have a little better handle on that, although it's just a little bit murky. I think-- I decided our role is to enhance and support the health of the general public by improving congruence between the multiple allied health professionals that have-- that function in the state, or anywhere; watching the professional boards, and just tracking legislation and being ready, then, to offer reflections on particular issues that may come up. Typically, I think that, that role of offering some reflection or possible opinion would be prompted by someone asking a question, yeah. Other than that, more of an observational role and liaison between the various professional boards and the-- and HHS.

FREDRICKSON: Thank you.

J. PAUL COOK: Mm-hmm.

HARDIN: OK. Senator Riepe?

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

J. PAUL COOK: Mm-hmm.

RIEPE: I'm looking on my-- I hope-- I'm, I'm, I'm curious, I guess, if I'm right here, because mine would say that you did attend the Louisville Presbyterian Theological Seminary? Is that you?

J. PAUL COOK: I did. That was me.

RIEPE: That was you?

J. PAUL COOK: Yeah.

RIEPE: OK.

J. PAUL COOK: That was a younger me.

RIEPE: OK. So, that was before medical school and not after.

J. PAUL COOK: Correct. Yeah.

RIEPE: OK. Very good. So, you're not currently a practicing priest or pastor or whatever in the Presbyterian Church.

J. PAUL COOK: No. No.

RIEPE: OK. Very interesting. Good background. My question would be, too, along-- if I may, Chairman-- about with the 407. We wrestle with that a lot. The process, the-- and some of this comes back, again, to my interest in outside the urban centers, and trying to both keep a standard of care and yet have people practicing, and-- [INAUDIBLE] the question, is some care better than no care, or how-- I don't know. I just give you that opening. Anything you say is correct, so.

J. PAUL COOK: That's huge, and the problems are multiple, and the challenges are difficult, so. I'm on the periphery of those discussions regarding 407. I have a great deal of admiration for my board colleagues who are really marshaling the effort to give intelligent reflection on the issues around 407. But yeah, what a trained professional is capable of doing and then allowed to do is difficult, and any time those boundaries are modified, it's inherently controversial. So, I think that's-- I don't know what to say about it, except that that is tough.

RIEPE: Well, you said a lot by saying you're willing to come back.

J. PAUL COOK: I've been told that once you're on the board, you're not allowed to leave, so. We'll see.

RIEPE: Obviously, you bought that. OK. Thank you very much. Thank you, Chairman.

J. PAUL COOK: Yeah. Yeah.

HARDIN: Other questions? You're in family practice, is that correct?

J. PAUL COOK: Yes.

HARDIN: And can I get your, your thoughts from the perspective of the board? Because you've been on there a little while, and I'm sure it was like drinking from Niagara Falls to be thrust into that role. Two brief reflections in opposition. What do we do well with our health situation in Nebraska? Secondly, is there anything that keeps you awake at night that we could improve here in the state, from that medical perspective? Can you wrestle with those two sides of that one coin? What do we do well? What do we not do so well?

J. PAUL COOK: Wow. Could you focus that in a little bit?

HARDIN: Sure.

J. PAUL COOK: What do we do--

HARDIN: I think we're good at certain--

J. PAUL COOK: What do we do well?

HARDIN: I think we're good at certain things here in the state, medically.

J. PAUL COOK: OK. How's health care in the state, or what does the Legislature do well?

HARDIN: Yeah. How's health care in the state? I mean, what do we do well within health care in, in Nebraska?

J. PAUL COOK: Yeah.

HARDIN: You certainly converse with other doctors, friends, colleagues from around the country. And what makes you go "Man, I'd rather be us than them?" Conversely, what things make you go, "How come we can't be more like them than us?"

J. PAUL COOK: Well, I think we're fortunate in Nebraska. I think there's a culture of can-do and some pretty good autonomy given to the person who's achieved some serious goals and then puts themselves out there to serve. And I-- so I-- as a physician, I would say that I appreciate that, and, and that's my experience. I think medicine in Nebraska can still be relatively small, which in my opinion is a good thing. There are pressures, significant pressures from multiple constituencies that are making medicine go big, and medicine and big business have some inherent conflicts of principles. So, I think where there's relative smallness in health care can be given in a very human and direct way. I think that's, that's an advantage, and I think we still have that in Nebraska. Yeah.

HARDIN: So, that's the upside.

J. PAUL COOK: That's the upside. A corollary to that would be that it's not over-bureaucratized, in my own experience. So again, it's-- health care has big business, and they're-- there are just constant pressures in that direction. For basic principles of economics, I understand that completely. I feel glad that in my situation, I'm able to spend as much time with my patients face-to-face as I think is appropriate for any given encounter, and I don't feel pushed by an administrative system to crank people through and increase the numbers, so.

HARDIN: OK. Those, those sound like two upsides, and that's good.

J. PAUL COOK: Yeah.

HARDIN: But thanks for wrestling with that for us, because it's-- certainly, we've got Doctor Ben Hansen here in the chiropractic world. The rest of us did stay in a Holiday Inn Express last night.

J. PAUL COOK: Ah.

HARDIN: And so, we really do like to get perspectives from doctors who were out there with real human beings and, you know, get your sense of what are we doing well, what are we not doing well? Because we truly do hear about it all from a third-person perspective.

J. PAUL COOK: Mm-hmm, mm-hmm.

HARDIN: So. But thank you. Any other questions? Seeing none. Thank you.

J. PAUL COOK: Thank you.

HARDIN: Online, anything? Nothing to report.

J. PAUL COOK: OK.

HARDIN: Thank you.

J. PAUL COOK: Thank you. Have a nice afternoon.

HARDIN: Thanks. Next, Mark Bertch. Welcome.

MARK BERTCH: Thank you. Good afternoon, Senators. My name is Mark Bertch. I'm going to refrain from the "alphaphonetic" version of spelling my name. It's M-a-r-k B-e-r-t-c-h. I have a handout of my testimony. As mentioned, my name is Mark Bertch. I'm a long-time citizen of the state of Nebraska, and resident of District 4, represented by Senator von Gillern. I'm also a licensed physical therapist that practices in the Omaha area. Last fall, Governor Pillen appointed me to the Nebraska state board, fulfilling the vacated position by Don Ostdiek, the-- specifically, the physical therapist role. And today, I seek confirmation. As a full-time clinician, I'm grateful to be the part of many Nebraskans' lives. In addition, some of my original work has been presented to peers at national conferences, and having accomplished goals set early in my career, I'm now compelled to giving back. Most recently, I volunteered as a state affairs liaison for our professional association, and all of this now serves as a springboard to where I am at today. I see the challenges

Nebraskans face regarding health through multiple lenses, whether it be that of a provider or a patient. Some concerning issues that we face include the limited number of providers in rural communities, provider burnout, costs reimbursement, health care coverage, specifically Medicaid, and the recent legalization of medical marijuana. Unfortunately, these among others not mentioned, aren't going to magically disappear. Rather, I suspect they will need to be thoughtfully addressed. My journey is based on the selfless acts of many wonderful people. I am proud to call myself a Gulf War veteran; I've served honorably in our United States Navy. Upon discharge, I pursued a Bachelor of Science degree, studying nutrition science at the University of Nebraska. Immediately thereafter, I began coursework in physical therapy at Creighton University, thus earning a Doctor of Physical Therapy degree. I since completed additional training in orthopedic manual physical therapy at Regis University. This has led to designation as a fellow of the American Academy of Orthopedic and Manual Physical Therapists, a status very few licensed physical therapists in Nebraska have attained. So, in closing, my vision is to someday reflect on my calling to be a health care provider and know that I helped shave [SIC] the lives of many Nebraskans. It's the patients who trust my clinical reasoning and decision-making, the students with whom I share knowledge and skills, enabling a new generation of providers in our state's health care workforce, and the policies that shape the health and wellness of Nebraskans that motivate me to seek this role. I could not be more honored to fulfill it. I respectfully request your consideration for this role.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. First of all, were you a Navy corpsman?

MARK BERTCH: No, sir.

RIEPE: Oh, well. You were Navy, so that's still close enough.

MARK BERTCH: I was Navy. I have fond memories of Navy corpsmen. They sewed me up on a couple of times.

RIEPE: Uh-oh. Sounds like some street fights or something.

MARK BERTCH: That page 13 entry wouldn't look good, sir.

RIEPE: I have a question, and-- are you-- as a practicing physical therapist, are you a member of a group? Are you a solo practitioner?

MARK BERTCH: I'm employed by Common Spirit Health.

RIEPE: Oh, OK. And what's your-- there's no right or wrong answer on this-- your thoughts as a health care practitioner, your thoughts on marijuana?

MARK BERTCH: Honestly, I'm very open-minded about it. I think it's got its pluses, I think it's got its minuses. I believe that there are some situations where perhaps it may be beneficial for a person. As an example, if a person has issues with normal intake of food that rely on total parenteral nutrition, if that helps stimulate their appetite to allow for the body's natural processes to function by way of consuming a normal diet, why not? But then on the flip side, I also think that it does need to be regulated.

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

HARDIN: Other questions? Thanks again for your service.

MARK BERTCH: Much appreciated.

HARDIN: We deeply appreciate it. Tell us about-- tell me about physical therapy in Nebraska. What are we getting right in the physical therapy world? And that can be a, a subjective world. I'm someone who's had lots of physical therapists have their hands around my throat and other kinds of things over the years of-- because of my own broken body. But tell me about physical therapy; what do you see the ups and downs are in the state of Nebraska right now? What do you reflect on in your, in your area?

MARK BERTCH: Great question. Speaking to you as a physical therapist, I, I believe that we're very collaborative.

HARDIN: Yeah.

MARK BERTCH: We welcome the opportunity to work with other professions, because at the end of the day, it's about the person. It's not about which profession is doing a greater service to the other; it's about how can we best influence and impact the quality of a person's life. On the flip side, there are also challenges that we face. We face enormous challenges with reimbursement, especially from third-party insurance carriers. And right now, most recently with Medicaid, we don't know what's going to happen. We're now learning of a pretty sizable cut coming at the federal level. How is that going to impact the rural communities?

HARDIN: We keep looking over our shoulder for those answers, too.

MARK BERTCH: I can only imagine, sir.

HARDIN: Thanks for sharing a glimpse into that world. Any other questions? Seeing none. Thank you.

MARK BERTCH: Thank you so much.

HARDIN: I've been assured by Mr. Duggar, our legal counsel, that there aren't any online reports to give in terms of pros and oppositions, so we'll skip that from here on out. That concludes our time for Mr. Bertch. I think we're going to skip over to the Nebraska Rural Health Advisory Commission, and I'll do all of the readings at the end, folks, on both State Board of Health and Rural Health Advisory Commission, unless you'd all like to stay and listen to lots of reading into the microphone. And so, Jeffrey Harrison. Welcome.

JEFFREY HARRISON: Thank you. Good afternoon. Jeffrey Harrison, J-e-f-f-r-e-y; last name Harrison, H-a-r-r-i-s-o-n. This would be my second reappointment as UNMC medical school representative to the Rural Health Advisory Commission. I currently serve as the chair of the department of family medicine at UNMC. 22 years prior to that, I directed our rural residency program in Scottsbluff, where I know we have representation; North Platte, Kearney, Grand Island. I spent about 12 years as assistant dean for admissions, and-- the focus I've really had throughout my last 25 years, 30 years at the med center is recruiting young people to go into rural health care, training them up, trying to get them launched out to be successful, and most importantly, sustainable. We spend a lot of time-- I sometimes have folks thinking I'm a physician, so that's all I think about are rural physicians, but you don't have high-quality, accessible health care without the entire health care team. We got to have nursing, we got to had allied health, we have to have pharmacy, we have to have dental, you know, to really build systems that are, that are going to give rural citizens the same quality care as somebody who lives in Lancaster, Sarpy, Douglas Counties. Been enjoyable listening to the discussions, because how do we do that? How does somebody who lives in Benkelman, how does somebody who's living in Broken Bow, how does somebody who lives in Lynch have the same accessibility and quality as somebody who lives ten blocks down the street from this building? One of my answers is going to be-- before you ask me-- is the solutions aren't going to be how we practiced medicine in 1980. We're going to have to have 2025, 2030 solutions to really be able to do that, which means we're going to have to do it in a different model. Unless we decide to suspend the rule of health care economics, which is really people-- people and patients, and that's come up-- we're going to have

to think about how we do it differently. I certainly have some ideas that may not necessarily be popular, so. Oh, I see my red light on, so it's time to be quiet.

HARDIN: No, we want to hear about those things that are not popular because it's only the yellow light. But-- keep going.

JEFFREY HARRISON: Oh, OK. I thought the red light-- the red light, be quiet. Shut up. No, it's-- you know, I mean, historically we've-- you know, I, I, I, I sit inside UNMC, and every year I see it comes out that we have 12 counties in the state without a full-time primary care physician. Well, of course we do. Each one of those counties has less than 1,200 people living there. It's not economically feasible, you know, to really build a health care system with that low of volume. Doesn't mean that we don't have an obligation to deliver the same quality of care. You know, I, I think it's no secret hospitals, for most rural communities, are a huge economic driver. You know, they have a number of high-paying jobs, they bring people into your community. But there's that critical mass you have-- you need to have to make it work, and, you know, as we talk about, you know, pending Medicaid cuts, I've always had anxiety that, you know, cost-based reimbursement for critical-access hospitals would be an easy place at the federal level to cut back. So, how do we do it? And, you know, this is really a place where I think technology comes in, where I think more regionalized healthcare with, you know, with access in those communities, so. I mean, clearly, you know, our rural communities are aging; the fastest-growing population in our rural communities are the 65-pluses; the fastest declining population are the under-30s. So, how do we do it? Do we expect every, every 72-year-old to drive, you know, an hour down the road to the next place? No. I think we've got to be-- I think we've got to bring it out there. You know, it's, it's really going to be a matter of the old hub-and-spoke model, if you will. You know here's the center, here's where we can afford to have a hospital, have a pharmacy, but we're still going to have to bring care out to there. And, you know, telehealth was-- telehealth is part of the solution. You know, one thing that we've learned is folks don't want to sit in their living room and do a telehealth visit with their physician; they want to go someplace where there's somebody to help check them in, greet them. Patients still want the relationship with somebody they know, and we've, we've actually explored some stuff with the, with the extension, you know. Every county has an extension office. Does that become a place, you know, where you don't have enough population to have a full health care system, but you have somebody in the extension office who comes in and greets you and takes your vital signs, sets

you up for your telehealth visit which whatever specialists you need to see, helps you get your meds order from this pharmacy, makes sure that everything has been done. But, you know, it's a whole different model than we've ever done, but I think it offers us our best solution because I, I, I don't see small rural growing in the next-- any time in the near future, so.

HARDIN: Did, did you see, Dr. Harrison, that Scottsbluff now has the Da Vinci 5 robotic surgical system?

JEFFREY HARRISON: Scottsbluff, since I became the rural director in '98, has always lived on the edge of-- particularly in the surgical fields, of being one of the most innovative communities across the state. Back in the days when Lloyd Westerbuhr was, was, was leading the group, they were just out there doing that thing, so it's not surprising. But it goes. So, how many places in the Panhandle can have a Da Vinci? Probably just Scottsbluff. How do we make it easy for folks in Alliance, folks in Chadron, folks in Sydney and Kimball to come in there and get that same, that same level of care that you would get in, get in Omaha or in Lincoln?

HARDIN: Sure. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for your service. And the question that I have, I guess, is have you looked at other models around the globe in terms of how we might both serve urban and rural correspondingly?

JEFFREY HARRISON: Yeah. I mean, it's very much the same; this is, this is the rural commission, but I've spent a lot of time thinking about our underserved communities both in north and south Omaha. You know, and part of what we've done-- and I'll, I'll, I'll spin this back, you know, we're, we're you know, UNMC is building a campus in Kearney, you know? And the real focus is, you know, getting rural kids closer to home. You know, most practitioners go back and practice close, close to the place they trained, you know. And we've also tried to, you know, work in that same way in Omaha; you know, how do we-- how do we recruit kids out of south Omaha, out of north Omaha and get them into the system much more likely to go back to meet those needs. I don't know if I answered your question. I got sidetracked thinking about other things that I wanted to share.

RIEPE: I just-- I guess I was curious. I've, I've been in, in the process of trying to study the Australian because they have urban, and

then they have the outback, and they have some, you know, tribal stuff, and I just-- I'm just-- I-- you know.

JEFFREY HARRISON: Yeah.

RIEPE: If we can find an answer and can it, we would all be heroes.

JEFFREY HARRISON: Yeah, I, I, I, I think we would. You know, one of the-- you know, one of the challenges-- the same thing that makes the U.S. health care system the envy of the world in high-end-- Da Vincis, high technology, doing things are also the things where, you know, we, we-- we've put a lot of focus there. We've not-- the Australians, the Canadians, the, the Europeans have done a better job of supporting primary care; you don't get nearly as many bells and whistles, but, you know, the ultimate goal is we don't need as many Da Vincis, we don't need as many bone marrow transplants, we don't need as many heart transplants, if we could do it well. Unfortunately, you know, most insurers, you know, are looking at-- my board of directors wants to know what's going to be our bottom line next year versus we're all in a system where, you know, we-- we're, we're commonly paying in, and preventing somebody going on dialysis ten years now is a big win, if that makes sense. So, I mean--

RIEPE: As a country, we tunnel-- throw a ton of money at it, too.

JEFFREY HARRISON: We throw a ton of money at it.

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

HARDIN: Senator Meyer.

MEYER: Thank you, Chair Hardin. I found it really interesting telehealth is-- number one, I don't care for telehealth. I, I like hands-on, but what I like and what I don't like is irrelevant here. But with telehealth, which is definitely going to have to be part of the equation, how do we provide the hands-on? Because, you know, diagnostically, those types of things, you can do with telehealth, but there still has to be that actual physical delivery of medical services. And so, you know, we struggle as a committee, and, and many of the, the directions of the questions we have when we have testifiers here is "how do we deliver health care to rural community?" You've addressed that to a certain extent, but how do we get that hands-on?

JEFFREY HARRISON: Yeah, that's where I-- you know, I think there's, there's a couple different levels. I mean, I think you can-- you know,

this is one thing that we have found. One of our endocrinologists at UNMC does an outreach diabetes clinic, and they found when they, when they went to a place and had somebody check them in, greet them, have that hands-on relationship, much better perceived than logging into somebody's living room or, or kitchen or home office. You know, and that gets you access. You know, I think we're still going to have to have-- people are still going to-- physicians, PAs, dentists-- still going to have to get in their cars and drive occasionally. But, you know, there's a lot of things where-- certainly, I think first visits, I think, you know, I think more complex things, yes. We're still going to have to, have to reach out and go more of what I call that hub-and-spoke model. But for a lot of day-to-day stuff, follow-ups, you know, you-- nobody has to drive an hour. I think we can do it. But again, it's, it's, it's going to come back to us thinking about a different approach than what we've done historically.

MEYER: OK. Thank you.

HARDIN: Seeing no other questions. Thank you for being here.

JEFFREY HARRISON: Very good. Thank you for your time. And I'll, I'll put a plug in for keeping the, the funding for the student loan repayment program at current levels, because it really, it really has been successful and--

HARDIN: That's great.

JEFFREY HARRISON: --moves. But I'm not here to testify for--

HARDIN: Thank you.

JEFFREY HARRISON: --that bill, but it got thrown in.

HARDIN: We, we appreciate that. Thank you.

JEFFREY HARRISON: Roger would be unhappy with me if I did [INAUDIBLE].

HARDIN: Rebecca Schroeder-- or, I may have pronounced it incorrectly, and it might be the German "Schrader" [PHONETIC].

REBECCA SCHROEDER: Nope. Nope. It's the Schroeder.

HARDIN: OK. Very good. I took enough German to be dangerous. Welcome.

REBECCA SCHROEDER: Well, you can't tell by the spelling of it. That's the hard thing about it. My name is Dr.-- Rebecca, R-e-b-e-c-c-a;

Schroeder, S-c-h-r-o-e-d-e-r, and I am a clinical psychologist in Curtis, Nebraska, Frontier County, which is definitely a little bit of the rural part of the state, especially as you noticed when you drive here today. I am-- I've been on the Rural Health Advisory Commission for many years, been reappointed several times. I really enjoy my time on the commission. I've seen a lot of different changes over the years. As Dr. Harrison was mentioning, four years-- or, he was kind of referring to-- four years ago, we had 50 people on our waiting list that were willing to go through in a rural area, but we did not have the funds for it. Well, thankfully we, we were approved additional funds, we got rid of the waiting list; now, our goal is to maintain the applicants as they come in, and that's what he was referring to when he said we really-- if by some chance our funding is reduced, we would probably have to go back to that waiting list, which obviously doesn't serve Nebraska well.

HARDIN: Certainly.

REBECCA SCHROEDER: So, you know, our goal-- our two main goals over the years on the commission-- although we talk about a lot of rural issues, the two main goals are to recruit and retain people in rural areas, in medical, physicians, we even have nurses now. We have-- and behavioral health psychologists, mental health workers, that sort of thing. One issue that we are dealing with and we have dealt with is that our loan repayment program does require a local match from the community. When you have a physician going to North Platte or Ogallala or even a smaller town, the hospitals will come right in and, and put up that money; there's no problem getting that type of match. You have a mental health worker or a dentist going to that same area, they struggle; it's very hard to come up with a match. So, we've been trying to be creative. We look at some federal thing-- federal funds, that type of thing. But, but that is an issue definitely for the future that we would like to see more of, is some way to meet that match in other ways. Perhaps in time, perhaps with some effort-- I mean, just looking at different ways to compensate for that match.

HARDIN: Let's pretend I'm a young medical student. We get into an elevator together, you overhear me talking to someone else, and you think, oh, we could actually maybe recruit that young person--

REBECCA SCHROEDER: I have done that before.

HARDIN: --to come out to rural Nebraska. What do you say?

REBECCA SCHROEDER: I say "Have you heard about our loan repayment program?"

HARDIN: And they say?

REBECCA SCHROEDER: And they say "No. What is that?" And then, I will let them know you can get $60,000 a year to pay back your student loans by serving in a rural area, you know, one year for each--

HARDIN: So, is it purely a financial? Could you say anything beyond--

REBECCA SCHROEDER: Well--

HARDIN: --financial piece? Is there a quality of life?

REBECCA SCHROEDER: I think you hook them on the finances at the beginning because, you know, the average debt coming out of medical school that we're seeing is huge. We see $200,000, $300,000 or even $400,000 of debt, so we're looking at a way to chip away at that, help them with that.

HARDIN: Certainly.

REBECCA SCHROEDER: But yes. But you know, the home-grown-- we want them to stay in there, too; we want to retain them.

HARDIN: Yes.

REBECCA SCHROEDER: And so, at that point, you know, you do want them to like the rural life. And people who have already lived the rural life are more likely to come back and stay. They know what they're getting into.

HARDIN: Can I ask this question? How many patients, shall we say, does the, the rural family doctor typically have across the state? Do you know, I mean, how many people that might be?

REBECCA SCHROEDER: Roger might be able to better answer that question.

HARDIN: OK, we can pick on him later.

REBECCA SCHROEDER: OK.

HARDIN: But I'm, I'm just curious what that looks like, because my sense is once they stick and stay, particularly if they've built a meaningful group of people who depend on them, they're most likely to retain.

REBECCA SCHROEDER: Exactly. If they develop those connections in the community, and their kids are in the school, and they're involved in JCs, are involved in some kind of community group. Yeah, they--

HARDIN: OK.

REBECCA SCHROEDER: --and are invested, and they get invested in that rural life. Yes.

HARDIN: I see. Other questions? Senator Riepe.

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

REBECCA SCHROEDER: Sure.

RIEPE: You mentioned loan repayments, and my-- and you also said rural. My question gets to be, is it all rural designated that's eligible for that, or are there some that are, I guess, whatever word they would say, federally underserved areas, so--

REBECCA SCHROEDER: Yes. There are some federally underserved areas--

RIEPE: It's not all rurals--

REBECCA SCHROEDER: --like with community health centers.

RIEPE: But it's certain designated areas within the rural communities.

REBECCA SCHROEDER: Yes. Yes. As far as behavioral health goes, almost every county, I think, except two are designated rural shortage areas.

RIEPE: OK.

REBECCA SCHROEDER: Because it's based on number of psychiatrists.

RIEPE: OK. OK. And are those the same--

REBECCA SCHROEDER: But yeah, there are those-- there are those isolated small dots in Omaha and Lincoln that are federal.

RIEPE: How do we address it then? I understand out at-- around Scottsbluff-- correct me where I'm wrong, Chairman-- is there's one psychiatrist, and-- a psychiatrist that some time-- is there a replacement for that psychiatrist out there, or just-- or is that just going to--

HARDIN: We have forbidden him to be hit by a bus.

RIEPE: Or to grow old?

HARDIN: That's correct.

RIEPE: OK, then.

REBECCA SCHROEDER: Or to retire, yes.

RIEPE: OK. The other question, if I may. It's just-- I'm curious about the role of the advisory. I've been on some advisory boards over the years, and I know sometimes they're interesting social events, but they're not necessarily incredibly productive. I've had some of them that I've been on are too big, or, or-- do you-- has this, has this been an impactful kind of an advisory commission?

REBECCA SCHROEDER: I believe it has, and I think if you look at the numbers of the number of people that we have placed in rural areas and that are still there, I think it's very impressive.

RIEPE: Do you have good continuity of membership on there?

REBECCA SCHROEDER: Yes.

RIEPE: OK.

REBECCA SCHROEDER: We-- it's a, it's an interesting mix of some of us old-timers like Roger and I who've been there forever.

RIEPE: Denied. [INAUDIBLE]

REBECCA SCHROEDER: And then we-- and then we have some new blood that comes in, too. So, it's an interesting mix of both, which maybe helps keeps us-- keep us up on what's going on.

RIEPE: What's the, what's the terms? I, I should know that, but how long is your term?

REBECCA SCHROEDER: Three years.

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

HARDIN: Sure. Other questions? Seeing none. Thank you.

REBECCA SCHROEDER: All right. Thank you, Senators.

HARDIN: This concludes our hearing for Dr. Schroeder. And Dr. Roger Wells.

ROGER WELLS: I'm a physician assistant.

HARDIN: Physician assistant Roger Wells. Welcome.

ROGER WELLS: Thank you. Roger, R-o-g-e-r; Wells, W-e-l-l-s. Good afternoon. My name is Roger Wells, and I'm honored to be considered for another term at the Nebraska Rural Health Advisory Commission, where I've served since 2003. The Rural Health Advisory Commission is appointed by the governor and consists of 13 multiple disciplinary members, and our purpose is to advise the Nebraska Department of Health and Human Services, the Legislature, the governor, and the citizens of Nebraska on all aspects of health care in rural areas. In December 2024, we distributed a report detailing the current state of the rural health care issues in Nebraska, which you were asking about. Our responsibilities including administering the Nebraska loan repayment program, the Nebraska Rural Health Student Loan Program, and determining state-designated rural health care shortage areas. We collaborate with the office of-- Nebraska Office of Rural Health to distribute the funds through the National Health Service Corps Loan Replacement Program, sometimes called SLRP. And the federal shortage area designations differ, and the funds are allocated to best fit the applicants' needs. We offer an incentive program to medical, medical, mental health, dental, pharmacy, physical therapy, occupational therapy, physician assistant, and other professionals. From 1994 until 2024, 579 prob-- practice obligations of these professionals were completed, with 156 awards right now under obligation to be completed as of November 1, 2024. Only 54 have ever defaulted, and eight are pending decisions, according to this December report. Interestingly, 40% of all the family medicine providers have participated in these programs in Nebraska. The data shows that the average family physician generates $1.4 million in revenue to the local community annually, and creates 23 jobs. However, only 35% of the medical doctors at this time enter family practice residency, and after three years, only 10% remain in primary care. Alarmingly, only 10% of family physicians complete an obstetric residency. OK? The current situation is dire; 21% of the Nebraska hospitals--which you have in your handout-- and I, I warn you that the, the area in red it shows in those handouts is not indicative necessarily of the site, so I don't want to, to localize hospitals for you. 21% of Nebraska hospitals are vulnerable to closure, 38% operate in a negative margin, 42 of 82 counties have primary care health care shortage areas, 81 of 82 counties have mental health shortage areas, and 28 of 22 [SIC] have dental professional shortages. LB261 proposed cutting the General Fund and allocations for programs from $2.1 million down to $680,000, and if this passes as-- at this time, we will not be able to contract any further contracts

for student loans until probably late 2026 or 2027. There will be no further student loans. None.

HARDIN: You're in the red.

ROGER WELLS: Because the allocations--

HARDIN: You're in the red, but keep going.

ROGER WELLS: OK, OK. Excuse me, I wasn't watching. Thank you, Chairman. The rural hospitals need your support. We have to advocate for medical teams, X-ray technicians, physical occupational therapists, mental health providers to provide support for the medical staff. And the commission-- as a commission member, I strive to identify new opportunities to address our crisis. And I thank you very much for allowing me to present myself here.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you. I'm going to speculate it a little bit that you probably know our good friend Dan Hughes.

ROGER WELLS: Yes. Yeah.

RIEPE: OK. I was just-- I assumed, seeing the district that you're from. Do you have a relationship with a critical-access hospital?

ROGER WELLS: Yes. I work in Lexington, Nebraska, which is a critical-access hospital, and I work in a primary care in a, a rural health clinic, which is a patient-centered medical home, certified medical home.

RIEPE: So you probably knew Dr. Miller, too?

ROGER WELLS: Yes.

RIEPE: OK. What about-- how are you doing with the rescue squads there? And how does that [INAUDIBLE] back with the committee?

ROGER WELLS: There are two--

RIEPE: Do you talk about that at the committee?

ROGER WELLS: Absolutely. Our community is very fortunate the hospital does support a paramedic unit because we have so-- we live by the interstate and we have a lot of transfers, about one in every 20 patients who get brought in by the emergency department. However, if

you go into the other aspects-- let's just go to Valentine, Nebraska; the average call time right now is 50 minutes. 50 minutes.

RIEPE: 50?

ROGER WELLS: That's per-- back and forth. The average para-- excuse me, medical technician is 280 hours of volunteer time to learn how to become that particular person, pass a national board, and then have 50 hours every two years to maintain their license, and it's, it's fading fast. There is no bright outlook. The best thing would be a hub-and-spoke-- like Dr. Harrison talked about-- in the future, which will have to be supported by some kind of helicopter. I prefer drones, but whatever. If you can buy up a bomb, you can pick up a patient. And so, those kinds of things need to be looked at in the future immediately. There is no help. They can't-- the-- these people that are there have [INAUDIBLE] by continued service, but these people are now elderly and they're fading away quickly.

RIEPE: I'll give you this to react a little bit. I had a constituent whose daughter was picked up at the university by helicopter, taken to Omaha to the med center--

ROGER WELLS: Mm-hmm.

RIEPE: $18,000.

ROGER WELLS: Yes. Right.

RIEPE: That's a-- for very many of those-- and flying conditions, that's not a very good option.

ROGER WELLS: No, it's not. Our other option is-- and the-- we got to look at it kind of like Dr. Harrison talked about, hub-and-spoke. And the reason is you cannot have a building, you cannot have staff for all these people. You have to be able to stabilize. In a, in a critical situation, it's called the golden hour. If you're outside that golden hour, you went from $18,000 to hundreds of thousands of dollars. You have to be within the golden hour. That is not being maintained at this time in the state of Nebraska on most of the [INAUDIBLE].

RIEPE: So, you have to treat them while you're moving them.

ROGER WELLS: Yes.

RIEPE: OK.

ROGER WELLS: Yeah, you have to have a plan. And, and it can be staged. I mean, the paramedics can come out and meet you; you can have-- you know, the flight is not the best things, but that would be the one option, a fail, a fail option so that we fly people out because they're having MIs, they need to be cathed within an hour. We give them anticoagulants, and they're being flown out. We've already called a helicopter. But that saves a life, which is hundreds of thousands of dollars and months of follow-up rather than transplants or other things.

RIEPE: OK. Thank you for coming the distance that you have.

ROGER WELLS: Oh, I love it. Thank you.

RIEPE: Thank you. Thank you, Chairman.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, for, for being here, and for your testimony. I, I-- and in your willingness to serve the state. I just want to share-- this is more of a comment than a question. I, I appreciate the handouts you gave. This is actually really informative, specifically the last page here. You gave us some information on the student loan program. We've had some bills this year on that, so this is actually helpful to see it kind of enumerated in how it's, how it's actually being implemented. So, thank you for doing that.

ROGER WELLS: Thank you. The biggest thing about the student loan program is we try to identify what is needed in that community. Is it a physician? Is, is it, is it a, a med tech? Is it a physical therapist? And we need to do a better job of that in the future, absolutely.

FREDRICKSON: OK. Thank you.

ROGER WELLS: Thank you.

HARDIN: Senator Meyer.

MEYER: Thank you, Chair Hardin. 250 hours of training.

ROGER WELLS: Mm-hmm.

MEYER: There is no way to get by that.

ROGER WELLS: No.

MEYER: I mean, we, we want, we want well-trained personnel. I know we've got an aging population out there as far as our first responders, and we're not replacing them. Do you have any ideas of, of how we can improve our delivery with our emergency personnel? Is there-- I know with the diminishing population and, and not as many going into the, into the communities and, and doing that, 250 hours seems like a great deal of time, but yet we don't-- we want them well-trained.

ROGER WELLS: Absolutely. Let's step back, as some of the Board of Health's testimony you saw a little bit ago. And I think that looking outside the box is the best way of doing that. By modifying the-- you were talking about a little while ago the 407 process, and we have to do, is do some modeling, and I think that'd be a great way, and I could do some evaluation by saying, OK, let's take an EMT or two, and allow them work in the emergency department so they could go out and be there, and still be positioned to get paid, to have insurance, and allow that model to see if it worked. Or at, at least be able to do home visits; that could be a community health worker, that you've seen models about. If they go out and look at the, the patient's ability and pay them, even if some kind of salary, have the hospital be able to bill that particular item. That will save hundreds of thousands of dollars per patient per year. If you saved one in congestive heart failure, or this one wasn't taking their medicine, or this one fell down or needed help with grab bars in the bathroom, those kinds of things that we've initiated with our, our, our, our service in our area-- we have two; one is Hispanic and one is English-speaking-- has made tremendous amount of reduction in cost. And so, there is an upfront cost, but with the model being able to prove that that cost is cost-effective, then we'd be able to move forward with some kind of special investigation or an allocation to a couple of communities, especially rural communities, in the future.

MEYER: I really appreciate your perspective on that. I think the opportunity for our emergency personnel to work in an emergency and get some type of compensation for that, perhaps some insurance, would certainly enhance their level of expertise and maybe encourage more people to get involved with it. They're seeing some bang for their buck and the time-- the, the amount of time they're putting into this, so.

ROGER WELLS: The, the issue being it'd allow them-- on a, on a limited basis, on a, on a model basis-- to be able to utilize, to be billed

for, for their services as a mid-level-- or, not a mid-level, but a-- as in, like, a nurse aide or something like that, where they wouldn't have-- they wouldn't be starting IVs. They'd still be participating, they'd be able to learn from the emergency room provider, and at the same time, be able to go out as a community health worker and build those services, which will eventually save you huge amounts of money. There is a model like that in Texas right now.

MEYER: I, I appreciate that very much. I-- I'm a little embarrassed I didn't think of it myself, frankly. And, and-- but I think that's, that's one of the innovative ideas that we as a board, and certainly as our health care providers in the state need to have a look at, so. I appreciate that very much.

ROGER WELLS: No problem. Thank you. I think the model would also work for medical teams to be able to strategically locate those teams throughout the state, and then be able to say, OK, here's this-- like Dr. Harrison was talking about-- this is how we're going to at least leverage the, the monies, OK? So that you have a reduced cost from Medicaid, and those patients that are noncompliant, and, and we can do a better job with what we have to work with, not necessarily throw the, the flag up white and want more money.

MEYER: Thank you.

HARDIN: Other questions? Seeing none. Thank you.

ROGER WELLS: My pleasure. My address is on there. If you ever have any questions, or would like to be-- I would love to be involved in any of your studies. Thank you very much.

HARDIN: Wonderful. Thank you so much. This concludes our hearing for Mr. Wells, and now we're going to go from the in-person appointment confirmation testimonies to the read portion. That's where I sit here and read, and do the very best I can. And so, first on that list is Brett Lindau. Doctor of osteopathic medicine for the state Board of Health. And Doctor Lindau writes: I'm an osteopathic physician currently practicing in Broken Bow, Nebraska. I graduated from the Chicago College of Osteopathic Medicine in 2009 and completed my residency in 2012 at the North Colorado Family Medicine Residency Program in Greeley, Colorado. I'm board-certified in family medicine and with the American Board of Family Medicine, and I'm currently practicing rural medicine in a town of approximately 3,500 people. I work in a privately-owned clinic, and also work at a local critical-access hospital covering the E.R., and also taking care of

patients in the hospital. I enjoy being the primary care provider for patients of all ages in rural Nebraska. I currently serve on the board-- on the State Board of Health, and wish to continue to serve on the board if allowed to. Brett Lindau, DO. Also, we have written testimony from Kenneth Tusha, D.D.S. To the HHS Committee and all concerned citizens. Please see my attached CV which is here, which I will not read in its entirety. While I may not be able to complete the five-year term of this appointment for a variety of scenarios-- retirement, health, family issues-- currently, I'm sure-- certainly are willing to serve as the dentist member on the Nebraska State Board of Health. Thank you for your time and consideration, and also for your service to our state. Kenneth R. Tusha, D.D.S. And each of you has a copy of his resume. Also, we're looking at Patricia Kucera, and she writes: To whom it may concern, I appreciate being considered for the opportunity to serve as a representative of the nursing profession on the Nebraska State Board of Health. I'm honored to care for our veterans in an inpatient setting as both a caregiver and an advocate. My passion for nursing started several years ago at Douglas County Health Center as a nurse aide to care for the underserved and abandoned population of those that suffer from dementia and undesirable violent behaviors. I knew that nursing would be a lifelong passion for me, and I obtained my LPN and then, eventually my RN. My passion for nursing is driven by the desire to improve patient outcomes, by enhancing clinical practice, and collaborating within the interdisciplinary team to improve quality of life and autonomy. I worked at Immanuel Medical Center on the post-op rehab unit, and also on the psychiatric intensive care unit at Immanuel. I went on to earn my graduate degree in nursing, and started working with our veterans at the VA medical center on the psychiatric intensive care unit as a staff nurse. While working on the PICU, I noticed gross discrepancies between various disciplines, and initiated a research project to quantify a patient's acuity level in order to properly staff that unit to meet patient needs. I was able to form different committees to address the different needs of the veterans while in our care, and kept management and coworkers motivated over a two-year time frame to completion. The research project was successful and eventually published, and is being utilized on a national level. Kucera, P.; Kingston, E.; Ferguson, T.; Jenkins, K. and several others is the reference for that particular work. She continues: during the publication of this acuity tool, I was diagnosed with stage-four cancer, and endured the treatment and side effects of a terminal illness. I was hospitalized several times, and almost passed away because of infection and hemorrhaging. The diagnosis, though brutal, was an invaluable learning opportunity to experience what it was like

to be the patient and not the nurse. It made me more compassionate and understanding of the frustration and sadness that comes with living in the realm of the unknown. I'm a better nurse and clinical instructor because of my illness, and I'm fortunate to currently be in remission. I'm honored to be an adjunct professor at Creighton University College of Nursing since 2021. I lead clinical rotations for the students on both the PICU and on medical surgical units. I feel that it's important to teach my students compassion, autonomy, and advocacy for their patients. Someday, we will all need their care, and I'm focused on making them the best possible nurses they can be. Though I have a graduate degree, I feel that my own personal experiences can be just as powerful as an education. In conclusion, as a member of the Nebraska State Board of Health, I feel that I will be able to represent the citizens of Nebraska with the goal of being able to expand the scope of practice, promote advocacy, define and shape policies, and enhance patient-centered care. My goal is to be a part of stabilizing the ever-changing policies that will provide resources and impact multiple disciplines, to promote patient-centered care for the best of outcomes. Being able to instruct the next generation of nurses is an honor. Using my experience of a wide range of nursing disciplines that include orthopedics, traumatic brain injuries, geriatrics, medical-surgical, and psych. Regards, Patricia Kucera, and she has a lot of letters after her name. This concludes her testimony and reading. Also moving on, Staci Hubert. Good afternoon, Chairperson Hardin, and Health and Human Services committee. My name is Staci Hubert, and I'm here asking to be appointed as the pharmacist member of the Nebraska Board of Health. I've been a resident of Nebraska since 1988. I've lived in Lincoln, Papillion, and Gretna, where I currently live with my husband of almost 35 years, David, who retired as a teacher/coach from Papillion- La Vista schools, and is currently-- coaches girls basketball in Ashland. We raised our three children in Nebraska, and now are enjoying our growing family and especially our six grandchildren, with two more on the way. Our family consists of several health care professionals, including a clinical pharmacist, a physician's assistant, a dentist and endodontist, a speech pathologist, and a dental hygienist. It seems that health care topics, regulations, laws, and well-being of our patients are a common topic of conversation around our house. I grew up in Onawa, Iowa, a small town in western Iowa. I graduated in 1994 from the University of Nebraska College of Pharmacy with a doctorate in pharmacy after attending undergrad at the University of Nebraska-Lincoln. I worked at Ashland Pharmacy after graduation, and worked into part ownership, and then full ownership until December of 2021. I then managed it under a different ownership, heading up their clinical operations until they

sold it unexpectedly in July of '23 and shut down the only pharmacy in town, and really the only health care destination for the surrounding area at that time. This vote-- motivated me to be more involved in helping independent pharmacies, especially in those underserved areas in Nebraska, so now I currently manage a group of 62 independent pharmacies across the state to help them get paid for services through grants and value-based contracts. Keeping a sustainable income for services will hopefully keep their doors open so they can continue providing key healthcare services to their communities. I've served on many different committees throughout my years, including UNMC College of Pharmacy Alumni Board, Ashland Chamber of Commerce, Gretna Saint Patrick's Catholic Church Pastoral Council, Cardinal Health regional and national advisory boards, Saunders County Health Board, and currently am serving on Community Pharmacy Enhanced Services Network's purchaser payer and partner committee, Nebraska's Medicaid Advisory Committee, and Nebraska Total Care's Provider Advisory Committee. I was asked to replace Dr. Chris Watts, doctorate in pharmacy, as the pharmacist member on the Board of Health, and would like to serve in this capacity for the next term to bring my background and expertise in my field to the board, to continue to work with DHHS Licensure Unit, and advise on public health issues in Nebraska. Thanks for your time. That concludes Staci Hubert. Diva Wilson would be the last read testimony for the day. She writes: I'm honored and privileged to be entrusted to serve on the Rural Health Advisory Commission in my capacities as a family medicine physician and faculty member for the Creighton University School of Medicine Family and Community Medicine Residency Program. I hope to serve as an advocate for health care issues and promote health equity for our Nebraska rural populations. In my teaching capacity, I also hope to promote rural health care opportunities to young learners early in their education and training. I'm heavily involved in promoting medical student and resident physician interest in full-scope medical practice, and my goal is to bring medical education and state needs together to best serve our rural communities, while simultaneously increasing awareness of rural Nebraska health care issues. I thank everyone for this appointment and opportunity. If you have any questions, do not hesitate to contact me. Dr. Diva Wilson. This concludes the reading of our gubernatorial appointments for today, and the end of our hearings today. We will be going into exec.