[LR22]

The Committee on Health and Human Services and the Committee on Banking, Commerce and Insurance met at 1:30 p.m. on Friday, November 1, 2013, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LR22. Health Committee senators present: Kathy Campbell, Chairperson; Bob Krist, Vice Chairperson; Tanya Cook; Sue Crawford; Mike Gloor; Sara Howard; and Dan Watermeier. Senators absent: None. Banking Committee senators present: Mike Gloor, Chairperson; Mark Christensen, Vice Chairperson; Kathy Campbell; Sue Crawford; Sara Howard; Pete Pirsch; and Paul Schumacher. Senators absent: Tom Carlson. [LR22]

SENATOR CAMPBELL: I think we'll go ahead and start. This afternoon we'll open the public hearing of the joint committees of the Health and Human Services Committee and the Banking, Commerce and Insurance. And we want to remind everyone today that we are having a special presentation from Dr. Zetterman, and then we have invited some testimony. But there will be no public comment, only the invited testimony today. And just as a general housekeeping, if you have a cell phone, please ensure that you have silenced it or turned it off. The invited testifiers do not need to complete an orange sheet. Is that correct, Brennen? [LR22]

BRENNEN MILLER: They do. [LR22]

SENATOR CAMPBELL: They do. [LR22]

BRENNEN MILLER: They do need to. [LR22]

SENATOR CAMPBELL: Okay. So we need to make sure that if you are an invited testifier you have an orange sheet. Are there any over there? [LR22]

BRENNEN MILLER: Pages. [LR22]

SENATOR CAMPBELL: Okay. Well have the page...if you need one, just raise your hand and the page will get it to you. I don't think there's any other housekeeping issues. Senator Gloor and I are going to, for the record, introduce the two committee. So I'm going to let Senator Gloor start with the Banking Committee. [LR22]

SENATOR GLOOR: Senator Pirsch is a member of the Banking, Commerce and Insurance Committee; Senator Schumacher, Senator Howard, Senator Crawford, and then Senator Christensen who is Vice Chair is also here today. But he's also on the Judiciary Committee so we'll see whether he can split time between the Judiciary and this hearing. But those are the members who are able to be here today. [LR22]

SENATOR CAMPBELL: And on the Health and Human Services Committee you will see an overlap for this. Senator Krist is testifying across the hall but then will be joining us; Senator Crawford is on the Health and Human Services Committee. Senator Watermeier, Senator Cook is here, Senator Gloor, and Senator Howard. I think I have everybody. Okay. I'm going to ask Senator Gloor just to give a few remarks. We decided to keep...and Senator Christensen is just coming in with us. [LR22]

SENATOR CHRISTENSEN: Where? [LR22]

SENATOR GLOOR: Perfect. [LR22]

SENATOR CAMPBELL: Perfect. He's had quite a day. He started at 9:00 with Judiciary and walked down the hall to us. So we so appreciate him coming. But I've asked Senator Gloor to kind of introduce LR22 into the record so that you know what the background was to this legislative resolution. [LR22]

SENATOR GLOOR: Some of you have heard this speech before and there's no way I

can change it or encapsulate it any other way except to say that some of us have been around long enough in the healthcare industry to remember the days when there used to be a very aggressive statewide planning effort; different regions of the state that had their own boards of directors who were involved in development of area plans, statewide plans, and also a very aggressive component of state government that was involved in planning, not just public health but everything down to where long-term care beds and acute-care beds should be. And the remnant of that, some of you know, is called certificate of need and relates now only in the long-term care arena and I think in the rehab arena if I'm not mistaken. That's all gone for a variety of reasons that we don't have to elaborate on. But now we find ourselves in a day of a Legislature that has term limits. And you have senators with eight years' maximum opportunity and experience, but you have policies that aren't built around any sort of look to the long term quite frequently. It doesn't mean that we don't have the best of intentions legislatively, but frankly there are no documents. There is no plan to go back to. Senator Harms introduced a bill several years ago that requires the Legislature to develop a long-term plan. But last year, during our discussions about the Affordable Care Act and Medicaid expansion, Senator Campbell and I and others got into a discussion about, wouldn't it be helpful if we had a 15-to-20-year look into the future as to how we would like our healthcare system in this state to be? A document that would help us not dictate, but help us in making policy decisions, decisions that have to do with educating enough primary-care practitioners as an example, issues that have to do with some preventative health decisions and long-term care. And that's basically the genesis for LR22. And with that, I'll let Senator Campbell climb on board with a review also. [LR22]

SENATOR CAMPBELL: I just would like to add that we really want to emphasize the importance of LR22 has to do with looking at what should the health and healthcare of Nebraska look like in 15 years? I mean, that's kind of the question and Dr. Zetterman is going to address that particular question. We have found in looking at other states, those of us who attend conferences, is that a number of states are ahead of us in that manner. They have formed committees or commissions or task forces, or whatever you

want to call them, that are doing what we are trying to do in Nebraska. So that we get to a point where we clearly understand what our health agenda is, what that public policy should look like, and importantly, how we spend our resources certainly from a state perspective. We are very excited about this process. I continue to run into people who were at the conference and have made comments to me about how pleased they were to be at the table with us. So both Senator Gloor and I figure that our first objective, to engage a lot of people across the state, has been met. And we have a number to go. I'd like introduce...Senator Watermeier has joined us. He's on the Health Committee. And before we start, we also have staff with us today. Would you like to introduce the Banking staff? [LR22]

SENATOR GLOOR: Yes, counsel for the Banking, Commerce and Insurance Committee is Bill Marienau, and the clerk for the committee is Jan Foster. And they're both seated over there on the side in the more comfortable seats. [LR22]

SENATOR CAMPBELL: And legal counsel to the Health and Human Services is Michelle Chaffee who is with us. And our clerk for the Health Committee is Brennen Miller who's fast and furiously trying to keep us all in tack. And the pages who are with us today--and if you need some assistance, certainly they'll be glad to help you--Peter Breunig. Peter, you want to wave your hand and he's kind of behind the screen there, and Phoebe Gydesen. Thank you, Phoebe. Okay, with that, we will start off this afternoon's hearings with Dr. Rowen Zetterman. Good afternoon. [LR22]

ROWEN ZETTERMAN: (Exhibit 1) Good afternoon. Senator Campbell, Senator Gloor, members of Health and Human Services and the Banking, Commerce and Insurance Committee and the other attendees who are here today, I am Rowen Zetterman, R-o-w-e-n Z-e-t-t-e-r-m-a-n, and I'm the facilitator of the LR22 workgroup. And I'm pleased to have the opportunity to speak with you today. I've been given the opportunity to provide an overview to a variety of issues that I think are of importance and relevance to us including both some national issues but especially some of the statewide issues

that affect healthcare within Nebraska. See if I can get this up. There we go. So today's presentation, I'm going to show you where we are as a state and as a nation regarding healthcare, talk a little bit about costs, talk a little bit about how we compare to other countries throughout the world. I'm going to show you the Commonwealth Fund Scorecard which shows you Nebraska and how it relates to the care of its vulnerable populations. We'll talk a little bit about healthcare shortage areas and the uninsured. And then I'll end with some comments about population health. I'll also have the opportunity to introduce you to the remainder of the LR22 workgroup, show you a little bit of our progress today. And I'm going to end with some commentary that came out of the workgroup and also from the stakeholders meeting that we held on October 2, in Omaha, Nebraska. So let's first talk a little bit about costs of U.S. healthcare. This is no surprise to anybody in the room and certainly to none of you on the committee. If you look here, you can see at the top a little red diamond that sits up there. It shows you the United States. This is costs of healthcare per person relative to the gross national product for each of these countries. And as you can see, in general for the vast majority of the countries except for Norway and the United States, it actually falls along a pretty common line relative to the gross domestic product. But we sit here as an outlier spending far more than almost any other country in the world. If you compare us to the 34 countries of the economic and cooperative development group, the red line shows you the average for those 34 countries, about $3,200 per person, and we're spending $8,200 per person. So on average, we're more than twice as expensive as the average of the world of these 34 countries. But importantly, we're almost $3,000 higher even than Norway which is the highest of the other countries in costs of healthcare per person. And there's a lot reasons why healthcare is expensive in this country. But we tend to get involved in some very expensive therapies. Proton beam therapy, something not yet in Nebraska, is now entering into the market in a variety of places. And it's as yet really unproven as to how successful it will be. But to compete, people are spending billions of dollars building these facilities. And in fact, if you want to see where we do well, if you want to look and see that in numbers of MRI units compared to the office...the Organization for Economic Cooperation and Development, we're actually

number two in all the countries with 31 per million versus 12.5 in those groups. We're second in MRI exams, third in numbers of CT scanners, third in the number of CT exams. We're third in the number coronary bypass. We're first in knee replacements, sixth in Caesarean sections. So you can see that when it comes to the numbers of things that we do, we actually outstrip all the rest which adds, of course, to the overall cost. And how about waste, do we waste money in our healthcare system? Well, unfortunately the answer is yes. And this is actually a graph from an article written by Donald Berwick. He was, for a while, the CMS director. And he talks about the various things. If you just look at the top of the bar going up, that's the expected increase in the amount of money relative to our gross domestic product that we will be spending up to 2020 if we don't change where things are today. And if you look at each of those areas a little bit, things in failure of care delivery, lack of preventative care, problems with patient safety, failure to use care processes, complications, readmissions, all the things that you've heard, all of these things, if you will, are some of the things that are driving the cost. We need to come to grips with these areas both nationally but also within the state of Nebraska. But it's not just simply about cost and waste. It's about value. If any of you go out and buy a suit of clothes, you look at the value of the suit of clothes. You look at the quality of the cloth and the quality of how it's made relative to the cost and that's how you determine the value. Well, the same should be true for us in our healthcare, that we look at the value of the care received and hopefully it matches what we want. So value is really quality outcome divided by the cost of the healthcare. And that's how we read the value in. As you've all heard, there's a growing push to move toward value-based purchasing: a growing idea that we pay physicians and hospitals and other people, nurse practitioners, PAs, all of us based on the value and quality of the outcomes that we all provide. Are we better off today? Have we changed in the last 20 years spending all of this money? Well again, compared to the Organization for Economic Cooperation and Development, life expectancy in the United States has increased from 75 to 78. Healthy life expectancy has increased from 65 to 68. But when you then compare us between 1990 and 2010 to the other countries, even though our death rate is better, we've actually dropped to 27th in that organization. Even though we

have improved our years lost to premature mortality, we've dropped from 23 to 28. And look at the difference down at the bottom. Healthy life expectancy from 14 to 26, go back up to the top and notice that both healthy life expectancy and U.S. life expectancy increased but in fact there's a more than 10-year gap in there that shows you that, yes, we may live longer, but we live longer with disability. And when you look at some of the reasons, the reasons shown on the left, it's because of our dietary risks, our smoking, high body mass index, high blood pressure, diabetes and the complications related to that, problems related to low physical activity, alcohol use, all the things that you see along there, all of the issues in population health that we have to come to grips with in Nebraska to improve the quality of life and make us the healthiest state in the nation. So let me show you the Commonwealth Scorecard. This actually is a little bit of good news when you look at this. They looked at the vulnerable populations of all 50 states. And they've used four broad areas: access and affordability of care, prevention and treatment, avoidable hospitalizations, and healthy lives. And then they looked at every state relative to those four things. And this picture shows you, Nebraska there in white, shows you that we're in the top 12 states in the nation in overall health system performance for low-income populations. So we should all pat ourselves on the back until you kind of look underneath the covers and see what's hidden inside of that. So if you look at access and affordability as an example, we're actually in the second quartile. We're not in the top quartile here. So we're in the top 24 of the states, or 25 if you add in the District of Columbia, on access and affordability. But just to show you some of the places where we have problems, 14 percent of Nebraskans live at the federal poverty level or less for income and a third of Nebraskans live at less than 200 percent of the federal poverty level or less. Remember, if you're a single Nebraskan, 200 percent of the federal poverty level is about $22,000, $23,000. So a third of our population makes less income than that. And of course, for a family of four, in a larger family that would be about double that. It would be about $44,000. Notice, we may have Kids Connection. We may have lots of things. Ten percent of the children in Nebraska remain uninsured. We're not counting people who are not otherwise Nebraska citizens. We're talking about Nebraska citizens, 10 percent. The best state in the country, only 3.2 percent of their

children are uninsured. And look at out-of-pocket medical spending. For that family or that person making less than 200 percent of the federal poverty level, they're spending more than a third of their income on their healthcare out of pocket. We're not talking about anything else, just the out-of-pocket money. But for those us that live at 400 percent of the federal poverty level or higher, so more than $45,000 for a single person, more than $80,000-some for a family, we spend only 2 percent of their disposable income on medical care--a remarkable difference just in those two populations. How about in prevention and treatment? Well, here we are in the top quartile again. That's good to see. The white is always going to be the top quartile. Percent of children who received both medical and dental preventive care in the past year: only 69 percent of the kids in Nebraska. The best state rate is 85 percent. The percent of adults age 50 and older receiving recommended screening and preventive care: less than 40 percent; best state rate: 52 percent. Let me give you one example. One in 17 Nebraskans will develop colon cancer. We have a very high rate of colon cancer. And yet this is the population that should be being screened by colonoscopy or barium enema or CT colonography or some technique. We're reaching less than 40 percent of those people. How about avoidable hospitalizations? Well, here we are in the second quartile again, so we're still doing pretty well. But our pediatric asthma admission rate is 100 admissions per 100,000 kids. The best state rate is half of that at 48. And adult diabetes admissions--you should never basically need to admit your diabetic if you're taking good care of them--181 admissions per 100,000. The best state rate is 149. So while we're doing okay perhaps compared to the national average, I would submit that's not where we want to be. We want to be where we're the best. And last, healthy lives: Again, we're in the second quartile overall for healthy lives performance and the many things they looked at. But breast cancer deaths per 100,000 women in Nebraska, 24; best state rate, 17. Colorectal cancer deaths, 18.5; best state rate, 13.3. And look at this: 20 percent of Nebraskans continue to smoke with a best state rate of only 11 percent. This is an important issue. And I'm going to show you some other data in a second to bring that home again. How about if we look Nebraska health by county. This I found to be one of the most fascinating articles that I've read this year. So they looked at mortality

factors in men. And you can see that male mortality in this country from '92...they looked at four years from '92 to '96, compared it to 2002 to 2006, ten-year difference. They showed that male mortality decreased in this country by almost 10 percent. But actually mortality increased in 3.4 percent of the counties of the country. What they found in factors that showed reduced mortality in the counties of the United States was a greater proportion of the population that was Hispanic in heritage, more adult college degrees, greater population density, and higher household income, okay. And if you look at the country, the red counties are the counties that have a higher rate of mortality in the second study than in the first. You'll see there are seven of the 93 counties of Nebraska that are actually worse. And a relatively small number in blue that showed substantial improvement. The rest of them only had minimal improvement. How about if we look at women? Well, this is a tragic slide because female mortality decreased by only 1.5 percent over that 10 years. And in fact, mortality of women increased in 43 percent of the counties of this country. The reduced mortality was related to exactly the same factors as for men. But notice that clearly when you looked at female mortality, increased mortality related to the fact that somebody in that home smoked. Whether that was the man or the woman or someone else in that household, smoking was clearly related to increased mortality. And let me show you the picture of Nebraska. This is Nebraska in red showing that 51 of 93 counties in Nebraska had increased mortality of the women in those counties over the 10-year period from '92 to 2006, 51 of 93. Of course, you all know about shortage areas. You hear about this every day. And it's in a crucial and important area and something that our committee will look at very hard because we've got to come to grips with how to deal with this. Now, this is the federally designated primary care medically underserved areas in population. So primary care, basically we're talking about family physicians, nurse practitioners, PAs, obstetricians, pediatricians, and general internists along there. If you look at the state-designated areas...incidentally, notice that there are some areas that there are populations inside of some of those counties where the total county may not meet the criteria. There are areas in those counties in green that do. So here's the state-designated shortage areas for family medicine. Notice also on these slides you'll see that the...that there are the

designated federally qualified healthcare programs that pop up on these slides. Here's the same data for general internal medicine. So these two amongst physicians make up the largest percentage of the primary care physicians in these areas. Here it is for general pediatrics. Outside of Lincoln and Omaha, only three counties fail to be designated. Look at this for general surgery. A majority of the state clearly lacks general surgeons to provide that urgent and emergent operative care that people need in the rural areas. Look at psychiatry and mental health. When you get outside of the Omaha-Douglas County area and the Lincoln-Lancaster area, the entire state essentially is short in mental health providers of all kinds, whether we talk about psychiatrists, psychiatric nurse practitioners, PAs, whatever you want to talk about, clinical psychologists, clinical social workers. We have a real problem in mental health in this country. Dentistry, as long as you live along Interstate 80, you're doing okay. But once you get away from Interstate 80, again, you can see that the state has a lot of dental need. And pharmacy need. Again, Interstate 80 with larger towns tends to have a number of pharmacists. But a lot of the rural areas lack the pharmacies that the people need in order to get access to medications and other services. How about lack of health plan coverage for Nebraska? You're suffering from a serious medical condition called lousy insurance. Unfortunately, for some people that means no insurance whatsoever. I made this slide to show you...just to pick out the ten counties that have two-thirds of the population. And no surprise, it's where we have some of our larger hospitals. So you've got Scotts Bluff, Lincoln, Buffalo, Hall, Adams, Madison, Gage, Lancaster, Douglas, and Sarpy County--two thirds of the population in those ten counties of the state. Now, this graph...or this slide of Nebraska shows you the counties. The blue county is the county that has less than 10 percent of the men under age 65 years...adult males under 65 years, less than 10 percent are uninsured. The brown counties have between 10 percent and 20 percent of the county that's uninsured. The orange has 20 percent to 30 percent of the county that's uninsured. And the black county at the top, Keya Paha, has more than 30 percent uninsured men. So the majority of the state has more than 10 percent of the counties uninsured. But the more rural you get, the greater the percentage of uninsured men. If you look at women, we do a little better in that we have

more counties in the blue and we have more counties in the brown. We still have one county that's black, so more than 30 percent. But we also still have eight counties that have greater than 20 percent and less than 30 percent uninsured women. The Center for Rural Affairs in Nebraska wrote a paper in December and came to these three conclusions. Nebraska's rural counties have lower health insurance coverage rates than the urban counties. Counties with uninsured rates of 21 percent or greater basically only exist in non metropolitan areas, and that lower health insurance coverage results in weaker rural communities and a less healthy rural Nebraska. So that brings me to population health because I think the key, this is a personal opinion, I think the key for a lot of what we do is we have to make this the healthiest state in the country. And to do that we have to look at the issues of population health. And population health really revolves around three broad areas: prevention, we'll touch on that a little bit; quality and patient safe care; and importantly, coordinating care between all the different kinds of providers that are out there to make sure that everybody has access that's affordable and available. So the health of the population depends on the environment. And actually there's a lot of fascinating research going on looking at the environmental factors that relate to things like obesity, that relate to hypertension, that relate to diabetes. And this is an area that we'll increasing do research on. Education, if you look at any kind of data, you'll find that the more educated your people are that live in the state, the better their general health. Job availability, we need to increase job availability throughout the state because that will also improve access to healthcare because we'll get more rural providers out there--quality of healthcare, individual behavior, and of course, effective programs and policies. You know, smoke-free laws for public spaces, I showed you the data on female mortality in homes where there's a smoker--seat belt laws, all the things that add to the health of a population. Improving health will likely require public health interventions as well as healthcare system improvement. So while our group will look hard at what healthcare systems should be looking like in 15 to 20 years, we're clearly going to have to look at the public health interventions as well. To manage the population health, you've got to focus on both individual and population health. And you...all the committee people today have had the opportunity to get a handout from us

that summarizes most of the data that we got from our stakeholders. And it's broken up into a variety of areas. But it talks about population health, and it talks about personal health. There must be an emphasis on prevention and wellness. Remember the over-50 age population in which only about 40 percent of them were getting preventive services? We've got to make that better. There's got to be good utilization of services. You've got to reimburse based on quality of care. Care has to be seamless. Whether you're an outpatient or an inpatient, you've got to connect all of the those providers together and have them collaborate. And we need to collect the data on the state. We need to have all of the healthcare data in one repository so that we can study everybody no matter where they live and no matter who provides their care because if we can identify best practices by doing that, then we can move those best practices out throughout the state to help others. And I bet you a dollar you're going to find best practices in some of our small rural areas that we need to bring back into our metropolitan areas. And of course, you got to have the citizens who are willing to participate in their health. They've got to be engaged in what they do. What fits best into your busy schedule, exercising one hour a day or being dead 24 hours a day? That's a great question to ask a patient sometimes when they tell you they don't have time to exercise. So let me tell you a little bit about LR22. The committees, of course, all are very well aware of this. But for the rest of you, we were directed to look at a comprehensive review of healthcare cost and coverage demands throughout the state, to bring the stakeholders together. We've already had one stakeholder conference and we'll certainly need to have more, work on strategy, that we're going to look at care and quality and value and all those sort of things. And then hopefully develop a framework that allows us to make a system transformation to all of the health that's here. Now the LR22 workgroup is made up of 14 people...I guess 14 people counting myself. And I'm going to go through and just tell you who they are. Bob Bartee, vice chancellor for external affairs at the University of Nebraska; Stacie Bleicher who's a pediatrician here in Lincoln; Jennifer Carter is the director of public health for Nebraska Appleseed; Marty Fattig is the CEO of the Nemaha County Hospital; Ann Frohman runs the Frohman Law Office here and is in government relations and has a background in insurance; Tom

Henning is the president of Cash-Wa Distributing in Kearney, Nebraska; Sade Kosoko-Lasaki is an ophthalmologist at the Creighton University School of Medicine; Chris Kratochvil is an associate vice chancellor for research at the University of Nebraska; Linda Lazure is the associate dean for external affairs at Creighton University College of Nursing; Gerry Luckey is a family physician in David City; Cory Shaw is the CEO of UNMC Physicians; Tom Werner is a family physician in Grand Island; and I'm the facilitator for the LR22 workgroup. So we've done a variety of things, and I'm not going to go through this in any detail other than to say, an important facet was we needed to have the stakeholders involved. And as you heard from Senators Campbell and Gloor, we had a meeting in October, about 165 attendees there. We had a large number of people that had lots of interest in healthcare throughout the state that were there. They're still sending us information. We did a survey after the meeting, and they provided even more input in that survey of things that they think we need to be working on. We asked them two basic questions. What should Nebraska's healthcare system look like in 15 years? And what are the opportunities and challenges that Nebraska's patients, providers, and payers will face in making that change? And what have we heard. Well, these are some of the comments and by no means all of them. It actually covers several typewritten pages. We must improve healthcare value. In other words, outcomes divided by costs have to be highly positive. We need to aggregate health outcomes data from all of the healthcare entities in Nebraska so we can find those areas in which there's pockets of great care and figure how to spread those pockets out to rest of the state. We've got to improve population health throughout Nebraska. We've got to make sure that happens. And we have to develop community-based systems of care. We need to get the communities involved in how we make the population healthy and also how we deliver care throughout those communities. Vermont has a plan of community care teams. And if you want more information about this, I'll be happy to share it with any of you. But they've developed a community plan in which they have care teams of nurse coordinators, social workers, dietitians. They work with the physicians, the hospitals, the specialists, with their public health entities in their areas. And they go out and touch the patients and deal with the patients to help make sure that

wellness occurs. And we need a statewide vision for population health and healthcare delivery for all Nebraska. Alan Weil spoke at our meeting in October and he said, a state vision is an expression of the state's priorities for health system improvement. This is a crucial issue I think. If we don't have a state vision, we'll not get there. And I'm lousy at quoting baseball players, but as I remember, the old joke goes something about if you don't have a map, you'll never know where you're going to go or something to that effect. We have to have a map. We need a vision that connects all the people to needed healthcare services, that provides integrated healthcare and invests in data-driven measurement of outcomes and utilizes population-based interventions to improve healthcare and decrease the burden of chronic disease. We need a definition of personal health. And I would submit this is the definition we want to use. This is actually the World Heath Organization definition. That health in Nebraska means the "physical, mental and social well-being" of all Nebraskans. It's not about not having a disease. Remember, I told you that 10 years of life for most of us is going to be encumbered with some sort of chronic disease. Rather, we should be physically, mentally, and socially well. But we've got a challenge I think and that's the conservative nature of this state that may be a barrier to establishing a healthcare vision. We've got to overcome that challenge because the very real opportunity for us is creating a statewide culture of health that can attract more businesses and more people to this state. And I think that's the opportunity we need to seize by developing a proper statewide vision. I want to leave you with one reminder, and then I'll say I'm grateful for the opportunity to speak today. Long-range planning does not deal with future decisions but with the future of present decisions. We've got to make these decisions today to reach whatever vision we're going to get to in 15 years. Thank you, Madam Chair, Senator Gloor. I appreciate the opportunity to speak. [LR22]

SENATOR CAMPBELL: Are there questions from the senators or comments that they'd like to ask? We'll also see that you get a copy of this and we'll be distributing. We continue to send out materials to the people who came to the conference who are on our list. So if you were not at the conference and you have not notified my office, please

do so and say, I'd like to be on the LR22 mailing list. And we will continue to provide information to you and particularly Dr. Zetterman's presentations today. Okay. Senator Cook. [LR22]

SENATOR COOK: Thank you, Madam Chair, and thank you for your presentation. I have two questions. The first is related to the mortality rates that we saw increasing over...that have increased over time for women in the state. And I couldn't reconcile that with the greater rate of insured women in the state. And maybe there is no correlation or causal relationship. Can you help me with that? [LR22]

ROWEN ZETTERMAN: Yeah, I think you'll find that there's not a direct relationship to insurability. [LR22]

SENATOR COOK: Okay. [LR22]

ROWEN ZETTERMAN: Okay. You'll notice that most of those counties again, however, were the rural counties of the state where the higher percentage was. And you'll always find the higher percentage of uninsured in the rural counties of Nebraska. So there could be a relationship. But in their study, they did not find that... [LR22]

SENATOR COOK: Okay. [LR22]

ROWEN ZETTERMAN: ...at least on a countrywide basis. They didn't just look at Nebraska, remember. They showed us the Nebraska data, but they looked at the data for the entire country as they looked at the county health issues. And insurability did not reach a statistical significance in that particular issue. [LR22]

SENATOR COOK: All right. Thank you. And my second question relates to the issue of rural stakeholders. When I saw the stakeholder group, and I know how hard it is to gather people, especially when there's already a shortage of practitioners and experts,

but what kind of outreach have you done to get input from those pockets across Nebraska without providers and access? [LR22]

ROWEN ZETTERMAN: I think it's definitely something we will go to as we move forward in working with this group. We'll need to bring, I think, some more people together to look at some of the questions. And the workgroup is considering, for example, holding workgroup meetings in some of the rural cities in order to look at that question and invite people to come in and give us their information that's there. We do have two rural family physicians on our committee. And so that's very helpful because they obviously can provide some input. And we have some organizations represented which have...on the workgroup committee that do have some rural connections. But I agree with you. We need to broaden the stakeholders list. And as Senator Campbell has mentioned, we invite everybody who's interested to put their name into the mix so that we can continue to send them information. And we'll seek information from anybody and listen to it. [LR22]

SENATOR COOK: Thank you. [LR22]

SENATOR CAMPBELL: Other questions from the senators? Did you have a question, Senator Gloor? [LR22]

SENATOR GLOOR: Doctor, could you elaborate a little bit? You made reference to Vermont's community-based systems of care. Could you talk about that a little bit more just from an education standpoint so we have a better understanding of how they saw that as a solution? [LR22]

ROWEN ZETTERMAN: Thank you very much. You know, I think the answer is, we're always going to have a number of physicians, nurse practitioners, PAs that's never going to quite be as many as we want in the state, would be my prediction. And Vermont looked at this and said, we have a lot of other providers that can go out into the

homes and work with the people and find out, what do they have in issues that prevent them from getting healthcare? What do they have in illnesses such as hypertension and diabetes? What are the social issues that are there? How can we work in the communities and build a more healthy community, which we have some states...we have some cities in Nebraska that actually are doing that quite well, working on activities for their citizens to do more, to be more healthy, bike trails, hiking trails, all the things that are beneficial. And so they decided that they would use all these additional workers in there. As I thought about Nebraska, Vermont is a very different state. It's not very big, and their population areas are fairly small but not distributed very far apart. Two-thirds of the population of this state lives in ten counties. If we took out those ten counties as a starting point, and then began to group the others and built those same sort of community programs as we added them together, I think we could make a great deal of effort. And I will be honest and I've told the workgroup this, I have a little bit of a bias because I have a son who's been family physician in Alaska working with Native health corporations in which some of the communities that he takes care of, he only gets to four weeks out of the year. Yet there's a healthcare worker there, the equivalent usually of an office technician for what most of us would have, who delivers all the healthcare every day. It's usually a young woman, but she also has access to my son every day. She can call him. She has an electronic health record and sends him everything that she does that day. He oversees it all. We need to learn how to use a lot of people in assessing the care of people and perhaps delivering much of the care. And so I think those are some things that we can do in this state. And that's where the community programs can come into play is because we're using people that maybe aren't as highly trained, as highly educated as the physician or nurse practitioner or PA. And yet they can be out there doing blood pressures, checking blood sugars, doing weights in the person with congestive heart failure, bringing that information back and sharing it, have algorithms to work through so that if the weight suddenly goes up in one of their heart failure patients, they know they need to call right away, all of those sort of things. [LR22]

SENATOR GLOOR: Thank you. [LR22]

SENATOR CAMPBELL: I think we'll go next to the folks who attended the conference. And we just tried to pick a sampling of those folks to talk to the two committees on what their perspective was after spending time at the conference. And we'll start with Dr. Luckey. And I know he's here. I saw him come in. As Dr. Luckey is coming forward, I'm going to read through the list and I'll keep so that the people who are testifying know sort of the order. We'll go from Dr. Luckey to Kim Russel, Marty Fattig, Dr. Spindola, Mark Intermill, Andrea Skolkin, and Beth Baxter. So I'll keep repeating that, but just so you kind of know where you're at. Good afternoon, Dr. Luckey. [LR22]

GERRY LUCKEY: Good afternoon. [LR22]

SENATOR CAMPBELL: Could you state your name for the record and spell it, please? [LR22]

GERRY LUCKEY: (Exhibit 2) Sure. Gerry Luckey. G-e-r-r-y L-u-c-k-e-y. I'm a family physician from David City. I have the distinct pleasure of following Dr. Zetterman who's a distinguished speaker, and I'm not. But we have similar backgrounds and have known each other for years and have taken different paths and have done a lot of things that...have a lot of things in common. I appreciate being here today. I'm here to give a perspective of what I saw at the stakeholders conference, and probably a rural perspective as well. Being in David City for nearly 40 years tells you that number one, I'm not very adventuresome because I haven't moved; number two, that I'm probably resistant to change. But healthcare has to change. And I think that's what this committee is all about. I applaud the senators for taking this initiative. I think it's clearly the right thing to do. Medicine is at a tipping point. We can either go off the edge or we can pull back and do a better job. And our problems, as Dr. Zetterman has mentioned, is that we have high cost and we don't have the best quality. So that's the goal. From the standpoint of the stakeholders I would say, we're all in this together, I'm very

gratified that you had the foresight to bring the stakeholders together so that we can all have input and try to make this...try to have a plan. So it's a visionary-type of thing. One of the questions that I was given...well, I guess the question that I was given is, what did I see? What did I take away from this conference? I don't have a PowerPoint. I have a handout, and I'm breaking this down into a couple of different areas. I'd like to address population health, personal health, work force, care delivery, and cost of care. Dr. Zetterman has mentioned population health, a lot of things in the literature these days about population health. How can we manage populations? Clearly, preventive care is foremost in doing population health. We have never...in my opinion, we've never spent enough time in preventive care. We've always...it's always been illness care. We need to move that toward preventive care. If we can shift, if we can prevent sliders...I always refer to sliders as people that slide from healthy to unhealthy--we need to prevent those people from sliding. Currently, we get to about age 68 before we become unhealthy. If we could move that to 75, think of the impact on healthcare costs. Think of the impact on the quality of life. I think we need to look at awareness of health in the population through education. I don't think there's enough healthcare education out there. A number of places we can do that, certainly in the schools, middle school would be a good place to address things like tobacco and drug abuse. These are some of things that I came away with, sexually transmitted diseases, that type of thing. We talked about the tobacco use. Just as a point of information, if you are homeless your odds of smoking are 70 percent. If you are in a higher socioeconomic level, your odds of smoking are about maybe 10 percent, maybe less. I'm not sure exactly what the break off is, but it's close to that. So we talk about healthy populations, the idea of having health awareness in the forefront. We have a new College of Public Health. I think that we should be using that College of Public Health to improve the health of Nebraska. There are many, many good things going on in that College of Public Health. It's just getting started, great opportunity there. Final thing I'd mention with population health is 50 percent of healthcare costs are choice driven. We choose to eat too much. We choose to smoke. We choose to use drugs. We choose to probably drink too much alcohol. You know, a little wine is fine but you know...(laughter). So anyway, I think, you

know, we need to address these issues. The issue of childhood obesity has come up, great cost savings if we can impact that area. Going on, that was population health. Going on to personal health. We need good access to healthcare. We have pretty good access in rural Nebraska. In our clinic, we're trying to do same-day access. We understand that that changes the cost structure. It changes the population health. If you can get in to see your provider, you likely will not show up in the emergency room. You potentially won't need to be hospitalized. So appropriate access is, I think, vital. Then the concept of care coordination, we need care coordination through the ages, care coordination through every episode of care so that people aren't accessing inappropriate care, care that's too expensive, care that isn't in the right place, right time, that type of thing. We need to have patients take more responsibility for their health. Example is this week I had a lady that I'd been trying to encourage to lose weight for years. And it turns out that I saw her a few months ago and she came in and brought this health profile in, so that her employer had done this wellness program. And she scored low. And she said, what am I going to do about this? And I said, well, you need to do this and this and this. And your numbers will go up, but the incentive for her is her health insurance is going to go up if she's not in the low-risk category. I saw her Monday. She's in that category. So a little bit of incentive and a little bit of awareness, a little bit of motivation, puts her in the healthy category. So who benefits? Well, she benefits clearly. Her employer benefits, and the insurance company will pay fewer claims down the road. We need more examples like that. Work force, clearly as Rowen mentioned, we need more primary care providers. Now that's not only physicians, we need nurse practitioners. We need pharmacists. We need dentists. We need physician assistants, social workers, mental health workers where we're short. We've learned to live without mental health workers because we just do it by ourselves and we think we're doing okay but probably not as well as other people could do it. The team-based approach, the care coordinator, the patient-centered medical home is kind of what we're pushing for, or what I heard as being important. I personally think that's vital. The educational process, I brought a medical student with me today and we were talking about that on the way up. And so we talked about the patient-centered medical home

and I asked her if she felt she was well prepared for that. And admittedly, she's a third-year medical student, so she hasn't gone through the whole thing. But she would like more...well, I think she should have more leadership training, the concept of the patient-centered medical home. If a primary care provider...now, we're talking rural Nebraska. We're not talking in the Nebraska Medical Center treating someone with a stem cell transplant. We're talking out in rural Nebraska now or in urban Nebraska in the primary care setting. But if we have well-trained primary care people who can coordinate a team, we will have better outcomes. Those are some of the things I heard. How do we get there? I guess if we look at why don't people go into family medicine, the thing that always comes up is loan repayment. I can be an orthopedic surgeon and have that sucker paid off in probably a year. But in family medicine, it might take me ten. So that loan repayment seems to loom very high, and we've been recruiting for a number of years. We've arranged a personal...I guess a local loan repayment process that we will do. And we have to do it to be competitive. That's very important. So loan repayment is important in keeping the work force. Delivery of care, I've touched on some of these, but the medical home concept has been proven to be cost effective. IBM saved a billion dollars on the patient-centered medical home. 3M has used it. I mean, it's nothing new, it's just that it's slow to get implemented. It's expensive to get implemented. We're doing that in our office. It's costing us a lot of money. From the standpoint of, first of all, the patient-centered medical home but at the same time, we have chronic disease management that occupies...that is responsible for maybe 50 percent to 60 percent of healthcare dollars. So we have to have excellence in chronic disease management. Again, keeping people out of the hospital, keeping them healthy, keeping them in their homes. The Vermont model uses a lot of low-tech stuff. I think we need to look at more low-tech things, kind of like this handout. [LR22]

SENATOR CAMPBELL: Dr. Luckey, I was going to say, could we kind of combine a couple, because I want to leave some time if there are questions for you? [LR22]

GERRY LUCKEY: I'll do that. I'll do that. The payment system will change. We'll cut to

the chase. The payment system will change. We will be looking at more capitation. We will be looking at more Fee-for-Service plus payment for quality, bundled payments, and that will drive behavior in healthcare as far as how we spend money. Waste has to be limited. So the goal down the road will be a team-based medical home model. It should be led by a highly trained primary care physician. It should be evidence based. Payments should be based on quality and outcomes, not on volume. It should be value driven. We need to kick the habit from volume and develop a passion for value. And most of all, it should be patient centered. The challenge is we have no clear vision. This committee is designed to create a clear vision. And I think we will be successful. Thank you very much. [LR22]

SENATOR CAMPBELL: Questions? Sorry, Dr. Luckey. Questions for Dr. Luckey? Dr. Luckey, have you had anyone in your practice who has gone through the loan repayment program that we have? [LR22]

GERRY LUCKEY: Yes, we have. Yes, we have. [LR22]

SENATOR CAMPBELL: I'm sure Mr. Fattig is going to cover that, at least I hope he's going to mention that. [LR22]

GERRY LUCKEY: Yeah. [LR22]

SENATOR CAMPBELL: But you have had, and that has been successful. [LR22]

GERRY LUCKEY: Yes. We have one who's completed it within the last year. [LR22]

SENATOR CAMPBELL: Excellent. How many physicians do you have in your practice? [LR22]

GERRY LUCKEY: Four. [LR22]

SENATOR CAMPBELL: And so you kind of cover a region around David City, would that be accurate? [LR22]

GERRY LUCKEY: Yes, we do. Yes, we do. We have about, oh, probably 10,000 patients. [LR22]

SENATOR CAMPBELL: Okay. Oh, Senator Gloor. [LR22]

SENATOR GLOOR: Thank you, Senator Campbell. Dr. Luckey, since this is an educational briefing as much as anything, would you mind taking a minute to explain as best you're able, I understand this can get involved, per member per month and... [LR22]

GERRY LUCKEY: Yes. [LR22]

SENATOR GLOOR: ...and capitation which are two terms that are familiar to some of us but maybe not all of us. [LR22]

GERRY LUCKEY: Sure. Fee-for-Service plus per member per month is a payment system where if you report quality measures and do quality care, you are paid for every time you see the patient plus a per member per month. It might be $2. It might be $4. It might $10. But again, this model has been proven to be beneficial from the standpoint of cost savings over and over again. And this was...well, the Medicaid pilot project used this model. They didn't pay extra for it, but it was the model. The patient-centered medical home model was used. So that's what we're basing ours on at this point. And we have contracts where we are now certified as tier I patient-centered medical home and almost to tier II. Well, the payer says, okay, you've got that. We know that saves money so that we will pay you additional dollars. Now that neutralizes out because it's not like we're putting more money in our pocket. Basically, it's paying for our extra...the

extra expense of doing this type of thing. So we've hired a care coordinator. We've hired more nurses. We've, you know, had to add staff. It takes a lot more time to see a patient because we're monitoring their...have they had a Pneumovax? Have they had a flu vaccine? Have they had a mammogram? Do they need a colonoscopy? All these things are addressed at that time. It's all documented in their chart so that we do the preventative care and hopefully save some dollars down the road. [LR22]

SENATOR GLOOR: Thank you. [LR22]

GERRY LUCKEY: Capitation. Capitation is where you pay so much per month for doing all the care. With population health, an ACO is an example of capitation where you have...let's say you have 10,000 Medicare patients. CMS knows it costs $92 million to pay for those. So you say, okay, we'll take that risk. And you come in at $92 million. You either share in the savings or keep all the savings. If you go over, if you're in a risk model, pull out the checkbook. [LR22]

SENATOR GLOOR: Or negotiate harder next time. [LR22]

GERRY LUCKEY: Right. [LR22]

SENATOR CAMPBELL: Thank you, Dr. Luckey, very much. [LR22]

GERRY LUCKEY: Thank you very much. [LR22]

SENATOR GLOOR: We're glad you're on the workgroup. [LR22]

GERRY LUCKEY: Thank you for asking me. [LR22]

SENATOR CAMPBELL: Kim Russel following him. And so he want may to make his way to the front, is Marty Fattig. There he is, right in front. Thank you. Good afternoon.

[LR22]

KIM RUSSEL: (Exhibit 3) Good afternoon. I'm Kim Russel, R-u-s-s-e-l. And thank you so much for the invitation to testify at today's meeting. I'm the CEO of Bryan Health which is a nonprofit, locally owned healthcare system. Thank you. We have three hospitals, two here in Lincoln and one rural hospital in Crete. So as you would expect, my comments today are based on the perspective of a hospital administrator. I have been in this field for 34 years so, again, my comments--I guess I'll apologize ahead of time--are going to be very hospital-centric. But keep in mind that we absolutely recognize that hospitals serve...or I recognize that hospitals serve their patients, and that's the perspective that I bring today. So I was very pleased when LR22 was established, and I was honored to be able to attend the conference in Omaha several weeks ago. I believe the premise of LR22 which is to try to proactively plan for the needs of our state in respect to healthcare are just absolutely essential to keeping our state healthy into the future. I would like to give you a little perspective on what hospitals are facing today, and I want to give you that perspective as a foundation as the committee considers where it might be going in the future with this. Many people say that the American healthcare system right now is undergoing the greatest amount of change since Medicare was introduced in 1965. And I absolutely agree with that statement. It's important to understand though that all the changes that hospitals and the patients they serve are undergoing right now are not solely related to the Affordable Care Act even though that's what's in all the headlines right now. The changes that we're facing are many. And let me just...and all happening at the same time. Let me just give you a couple of examples. The American Recovery and Reinvestment Act or ARRA, it basically mandates the use of electronic health records in hospitals and throughout the healthcare system--major, major change both from a capital investment standpoint as well as process time, etcetera. We're also in the midst of change for something called ICD-10 and what that stands for is the International Classification of Diseases. It governs the way in which all medical activity on patients is actually recorded and documented. And this is a change that's going to be going into effect

across the U.S. starting in October of 2014--major, major change for our physicians and hospitals. Sequestration: All hospitals, and this also includes rural hospitals, received the sequestration cut this past January. Two percent was the cut in Medicare funding that hospitals experienced. And another major change, private employers are making drastic changes in the composition of their health insurance benefits. And we just heard Dr. Luckey talk about one aspect of that. But many employers locally and statewide are instituting very large copays and high deductibles. And the impact there to hospitals is very often individuals simply do not have the funds to be able to pay those high deductibles and that then becomes generally charity care that's advanced by the hospital. The payment system for hospital services is also beginning to change, and Dr. Zetterman referenced this as well. For decades, hospitals and physicians have been paid for each visit, each time a patient comes in or each time a procedure or treatment happens. Well, Medicare is beginning to edge toward paying hospitals and physicians based on medical outcomes. And I like to kind of use my grocery store analogy to explain that. So you know, bear with me on this. But when you go to Hy-Vee, a cashier rings up everything in your basket, right? Pay your...for every item, the end of your transaction, you pay Hy-Vee the total amount. Well, just think what a change it would be if at Hy-Vee, if Hy-Vee would be paid based upon the outcome of the overall grocery basket full of food that was sold to each customer. So if the customer developed diabetes or hypertension after eating their grocery basket full of food, then Hy-Vee would not be paid or in fact might be fined by the federal government. That's exactly what's happening in healthcare right now. Or you know, if the customer's grocery cart of food helped the customer lose weight, well, then maybe Hy-Vee would get paid and maybe they'd even get some sort of an incentive. So that's exactly what's happening right now in healthcare. You can see what a major change that would be for Hy-Vee in every aspect of the way that they ran their store--same story for hospitals. So Nebraska hospitals are in the very midst of adapting for this new payment system from the federal government. So while all of this change is afoot, healthcare systems like Bryan Health are also charged with the awesome ongoing responsibility of serving as the safety net for our local communities. Frankly, when society support services fail, people turn to the

local safety net hospital, usually ending up in our emergency department or other like services. At Bryan Health, we provided over $14 million of charity care last year. We expect that number to continue to climb for many of the reasons I mentioned previously. We have thousands of people coming to us for our very specialized mental health, substance abuse, trauma services, etcetera. All those services need to continue to operate for our communities. You cannot even imagine what our communities and our state would be like without services of that nature. So the biggest concern that I personally have as the leader of Lincoln's safety net hospital, the hospital where the behavioral health and the substance abuse and the trauma services are performed, is the funding that we're going to be losing as a result of the Affordable Care Act. We will be losing over $5 million a year at Bryan Health in what's called disproportionate share funding cuts, which are part of the Medicare program, plus numerous other cuts in addition to disproportionate share and in addition to those that I mentioned previously. So I give you that backdrop just to kind of paint the picture of where hospitals are today in Nebraska. So this is why it's so very important, this work that this joint committee is doing with LR22. So as I envision the future, I really believe we will see many hospitals in our state struggle with the simultaneous changes that I was just mentioning. I believe we will need to see...many hospitals will adjust their service offerings. It would not surprise me at all if some hospitals that are today offering inpatient care may become more like outpatient centers or outpatient clinics. So as the work of this committee continues, this joint committee, I hope that you all will keep in mind that hospitals and most importantly the patients that hospitals serve are greatly impacted by state health policy. Hospitals, in order to cope with this changing environment, will need as much flexibility as possible with respect to state laws and regulations. We must be very sensitive to passing laws that add, perhaps unintentionally, to the cost of medical care. And I truly hope that the state will continue to be a partner with hospitals to effectively leverage new federal programs and funding that may come about. And of course, as already been mentioned, state health policy will play a critical role related to work force development, specifically with health professionals. So again, essential that this LR22 work be done. I believe that the proactive planning that this group is undertaking should

be used as a foundation as our state continues to move forward with health-related policy in the future. So thanks to all of you for taking this step and for being involved. And I'd also like to conclude by stating that all hospitals across our state, including Bryan Health, are very, very committed to assisting in any way that we can with this process. Thank you. [LR22]

SENATOR CAMPBELL: Thank you. Senator Krist has a question. [LR22]

SENATOR KRIST: Thank you, Senator Campbell. In the future, given a whiteboard approach, would it be possible to set up a healthcare system that is unique to Nebraska without any outside aid or federal assistance? [LR22]

KIM RUSSEL: I'm not sure what you mean by unique to Nebraska. [LR22]

SENATOR KRIST: Nebraska's own, not being reliant on any federal money coming in, not looking at the change of regulation. Do you as a CEO of a healthcare facility think that it's possible to set up a medical model inside the state that is unique to Nebraska? [LR22]

KIM RUSSEL: If you're talking about covering individuals from birth through death, I don't believe it's possible without the assistance of the federal government. And that's because in particular the influence and the need for the Medicare program and Medicare funding because not only is Medicare funding a huge portion of medical care for individuals age 65 and above, Medicare is an essential part of helping to pay and support for graduate medical education at our medical schools. So... [LR22]

SENATOR KRIST: So if we decided, for some reason, that we wanted not to take any more federal dollars, our healthcare institution inside of the state of Nebraska would not be sustainable. [LR22]

KIM RUSSEL: I honestly don't see how it could function. [LR22]

SENATOR KRIST: Okay. Thank you. [LR22]

SENATOR CAMPBELL: Other questions? Senator Gloor. [LR22]

SENATOR GLOOR: Thank you. Kim, thanks for taking the time to be here. The comment under sequestration is all hospitals including rural hospitals received a 2 percent cut. By definition, does rural mean critical access? Does rural mean... [LR22]

KIM RUSSEL: Yes. Thank you for clarifying that, Senator Gloor. What was...yes, the sequestration cut hit critical access hospitals as well as all the urbans and all the tweeners so to speak. And that was what was so interesting because in the past, the critical access hospitals have been frankly protected by the federal government. And this is for any sort of cuts like that. This is the first time that the critical access hospitals have taken a hit along with all of the other hospitals, and I think that that's quite an indication of what may be coming in the future for our critical access and other rural hospitals. [LR22]

SENATOR GLOOR: Yeah, that's interesting. I didn't know that. And I would agree with you. At least in my experience, they have been somewhat...I guess I would say the federal government's only rural health initiative seems to have been critical access. And because of that, they've pretty much left critical access alone in terms of funding. But... [LR22]

KIM RUSSEL: Right. [LR22]

SENATOR GLOOR: Two more questions, the first is more of a comment. You can nod your head to it. But the loss of disproportionate share is a result of the state's opportunity to expand Medicaid. Is that correct? [LR22]

KIM RUSSEL: No. [LR22]

SENATOR GLOOR: I thought they were...the two were linked. [LR22]

KIM RUSSEL: The disproportionate share cut was built into the Affordable Care Act and essentially the disproportional share funds are being cut across the whole country. And the premise behind it was that hospitals would no longer need those funds because everyone would have insurance. [LR22]

SENATOR GLOOR: Correct. Okay. Better said than mine. Thank you. And the last one was...that was an underhand throw. This is an overhand throw. (Laughter). [LR22]

KIM RUSSEL: I'll see what I can do. [LR22]

SENATOR GLOOR: Lincoln used to be famous for the fact that there was a very specific delineation of services: Bryan, heart; St. E's, burn and family care; General was the trauma hospital with head injuries. And it was pretty unique, even in the United States for a variety of reasons primarily because of, I think, market realities. That went away. But do you think and do you hear from your peers across the country and from some of the discussions that we may be headed back to some sort of centers of excellence within communities, within states? I do a little reading on all this and I'm still not sure whether I'm hearing that. But it seems to me that there may be, especially with the development of ACOs, a push in that general direction. [LR22]

KIM RUSSEL: Well, yeah. A couple comments in reference to that and I came to the Lincoln community after the time that you're referencing. But many people have described that to me about kind of the unique setup in Lincoln. What I was told was the reason that those discussions could no longer continue was because of potential FTC anticompetitive violations. So that's the history as I know it. But your questions, Senator,

about going forward, will we see more at least collaborative attempts between hospitals and other members in the healthcare system? I believe the answer to that is yes. In fact, Bryan Health is involved in putting together a statewide collaborative kind of bordering from the western part of the state to the eastern part of the state trying to work on shared services, you know, similar protocols, things like that. And there's examples of that popping up around the country. So yes, I believe that we will see some more collaborative attempts. Will that solve all the problems that we're all facing? No, but it will certainly be a help. [LR22]

SENATOR GLOOR: Well, certainly there has been a common complaint that part of the problem in healthcare has been the fractionalization that...between individual dentists' office and therapy offices and doctors' offices and hospitals that don't have affiliations with other hospitals. That fractionalization doesn't work for us, it works against us. So I think your comment is, that's slowly but surely being reconciled and whether it's the Affordable Care Act or whether it's the dollars and cents, I think that's true. Thank you. [LR22]

SENATOR CAMPBELL: Other questions? Senator Schumacher. [LR22]

SENATOR SCHUMACHER: Thank you, Senator Campbell. I just need a little clarification on how the system works, and I haven't been involved in the system that much. But somebody in cardiac distress shows up at the emergency room. Now, there's a federal law, right, that says you've got to give them some treatment? Is that correct? [LR22]

KIM RUSSEL: Yes. If we're...have the medical capabilities to do so. [LR22]

SENATOR SCHUMACHER: Okay. And let's say that you can relieve the distress but it's pretty clear that they need an expensive corrective procedure. At what point is the practice in Nebraska where you say, sorry, you don't have any insurance. You don't

have any money. Good luck. Or doesn't that happen here? [LR22]

KIM RUSSEL: I believe that the hospitals in Nebraska, from what I've seen and I've been in this state just over five years now, I believe that the hospitals in Nebraska are very caring and very generous. And if somebody needs...if there is a medical need for a service like that, it gets done. And that's why we're seeing frankly, you know, our charity care and, in some cases, our bad debt numbers increase. [LR22]

SENATOR SCHUMACHER: Okay. Then at the next level, you do the expensive procedure, what is the mechanism for covering the cost of it? Who pays that bill? [LR22]

KIM RUSSEL: Very good question. Essentially, the hospital, so to speak, ends up paying for it. And you say, well, where do those funds come from? Basically, from services that are marginally profitable, I mean, that is basically where some of the dollars come from to be able to help pay for those who come to us without any financial resources. [LR22]

SENATOR SCHUMACHER: But the hospital doesn't employ Ben Bernanke so it can't print that money. [LR22]

KIM RUSSEL: That is true. [LR22]

SENATOR SCHUMACHER: So is that passed on to the government program, to private insurance, to self-payers? How does that work? [LR22]

KIM RUSSEL: You know, the way many people would describe it is that it's essentially passed on through the...because our payment is fixed from Medicare and Medicaid, it's essentially passed on to the commercial market. The way others would describe it is people who work for hospitals pay for it by having lower wages than they would have otherwise. So it comes out of the expense budget so to speak. That's another way of

looking at it. [LR22]

SENATOR SCHUMACHER: So the bulk of it...fair to say the bulk of it is then passed through to the folks who pay for insurance. [LR22]

KIM RUSSEL: That's fair. I'd say that's fair statement. [LR22]

SENATOR SCHUMACHER: Thank you. [LR22]

KIM RUSSEL: I'd say that's fair statement. [LR22]

SENATOR CAMPBELL: Other questions or comments? Kim, I have one question because we've gotten an inquiry into the office that this whole issue of how many miles can be between a critical access hospital. That is really a federal issue. It's not within the purview of the state to take action on that because someone has written to all the senators if you've watched your mail and asked us to something about that. We're not in a position to do that, are we? [LR22]

KIM RUSSEL: My understanding is that that's purely a federal issue. But the true expert on that is following me, Marty Fattig. [LR22]

SENATOR CAMPBELL: Okay. [LR22]

MARTY FATTIG: I plan to talk. [LR22]

SENATOR CAMPBELL: We shall ask him that question. So any other questions? Thank you, Kim. [LR22]

KIM RUSSEL: Thank you. [LR22]

SENATOR CAMPBELL: Our next testifier is Marty Fattig. Marty. [LR22]

MARTY FATTIG: Good afternoon, everyone. [LR22]

SENATOR CAMPBELL: Good afternoon. [LR22]

MARTY FATTIG: Thank you for allowing me to be here. Senator Campbell, if I may, I'll go through my written remarks. And then I will come back to the loan repayment programs. [LR22]

SENATOR CAMPBELL: Sure. We just need to have you identify yourself and spell your name. [LR22]

MARTY FATTIG: And I will do that. [LR22]

SENATOR CAMPBELL: Good. Thank you. [LR22]

MARTY FATTIG: Senator Campbell and members of the Health and Human Services Committee, Senator Gloor and members of the Banking, Commerce and Insurance Committee, my name is Marty Fattig, and that's M-a-r-t-y F-a-t-t-i-g, and I'm the administrator and chief executive officer of Nemaha County Hospital in Auburn, Nebraska. And I thank you for asking me to serve on the LR22 workgroup and to testify before you today. I am proud to have been involved in the delivery of healthcare in various capacities in this state for over 35 years. And I have a passion for all things rural and believe that rural Nebraska is the best place in the world to live, work, and to raise a family. Ninety-eight percent of Nebraska's geographic area is rural. And 865,000 of its residents or 47 percent of the population are living in these rural areas. Our rural communities are wonderful places to live, work, and visit. They are places where neighbors know each other, listen to each other, respect each other, and work together to the benefit of the greater good. Rural communities are some of the best places in the

world to test the entrepreneurial spirit and start a business. Rural communities offer healthcare providers tremendous opportunities to deliver innovative, resourceful models of high-quality care. Rural healthcare providers can have a good professionally rewarding career and still maintain a good quality of life. The main emphasis of the rural healthcare has always been on providing affordable, patient-centered, holistic primary care. Rural hospitals and healthcare practices serve as economic pillars of their communities, typically being the largest employer in the rural communities and strengthening the economic health of their communities by ensuring a healthy work force. If a rural community has a good educational system and good healthcare services, it has the capacity to grow. But today, rural areas of our state are facing difficult challenges. The population of almost every rural county in the state is declining. Where there used to be two to four families on each square mile of land, there are less than one. School consolidation...schools are consolidating leading to further demise of the small rural town. Main-street businesses close due to a lack of business. And so the cycle continues. Rural communities also face unique healthcare needs. Today more than ever we must address the needs of struggling rural hospitals and a lack of healthcare providers, the need of an aging population suffering from a greater number of chronic conditions including mental health diseases and a larger percentage of uninsured and underinsured residents than their urban counterparts. Emergency medical services are provided by a small group of volunteers whose average age is increasing at an alarming rate. How are the healthcare needs of the rural residents of this state going to be met 5, 10, or--as our charge as members of the LR22 workgroup states--15 years from now? What model of delivery of healthcare in rural areas of the state will be sustainable and still meet the needs of the rural residents? These are important questions that to me the answers to which are far too important to be left to chance. In my opinion, we must clearly define this ideal sustainable model for healthcare delivery that is appropriate for all Nebraskans including its rural residents. How will primary care services be delivered, especially in the most rural parts of our state? How will specialty care be delivered? Is there a basic level of care that should be available for all residents, regardless of their ability to pay? How do we make the best

use of limited resources? Don Berwick, former director of the Center for Medicare and Medicaid Services, described something called the triple aim, which is: better health, better healthcare, and lower costs. What does this model look like in this state? I have been involved in many different organizations across the state and I have found that organizations with a clear strategic plan defining where they're going tend to make far greater progress than those with no clear idea where they're going or how to get there. I believe that LR22 provides us with the opportunity to define the model for how healthcare will be delivered in this state rather than react to some mandate handed down from Washington. We have the opportunity to be proactive rather than reactive. With the future of healthcare delivery clearly defined, we can use our limited resources wisely over the next few years to build capacity to sustain the ideal model of healthcare delivery. It is my opinion that any plan for providing healthcare to rural areas of this state must include plans to maintain the critical access program. There are 65 critical access hospitals in this state. And in most of the rural areas, they are the only source of healthcare coverage for miles around. They are especially important to provide timely emergency care in the case of trauma, stroke, or a heart attack. Over the last year, there has been talk of modifying the program in several different ways from requiring critical access hospitals to be more than 10 miles apart from the nearest hospital to requiring them to be more than 35 miles from the nearest hospital. I realize that the critical access hospital program is a federal program. But if it comes under fire, we will need the support of all of you to help ward off the attack. I know there are those who believe it is best to wait and see what Washington decides to do before we move forward with the healthcare strategic plan for this state. I am of the opinion that regardless of what Washington decides to do, we need to have our house in order. To do this, we need to start planning today. I am extremely excited to be involved at the ground level in defining the future of health and healthcare in Nebraska. This a monumental task that will require efforts of many, long after the official charge of LR22 has been completed. We can define the future model of healthcare delivery in this state and the action plan to get there or we could react to federal mandates that aren't a good fit for our state. I believe that we even have the opportunity to develop a model for

successful healthcare delivery for the rest of the nation if we choose to do so. [LR22]

SENATOR CAMPBELL: Questions? I know Senator Krist has that question. [LR22]

SENATOR KRIST: Did you want to answer...? [LR22]

SENATOR CAMPBELL: Did you want to add to that? [LR22]

MARTY FATTIG: Sure. As an aside here, I also sit as the chair of the Rural Health Advisory Commission appointed by the Governor to that body. I am just starting my...will be starting my fourth 3-year term in January. And I am currently serving as the chair of that group. And one of the things that we are required to do by statute is to administer the loan repayment program and the student loan programs that are through Program 175 that was established back in 1992 by statute. The loan repayment program, I have come before this body a number of times asking for money on bended knee so that we can continue to provide those loan repayments to those people who are willing to practice in rural communities. This last session of the Legislature, Senator Nordquist worked with the Appropriations Committee and was able increase that, what we receive by $500,000 a year for the next two years. And this came at an absolutely perfect time because we had...when the monies became available, we actually had right at 20 people on our waiting list that were ready to or were already practicing in rural communities. And we didn't have any money to fund the loan repayment program. We had communities ready to participate. We had practitioners ready to go to the rural communities, and we had no funds. Now we do, and we've been able to pay for all those that have applied at this time. And these are people that are already in place. It's not like, you know, well, if I get the money I'll come. It's people that are already in place and communities ready to back up because it requires a community match of everything that the state puts in. So I think that's important to note. We have...as I've been on this commission, I have seen the amount of student debt rise by double. When I started, around $100,000 was about what a physician would have in debt. Now, it's closer to

$200,000, and if they go through a private school it's much higher than that. So to give them $120,000 in loan repayment as an incentive to go to a rural underserved area I think is money well spent in this state. [LR22]

SENATOR CAMPBELL: I'm going to go to Senator Krist's question. [LR22]

SENATOR KRIST: I asked Kim Russel if we were sustainable inside of Nebraska if we cut ourself off from the federal funding. And I'll just make this soapbox speech now and I won't say anything the rest of the hearing. We had a hell of time last time this last year in this session because we had people that believed that we should not take additional federal dollars in one category. I'm now a believer having watched what just happened in the last few months that we would have set ourself up for some problems, not insurmountable. But they might be problems in the future. The only reason we're having this conversation and LR22 is upon us is what the federal government is doing to us in healthcare... [LR22]

MARTY FATTIG: Yes. [LR22]

SENATOR KRIST: ...and ACA is the impetus behind these conversations. Several times during the LR22 process and people that I talked to, they said, if we could do it, and you said it in your comments, if we could do it and set the example here, we could be the model. What greater economic development tool is there than to say, great education and great healthcare? They'll come pouring into the state if that's what you really want. I'm kind of mixed on that emotion but if that's what you want. So again, the reality is, at least from Ms. Russel's standpoint, that we are dependent upon federal dollars, even more so in the rural hospitals as I understand the situation. So when we come to grips as legislators with what kind of federal dollars we're going to accept and, as an administration, what kind of federal dollars we will accept, we also have to come to grips with what we're doing internally that we don't have to be doing right now in terms of cutting Medicaid programs, cutting...increasing cost share programs and all that. I would

hope that as a rural expert that on LR22, you will look at opportunities to look at those federal dollars that absolutely have to continue to come for us to survive. Because if we're going to look at this for 15 years down the road, what's sustainable? Depends upon who gets elected President, I guess. So if you want to speak to that, that's fine. But that was kind of my comment with Ms. Russel when I...and I do think it's important. I think it's important for all of us to come to grips with the fact that we can't just say, we're not going to take federal dollars when they come available in different areas. There's some risk factors involved, my opinion. [LR22]

MARTY FATTIG: Excellent. Excellent question, excellent statement and one that I've given considerable thought to. I would love to say to the federal government, allow us to keep the dollars that you would send back to us. The taxpayers, allow those dollars to stay in this state and not go to Washington and let us build a system and take care of our own. I think that would be a wonderful thing to try. I mean, in an ideal world, that should work. Where we get into problems is number one, with the low population of this state, number two, with the average age of our population. We have a lot more older people using federal dollars than some of the younger states. So we're probably actually getting back a higher percentage of Medicare dollars than many other states do simply because we have a large number of...I mean, our inpatients in Auburn...80 percent of our inpatient days are Medicare. Without federal dollars, our doors are closed immediately. I would love to keep the dollars here. It would take a total rewrite of how that whole system works. You know, there are some demonstration projects out there that people try, especially on the Medicaid side. I don't know if it would work on the Medicare side or not. But you know, as long as we're dreaming, and that's what we're doing with LR22, let's dream out there. Let's see what that looks like. It would be very tough. [LR22]

SENATOR KRIST: Thank you. [LR22]

SENATOR CAMPBELL: My guess is we're also going to hear some of that from the

speaker, not next, but the next speaker Mr. Intermill. Any other questions? Senator Crawford. [LR22]

SENATOR CRAWFORD: Thank you, Senator Campbell, and thank you for being here. I have a comment and then a question. The comment first, I appreciate your testimony, that you're talking about the importance of economic development and economic development implications of what we're doing here in LR22. So if you have to drive out of your community to get care, you're likely to go shopping while you're outside of your community as well. And so both for maintaining some ability to purchase things in your own community and allow the elderly to get groceries in their own community and as well as attracting families in those communities, making sure there's access to healthcare in as many rural communities as possible seems to be important not only for our goal of... [LR22]

MARTY FATTIG: Right. [LR22]

SENATOR CRAWFORD: ...maintaining a healthy Nebraska but also for the sake of economic sustainability for the state. So that's my comment and you can feel free to respond to that. My question is related because I want to come back to this notion of a 30-mile radius or 35-mile radius and why that is...why it matters to make sure that you have care within that radius, why it's not unrealistic to say, well, if you can get care within a 30-mile radius, don't worry about it. And that's relevant I think for the discussion of critical care hospitals but also it's also relevant in our discussions about telehealth because I think in our state we have some regulations about telehealth. Say, if you're within a 30-mile radius, you shouldn't be able to access telehealth. And I think if we're providing the best care and coordinating care, then making sure people can do the monitoring and the chronic care management even if you only live a mile away from the hospital may be important. [LR22]

MARTY FATTIG: Exactly. Excellent question. And first, on your comment I agreed with

everything you said. So I'm not going to... [LR22]

SENATOR CRAWFORD: Okay. [LR22]

MARTY FATTIG: ...respond to that. But you bring up an excellent point. If you were to look at it on the surface, you'd say, hospitals 35 miles apart, that doesn't sound like any big deal. What would happen if the federal government said, no critical access hospital can be within 35 miles of another hospital. Auburn and Tecumseh: Well, it isn't, which one stays; they both go away. They both lose the designation. So now you've got two struggling rural hospitals. Not, well, let's flip a coin and see which one of us keeps it. No, we both lose the designation. So the one that survives the longest...if we survived, if Auburn survived and all the other hospitals within 35 miles of us closed, then we could apply to be a critical access hospital again. [LR22]

SENATOR CRAWFORD: Only after they died. Right. Yeah. [LR22]

MARTY FATTIG: Only after they closed because we would still be...and so that's one piece of the law that is really flawed. And the other thing I think is emergency care. Many, many times when you're in the middle of a heart attack or an auto accident or a farming accident which we know happens far too often, 35 miles might be just about 15 miles too far. So that's where I see the problem. [LR22]

SENATOR CAMPBELL: Senator Gloor. [LR22]

SENATOR GLOOR: Thank you. And Marty, you and I go back in critical access to the days when we both had brown hair. [LR22]

MARTY FATTIG: Yes. [LR22]

SENATOR GLOOR: You know, here's part of our challenge as we go through this LR22

process. Critical access was considered to be one of those designations that would be so unique when it first started that the 35-mile rule wasn't considered in mind. I mean, critical access was going to require hospitals to self-limit themselves to the point where a lot of boards of directors of those small hospitals said, we don't want to agree to a limit of services or three-day length of stay and limit the number of beds we have and all this. So it was a little onerous for some of those hospitals to make the decision. No big issue, nobody complained about the 35-mile rule because it was going to be and was initially so few hospitals that were willing to take plunge. But slowly but surely, critical access became one of the ways the federal government could, through a program that was already in existence I believe, funnel money to rural healthcare. As I said earlier, it was really their only and has been their only real rural healthcare program. Now, they're paring back on it. And so our challenge in LR22 is if we can't count on the federal government for those monies or at least in the amount they had in the past, if they're going to change the rules and revert back to what critical access was intended to be like when they first started it, how do we fill that gap? And what's it going to look like? [LR22]

MARTY FATTIG: Right. [LR22]

SENATOR GLOOR: And where are we going to get the money to be able to do it? And I think that's...15 years from now, if critical access goes back to what its original intention was with the limited amount of federal monies that were available to it, what are we going to do as a state because it doesn't appear that the federal government has any other plans for how to help provide care to people in rural settings? And therein is our predicament, programs going away. And if we don't help ourselves, I don't think we can count on the federal government to help us. And that's part of what we hope to do with LR22. [LR22]

MARTY FATTIG: I think there's some models of care. It'll take a totally different model of care I believe, Senator Gloor. [LR22]

SENATOR GLOOR: Sure. [LR22]

MARTY FATTIG: And I think that we as Nebraskans, I think we're creative enough and innovative enough that we can work on that. Some of the things that we're doing in our own small rural hospital to...that are actually...actually cost us money is we go out and we put telehealth equipment in the home of a person who we know doesn't take care of themselves when they have chronic obstructive pulmonary disease or congestive heart failure. We actually put the telehealth equipment in their home so we can monitor their weights, their blood pressures, their intake and their output every day. And then that information comes into a Web site and we monitor it. And if they're going in the wrong direction, we call them and say, hey, what are you doing? And it actually keeps them out of our hospital which is counter to our...our CFO is beating me over the head. You know, we can't do this, we need...but it's the right thing to do, so we're doing it. And if we can do some of those things on a large scale and some of the population health things that Dr. Zetterman talked about, I think we can cut these costs. But it's going to take all of us working together creatively to do that. [LR22]

SENATOR GLOOR: And I want to make sure I'm correct in this. Your physicians in your community are employees of the hospital. [LR22]

MARTY FATTIG: No. They are not. [LR22]

SENATOR GLOOR: Okay. But that would be unique anymore for a lot of critical access hospitals. [LR22]

MARTY FATTIG: Most critical access hospitals do employ their physicians. [LR22]

SENATOR GLOOR: Which is also one of those paradigm shifts... [LR22]

MARTY FATTIG: Absolutely. [LR22]

SENATOR GLOOR: ...from the early days of critical access. You're the exception to the rule. [LR22]

MARTY FATTIG: We are. We are. [LR22]

SENATOR CAMPBELL: Other questions? Thank you, Marty, very much. [LR22]

MARTY FATTIG: Thank you. [LR22]

SENATOR CAMPBELL: Our next testifier is Dr. Lazaro Spindola. Good afternoon. [LR22]

LAZARO SPINDOLA: Lights are off. (Laughter). [LR22]

SENATOR CAMPBELL: But I'm watching the time. I decided not to impose the lights, but I am watching the clock. [LR22]

LAZARO SPINDOLA: (Exhibit 5) Good afternoon, Senator Campbell, Senator Gloor, members of the Health and Human Services and Banking, Commerce and Insurance Committees. Thank you for receiving me today. For the record, my name is Lazaro Spindola; that's L-a-z-a-r-o S-p-i-n-d-o-l-a, and I am the executive director of the Latino American Commission. Recently, the University of Nebraska Medical Center held a conference for stakeholders on LR22, and I had the privilege of being invited to that conference. One of the activities consisted in attendees breaking into workgroups. And the workgroup in which I participated was concerned with access to, delivery of, and work force availability in the healthcare system for the next 20 years in Nebraska. Those three factors are codependent. Delivery depends on availability of the work force. Access depends on what services are being offered or delivered and at what cost. According to some reports, these 3 interdependent factors will be critical within the next

20 years here in Nebraska. And I would like to add another factor which is health disparities as a potential area of conflict. You have a report in your hands called Key Disparities in Nebraska. This report analyzed the 7 socioeconomic indicators, 29 health indicators (inaudible), and 10 health behavior indicators. There are color categories assigned to each ethnic minority group in Nebraska compared to the non-Hispanic white population. You will find that the red categories are defined as unacceptable disparity. And finally, you will see that 12 of the indicators have 1 or more ethnic groups categorized as unacceptable disparities. If we include the purple category which is defined as disparity requiring intervention, we will see 11 additional ethnic groups affected for a total of 19 out of 46 indicators. That's 41 percent. Will these disparities persist? I don't know. But if we look at the individual indicators, we see that eight of them actually got worse between 2005 and 2008...2010, and seven improved for a net loss of one. How to improve this? We only have to look at a couple of reports by the Institute of Medicine. One is called Unequal Treatment, and the other one is called In the Nation's Compelling Interest. And we will find the road map towards the solution. If we look at page 6 of this report, we will notice that ethnic minorities are disproportionately affected by income on the federal poverty level, unemployment, and lack of high school education. And I would like to make an observation regarding health education. I have never seen a population better health educated than the United States population, or more health conscious, and one population less willing to act upon that knowledge. (Laughter). [LR22]

SENATOR COOK: I know. [LR22]

LAZARO SPINDOLA: On page 7, we can see that results are disproportionate in teenage birth and inadequate prenatal care. And as we keep looking through the report, we will notice more disparities that if they persist, they will determine poor health outcomes for Nebraska as a whole within the next 20 years. Some trends seem to indicate that the challenge goes beyond minority health. Sixty-eight of the state's ninety-three counties lost population from 2000 to 2010 even as the state's population

grew 6.7 percent. More than half of the population growth was Hispanic. In fact, the only rural counties where younger population between 19 and 25 years of age increased are those counties with a high percentage of Hispanic population. Rural Nebraska is slowly becoming depopulated. And this is a worrisome trend since healthcare services usually follow the law of demand and supply. Currently, the United States has approximately 1 doctor for every 400 individuals. And as I drive to Lincoln, I drive by several small towns that have less than that. Obviously, doctors will not be lining up to practice where the market is so limited. In the last page of the report, you have a map that highlights Nebraska's medically underserved area. And many of these are among the underpopulated areas of the state. What could possibly attract new medical providers to this area? I can tell you one thing. When I was just graduated from high school after about 10 years of studying, anybody who would come and tell me, this is a wonderful rural area where all the neighbors are friendly. And you have these great, you know, lakes and things like that. And the weather is good, which it isn't here. (Laughter). That wasn't enough to drive me there. What actually made me go to serve in the rural area was the fact that I was paying my social debt with the government by doing social service. I keep hearing that Nebraska will face a shortage of medical providers within the next 20 years. And it's funny because in 2009, the Missouri Foundation for Health held a summit in St. Louis where the main theme was exactly this. And I gave two presentations on this summit. And I tried to answer the two core questions. How do we keep our youngest and brightest? And how do we bring new providers to the state? The traditional approach assumes that individual communities are responsible for recruiting whatever providers they need. The method is usually to contract with a local or national employment agency, also called a headhunter agency, that will offer the job to potential candidates, invite the candidates to the community, and try to persuade them to stay in the particular community and not another one. In other words, our communities are competing with other communities. In Missouri, the competition didn't go too well. People would rather go to New York or Florida or a place where the weather was nicer. But two of the most obvious solutions, providing financial enticement and the previous testifier mentioned something very important, educational debt, and the use of foreign

medical graduates were not considered in that conference. A third element to consider is the fact that Latino graduates prefer to go back to their communities and stay close to their families. And we have seen trend in both Lexington and Grand Island. So there is an additional map over there that shows the counties in the United States where people over 65 are over 20 percent of the population. And if you look at Nebraska, you will notice that it is one of the states where this happens the most. The map is not stapled. It's a loose-leaf. Yeah. Now, having a supply of medical providers, let's remember this does not guarantee automatically that healthcare expenditures will be lower. There is a report by the same organization of community development mentioned by the first testifier that shows that even though the United States has...it shows that the United States has less medical providers per 1,000 individuals than other countries. And in those other countries, the healthcare cost is lower. So it seems like the law...the capitalistic law of supply and demand works there. But when we come to the United States, we find that the areas where there is a highest concentration of medical providers have the highest healthcare costs, something to keep in mind. So we have challenges. But we also have opportunities. It is mostly a matter of having the leadership and willpower to explore those opportunities. Thank you and I'll be happy to answer any question you might have. [LR22]

SENATOR CAMPBELL: Questions? [LR22]

SENATOR COOK: I have a question. [LR22]

SENATOR CAMPBELL: Senator Cook, did you have a question? [LR22]

SENATOR COOK: I do. [LR22]

SENATOR CAMPBELL: Okay. [LR22]

SENATOR COOK: Thank you, Madam Chair. [LR22]

SENATOR CAMPBELL: You're welcome. [LR22]

SENATOR COOK: And thank you, Arturo, Dr. Spindola for coming today. [LR22]

LAZARO SPINDOLA: Arturo, Arturo. My friends call me Arturo. [LR22]

SENATOR COOK: Arturo. I thought so. But then you gave all these other fancy titles... [LR22]

LAZARO SPINDOLA: By the end of the afternoon, we will know how you consider yourselves. [LR22]

SENATOR COOK: ...and another first name and I didn't know. Thank you, Arturo. I have a question from one of the...second to the last statements you made about the number of providers not necessarily impacting the healthcare expenditures. I'm wondering if there are lots of, let's say specialists or lots of different kinds of people that you can kind of be referred to. Why do you think that is the case or may be the case? [LR22]

LAZARO SPINDOLA: Yeah. In countries that have a higher percentage of doctors, they tried to figure out whether they had more primary care providers than the United States. [LR22]

SENATOR COOK: Okay. [LR22]

LAZARO SPINDOLA: It did not happen that way. Even though they had more specialists, the cost was lower; whereas in the United States, when you have even less specialists in areas with a high availability of medical providers, the cost is higher. And that probably has something to do with some of the things that first testifier mentioned... [LR22]

SENATOR COOK: Okay. [LR22]

LAZARO SPINDOLA: ...the usage of the latest and improved technology, wasted resources. I would like to add the defensive medicine that is practiced in the United States where the threat of liability is always present and increases malpractice insurance. [LR22]

SENATOR COOK: Thank you. [LR22]

SENATOR CAMPBELL: That came up in several of the small groups, I think, what you're talking about, the liability. Other questions? Thank you very much. [LR22]

LAZARO SPINDOLA: You're welcome. Thank you for having me. [LR22]

SENATOR CAMPBELL: Our next testifier is Mark Intermill. I specifically asked Mark to testify today because he usually is caring for that aging population. But I thought that he might be able to see what the...those people who in 15 years will be aging and thought he might have some interesting perspectives. So please, go ahead. [LR22]

MARK INTERMILL: (Exhibit 6) Thank you. Thank you, Senator. And thank you members of the committee. My name is Mark Intermill, M-a-r-k I-n-t-e-r-m-i-l-l, and I appreciate the opportunity to be here today. I did attend the conference on October 2, at UNMC. I was also asked to share any observations. And I...this is kind of a self-confession here, but when I hear interesting things I tend to dwell on them and process them. And one of the first things I heard from Alan Weil at the conference at UNMC was the need for leadership in the development of the process that you're undertaking here. And that really struck a chord with me. I think there's leadership that's needed at the local level in terms of developing the service responses. But at the state level, I think it's a matter of being able to come up with a definition of what it is that

health is. We need to know what it is that we're trying to achieve in order to be able to achieve it. And we saw from Dr. Zetterman's slides that from the proton beam therapy, if we define health one way, it takes us that direction. Or if we define it in a more functional manner, it might take us a different direction. In my written statement, I mention an article that was in the Journal of Community Psychology that was written by Kate Brown who at the time was at the Creighton University Medical Center. And it described an ethnographic study of a rural community in south-central Nebraska that she undertook. And what she did was she went and talked to the members of the community, especially the older members of the community and asked them, what is health? How do they define health? And what she found was that what they said was health is being able to get up in the morning and do the things you need to do to stay a part of the community. They didn't talk about it in terms of medical conditions or treatments. It was a very functionally-based definition of what health is. No group is more affected by how we define health than the people who are eligible to be AARP members. We tend to be heavy users of the healthcare system. And a substantial portion of healthcare spending occurs in that last week of life. And as we get older, we get closer to that last week of life. I've seen examples where the focus of treatment at end of life is on providing comfort and providing palliative care. And I've also seen examples where it is focused on heroic measures, every last thing that we can do to make sure we allow that person to live as long as possible. I'm not saying one is right or wrong, but they have different consequences for individuals, for the healthcare system. So how we define health is important, but it's also...it leads us to a discussion of, how do we measure the healthcare system? And I think that's going to be an important part of what this LR22 process does is talk about what is it that...how do we keep score basically? How do we know that we've achieved success? I've included on page 2 of my written comments just a couple of performance measures. One of them has to do with the cost of healthcare. And the Affordable Care Act does provide us with some new ways to begin to assess and compare costs. And what I've included here is a chart that shows the premium for a 58-year-old for the lowest priced silver plan before tax credits. I am particularly interested in public policy effect on 58-year-olds these days. (Laughter)

So that's why I looked at that. And you can see that there's a wide range of premiums that a 58-year-old would pay whether they lived in Des Moines, Iowa, or Cheyenne, Wyoming, almost a 2-to-1 factor. You'll also notice within Nebraska there's some variance. In Omaha, a 58-year-old in Omaha would pay about $42 more than a 58-year-old in Lincoln. And since these are based on...we were going to a modified community rating system where we have a standard benefit package, this begins to give us a way of comparing prices and, I think, possibly reflects the cost of healthcare in those areas. So I think this type of information is going to be useful as in maybe just asking the question of why does the premium in Omaha cost $32 more than the premium in Lincoln or significantly more than that for the premium in Omaha? The other performance measure that I listed, this is an example of something that I've been involved with and leadership provided by the quality...the QIO, the Quality Improvement Organization that served the state of Nebraska to look at quality of nursing home care. And there are a number of performance measures that relate to nursing home care, and what we see in the table on page 3 is that Nebraska does very well. And I think this is due to the leadership that the QIO took in terms of providing, initiating that process, but also the leadership that the nursing facilities in the state of Nebraska took to implement it. And I would cite the leadership of the Nebraska Health Care Association in terms of doing the training and providing the information to staff about how they can improve these qualities. So it takes leadership both at the state level to initiate something but also at the local level to implement it. In terms of the aging population, I was born in the middle of the baby boom, nine years before it started, nine years after it ended. Did I get that right? We have, baby boomers have touched every institution, or we have shaped every institution we've touched, whether that's the maternity wards in the hospitals, the elementary and the secondary schools, the colleges, in some cases, the prisons and jails, the work force, the stock market, and here soon Medicare as the oldest baby boomers have just crossed over the age of 65 and are beginning to receive Medicare benefits, and in the not too distant future, assisted living facilities and nursing facilities. We will have a substantial impact on those institutions. In 2026, the oldest baby boomer reaches the age of 80 and the youngest will be eligible to receive Social Security

benefits at the early retirement age. After 2026, we're into a 20-year period where there will be 4 percent average annual growth according to some projections in the 80-plus population. And to put that in perspective, if Nebraska were to grow by 4 percent over a 20-year period we would have almost 4 million people by 2033. So how we define health and how we establish performance measures does have an impact on how that population will be served both in the acute and the long-term care system. We're engaged in a separate interim study pursuant to LR273 that was assigned to the Appropriations Committee that looks at how we develop a budget to prepare for 2026 and beyond. How do we make sure that we have the resources in place, or what do we need to do to make sure we have the resources in place to be able to address the demands that we're likely to see? So we are going to...we're in an aging society. And I think there are things that we need to be looking at as we move into that aging society in terms of healthcare that in terms of identifying what it is that healthcare should be providing but also how do we measure if it's doing that. So be glad to try to answer any questions. [LR22]

SENATOR CAMPBELL: Questions for Mark? Thank you. Your paragraph in talking about 2026 is exactly what I thought you might do, I mean, in the sense of giving us a picture of what that looks like. And for some of us who were at the beginning, I mean, who started the baby boom aging out and watching those people behind me, I am very concerned about the numbers in that population and that healthcare and what that means. [LR22]

MARK INTERMILL: Yeah. There are a lot of us coming into that group. [LR22]

SENATOR CAMPBELL: Exactly. All right. Thank you very much, Mark. [LR22]

MARK INTERMILL: Sure. [LR22]

_____: You're not that old, are you? [LR22]

SENATOR CAMPBELL: Yeah, I am that old. (Laugh). In my mind I'm not that old. Our next testifier is Andrea Skolkin. I know Andrea is there. Good afternoon. [LR22]

ANDREA SKOLKIN: Good afternoon. An end of a long afternoon, or coming to the end. [LR22]

SENATOR CAMPBELL: Go right ahead. [LR22]

ANDREA SKOLKIN: (Exhibit 7) My name is Andrea Skolkin, A-n-d-r-e-a S-k-o-l-k-i-n. I'm the chief executive officer of OneWorld Community Health Centers. I'm also vice chair of the Health Center Association of Nebraska. And I'm pleased to join you today to offer thoughts and suggestions on behalf of Nebraska's six federally qualified health centers which are the healthcare home to 63,000 low-income patients across the state. We are critical primary care safety net providers within Nebraska's healthcare system; 65 percent of our patients live at or below 100 percent of poverty, 90 percent below 200 percent of poverty with a majority uninsured and for those patients who are insured, a majority of those are Medicaid. I do have prepared comments on behalf of the six centers, so I do want to go through them. It's not as conversive as I've seen other testimony. In our invitation to testify, we were asked to answer three questions: What was our big takeaway from the October meeting; Why is LR22 important to the health and healthcare of Nebraskans; and our observations about the future of our healthcare system. So first, the takeaway. At the October meeting, lessons from other statewide planning efforts were shared. One of the lessons reported to us said that any effort must address three elements: access, cost, and quality. Failure to address any one of these would result in failure. And as health centers, every day we see those challenges in the people that are unable to access healthcare. Our health centers are working hard to meet the demand for this population, but we're stretched to do so. It's also important to note that access is not just the ability to find a healthcare home, but it includes culturally appropriate services, interpretation, the ability to care for people with special needs, and

making sure that there's evening and weekend hours. We need to remember when we're thinking about a healthcare system that for many people even a small copay is a big challenge, including people who churn on and off insurance and including Medicaid. We need to protect this healthcare safety net. Certainly we need to spend our healthcare dollars in a very smart way, assuring that the services we provide result in quality outcomes. This should include moving to a healthcare system that embraces prevention and population health as we've heard about and strives to ensure that all Nebraskans, that's all Nebraskans, have access to a healthcare home--again, access, cost, and quality. The second question is why LR22 is important. We are, as we all know, at a historic time. The implementation of the Affordable Care Act is just one piece of the changes in trends that have been occurring, but it certainly is a catalyst. All parts of our healthcare system in Nebraska will see change, and we all have a shared responsibility. Never before have we had the data that will now be able to guide our decisions. Never before have we had the technology capable of reaching patients at the personal level to improve their care. And never before do patients have the behavioral health coverage that we think will be available soon. And never before have we had the opportunity to integrate primary care and behavioral health as we will today. The healthcare system as we've heard is under more strain than ever. Insurance companies and the healthcare system seem to be drifting further apart faced with an unknown future healthcare system. Insurance companies want providers and hospitals to accept less as payment because they can't predict what the future will be or how insurance regulations will affect them. Hospitals and providers fear, rightly so, that the system may make them financially unstable. Now more than ever, we have to talk openly about these issues, and I congratulate you on this effort. The system is in flux. It is fragile, and by only having this kind of frank, open dialogue will we be able to have a vision for the future. But just remember as we go through these discussions around healthcare no matter the topic, it is people's lives at stake. They are not numbers. They are people. They are individuals that are vulnerable to the high cost of medical care. And they're vulnerable when we fail in our quality and the delivery of quality care. We can't just say that this has been done and failed. We must say that we are not going to give up until

the system is righted, stabilized because too many Nebraskans depend on the healthcare system. Failure to improve the health of the citizens of Nebraska is failure to allow people to realize their maximum potential to contribute to the economic well-being of the state. If people are healthy, they can learn and become educated. If they're educated, they can work and some will be entrepreneurial and create jobs and contribute positively to society. They'll pay their taxes and make our state stronger. We must all work to make Nebraska healthier. We must make sure that those people that have not join the people that have and have access to healthcare. Finally, you asked the FQHCs to give you broad observations on the future of Nebraska's healthcare system. There are systems of healthcare that are cost efficient and quality driven within this state. There are hospitals whose average charge is lower and whose quality is higher. Their voice needs to be heard in how they achieve their goals. FQHCs are a similar system but a primary care system where we are provided affordable quality healthcare. And we are ready to help and share how we've been the answer across the nation in meeting some of America's largest healthcare problems over the past 40 years. We don't serve populations with easy access to healthcare, yet in many areas where healthcare is delivered through the FQHCs, our outcomes surpass that in systems with much higher price tags. We cannot continue to afford 18 percent increases as an employer this year in health insurance, and 10 percent increases in healthcare delivery costs with higher deductibles on 2 percent and 3 percent cost-of-living increases. Nebraska's health centers have the ability to impact medical care in Nebraska. As primary care clinics, I want to emphasize that we are evolving just like the rest of the system. We are outpacing the rest of the country in achieving patient-centered medical home status. And we've become one-stop shops for healthcare including dental in addition to primary care, behavioral health, pharmacy. And many of us are working in our communities around the social determinants of health like housing and education. Like the larger healthcare systems, health centers are focused on cost and quality, and we are a good value for our patients. But equally important, we are a good value for the state and federal dollars invested in us. In conclusion, we want you to know we want to be stronger partners at the table at the

state level. And we welcome the opportunity to sit with all Nebraska's healthcare providers in this endeavour. We're ready to be part of comprehensive healthcare networks of the future, and we're honored to be offered the opportunity to be here today and appreciate the opportunity to testify. [LR22]

SENATOR CAMPBELL: Thank you, Andrea. Questions? And questions? Andrea, one question, are we making any headway on adding another federally qualified health clinic to the state of Nebraska? Certainly, look to my left, in the community of Grand Island, I know we've looked and wanted to know if we are going to get another clinic. [LR22]

ANDREA SKOLKIN: Senator Campbell, I wish the answer to that was, yes. But right now, the answer to that is, no. I know that the community of Grand Island is trying hard. There was recently an announcement of additional 25 health centers to...new or satellites of existing health centers across the nation. There were maybe about one in all of the Midwest that was awarded. So they'll look at higher density populations...is certainly, I think, something at a national level. We're hopeful that they're, depending how the budget unveils, that there will be another announcement from the applications that were previously submitted, but hard to say given all the budget discussion. [LR22]

SENATOR CAMPBELL: Okay. Senator Cook. [LR22]

SENATOR COOK: Thank you, Madam Chair, and thank you, Dr. Skolkin, for coming today. I was wondering to myself just now on a Friday afternoon, midafternoon, whether or not there are any Nebraska state policy barriers to maximizing our federally qualified health centers beyond appropriations or to put us in a better position nationally to...I guess we're kind of competing for the opportunity to expand. Are there? [LR22]

ANDREA SKOLKIN: Senator Cook, good question. I'd have to give that some thought. There's no policies that prohibit us from competing. And we'd have to think about what makes us score better nationally, some of it is based on how you write your application.

But from a...there's lots of policies that impede the work of all healthcare providers which we could probably talk about for hours. But directly related to kind of the application of a health center, I really don't think there are any. [LR22]

SENATOR COOK: Thank you. [LR22]

SENATOR CAMPBELL: Senator Gloor. [LR22]

SENATOR GLOOR: Thank you, Senator Campbell. Andrea, just by way of clarification, do all FQHCs have to have a dental and a behavior health component? Is that part of the stipulation for the dollars? [LR22]

ANDREA SKOLKIN: Thank you, Senator Gloor. They do not necessarily have to have dental and mental health, but they have to ensure that it is provided. So you could contract within a different provider in the community... [LR22]

SENATOR GLOOR: Okay. [LR22]

ANDREA SKOLKIN: ...either in a bigger way or a smaller way. In some way it has to be present. It doesn't have to be in the facility. [LR22]

SENATOR GLOOR: And what...I guess I say this as an informational item, I could seek care from an FQHC even though I have a traditional health plan. There is no limitation on the fact or of the payer source. Obviously, FQHCs are funded hoping to fill a gap in the service. But in reality, if it's seen as worth funding, there's also a recognition that there may be some private pay or insured who actually seek care there. Is that correct? [LR22]

ANDREA SKOLKIN: That's correct. Anyone is welcome to come to a community health center no matter the payer source or if you don't have a payer source. [LR22]

SENATOR GLOOR: Okay. [LR22]

ANDREA SKOLKIN: Our target, of course, is the low-income population, and all the commercial insurance that we are able to garner helps us as you've heard balance our overall budget. [LR22]

SENATOR GLOOR: And I have to add, this is just more for the record, that whether Grand Island makes the jump to an FQHC or not, they have had for almost two decades now a community clinic with physicians and other providers who volunteer their time that operates most days of the week and does so without any federal dollars. And that, whether they should make the leap and could provide more services or not, I'm too removed from it now to be able to judge. But there is a program that seeks to provide at least some of the services available in the community including dental I think. So just so people don't think too poorly of my district, there is an initiative out there that has sought for years to try and fill that gap. [LR22]

ANDREA SKOLKIN: Senator, the clinic is well known. And I believe there's probably other clinics down the I-80 corridor. While I can only speak from our experience, the difference in that federal investment made in what we have been able to achieve in numbers of people served and being able to be there for the community. [LR22]

SENATOR GLOOR: Certainly. No doubt. [LR22]

SENATOR CAMPBELL: My hope had been that the clinic in Grand Island would be recognized and designated as one for the work they've done. So thank you. [LR22]

ANDREA SKOLKIN: We'll keep hoping. [LR22]

SENATOR CAMPBELL: Yes. Thank you very much. [LR22]

ANDREA SKOLKIN: Thank you. [LR22]

SENATOR CAMPBELL: Our last testifier this afternoon is Beth Baxter. Again, as a reminder as Beth is coming forward, if you are not on the mailing list and would like to be, just contact my office. You can do so through the legislative Web site, and we'll add your name. Good afternoon. Thank you for your patience. [LR22]

BETH BAXTER: (Exhibit 8) You're welcome. And thank you for the opportunity to be here. I guess I'm bringing up the rear. I'm used to being the last on the ground. You know, hopefully, wrap this up for you which has been really an interesting endeavor for me. Good afternoon, Chairwoman Campbell and members of the Health and Human Services Committee and Chairman Gloor and members of the Banking, Commerce and Insurance Committee. My name is Beth Baxter, B-e-t-h B-a-x-t-e-r, and I serve as the regional administrator for Region 3 Behavioral Health Services which encompasses 22 counties in central Nebraska. And first of all, I'd like to thank you for the opportunity to participate in the stakeholders conference in early October and then obviously appreciate the opportunity to be here today and share some of my thoughts and observations. The stakeholders conference provided a forum for me to learn about what other states are doing kind of in healthcare transformation, and then also to visit with my peers and other stakeholders across Nebraska about what are our strengths, our challenges, our gaps, what would we like to see within Nebraska's healthcare system. The biggest takeaway for me from this conference was just because the future is uncertain doesn't mean that we don't plan for it. And that's hit home for me. Just because I don't fully understand the impact that healthcare system reform is going to have on Region 3, the people I serve, my stakeholders, and so forth, it still behooves me to plan, to prepare, to strategize so that we can take advantage of those transformations and we can add value to our emerging healthcare system. LR22 is important to Nebraska because I believe our healthcare system is in transition. If we Nebraskans want an effective healthcare system, we have to move away from a

structure that's really built around acute care, around...and one that's responsive to prevention and the management of chronic conditions and the promotion of health and mental health. Given this, I would like to take this opportunity to focus my comments and observations on two specific areas that are really in the behavioral health field and that I believe are really important to healthcare system transformation. During the afternoon breakout session of the stakeholders conference, we were given the assignment to discuss the opportunities and challenges within our current and our emerging healthcare systems. During that group discussion, I shared the World Health Organization statement that there is no health without mental health. We know that poor mental health is a risk factor for chronic physical conditions as well as people who have chronic health conditions. They are at risk for poor mental health. It's a cyclical challenge that we have to address to improve the healthcare of all Nebraskans. One way to improve the long-term health of Nebraskans is through mental health promotion. Mental health promotion focuses on enabling people to maximize their well-being through influences on the social determinants of health and mental health, such as education, income, where we work, those...our working conditions, and our access to healthcare. Where social environments promote good mental health and reduce harm, and individuals are equipped with the skills to maintain mental health, we're going to see improvements in quality of life, resilience, and social and economic participation. The gains from mental health promotion activities will extend to improvements in physical health as well as improved productivity at school, within our families and communities, and within the workplace. A comprehensive approach to behavioral health means viewing promotion and prevention really as part of a continuum of care. The behavioral health continuum of care model helps us recognize that there are multiple opportunities to impact health and behavioral health along the continuum. Another extremely important but often overlooked aspect of health and well-being is the impact of trauma on individuals and families. And the trauma that I'm referencing is really trauma that comes from abuse, that comes from neglect, that comes from areas that really impact a child and a family's ability to function. Individuals with histories of violence and abuse and neglect from childhood into adulthood make up the majority of those we serve in

our public behavioral health system. The vast majority of public mental health consumers with severe mental illness, including schizophrenia and bipolar disorder, have been exposed to childhood physical and/or sexual abuse. Most have multiple experiences of trauma. Seventy-five percent of women and men in substance abuse treatment report abuse and trauma histories. Ninety-seven percent of women who are homeless with mental illness experienced severe physical and/or sexual abuse, and 87 percent of those women experienced it multiple times, both as children and again as adults. Research tells us that if we address and treat the trauma experience by people growing up, we will improve the efficacy of treatment and the support that we provide individuals. Given the prevalence and impact of violence among consumers across the life span in our public behavioral health system, the need for integrated physical and behavioral health services that are informed of trauma theory and include interventions designed to address the impact of trauma is truly critical. The adverse childhood experiences, the ACE study is one of the largest investigations ever conducted in this country and probably worldwide to assess associations between childhood exposure to traumatic stressors and later life health and well-being. The ACE study findings suggest that certain childhood experiences are major risk factors for the leading causes of illness and death as well as poor quality of life. Progress in preventing and recovering from the nation's worst health and social problems will most likely benefit from understanding that many of these problems arise as a consequence to adverse childhood experiences. The ACE study takes a whole-life perspective beginning with the individual's exposure to an adverse childhood experience, such as abuse, neglect, abandonment, and so forth, or a child living in a home where one or more parent has significant substance abuse or a mental illness. The childhood trauma often leads to social, emotional, and cognitive impairment that then may lead to the adoption of health risk behaviors, risky behaviors, that in turn lead to disease. They can lead to disability and/or social problems and if untreated eventually they lead to early death. The attached chart lists adverse childhood experiences in the first column followed by the impact that those experiences have and the health risk behaviors that people who are dealing with trauma engage in or experience because of the pain of that trauma. The

last column lists the long-term health consequences of unaddressed trauma. These long-term health consequences rob people of a life of quality, and they drive up the cost of healthcare across our state and across the nation. As earlier stated and kind of in summary here, Nebraska is in a state of transition. And hopefully, we're moving to a more cost-effective and outcome-oriented healthcare system. As we identify the short- and the long-term strategies to improve our individual and collective health as well as our healthcare system, we must be responsive to a healthcare system designed for prevention and management of those chronic health conditions and promotion of health and mental health. We understand that we are at a crossroads and the decisions that we make today and in the near future will determine the physical, mental, and financial health, I think, of all Nebraskans. We have to decide what our outcomes need to be and design an infrastructure and policies to support getting us to those outcomes. As we move along this transformation process, we need to formulate and implement trauma-informed policies supporting mental health promotion, health promotion, mental illness, and substance abuse prevention. Thank you very much for this opportunity. And I certainly would like to answer any questions that you may have. [LR22]

SENATOR CAMPBELL: Questions? Senator Gloor. [LR22]

SENATOR GLOOR: Thank you, Senator Campbell. Thanks, Beth, for making the long drive out here. I'll be right behind you in a couple of minutes, I think, going back. But on the acute care side, on the physical health side, we're making pretty good inroads of coming up with accountability standards, you know, reduction in weight for obesity and blood sugars for improvements with diabetics and, you know, readmissions after discharge from hospitals, ways that we can measure and appropriately reimburse or adjust reimbursement for the care we're providing on the physical health side. But how about on the behavioral health side, the outcome measures? Clearly we're dealing with a whole different way of trying to measure, is this person a little bit better, a little less challenged than they were, a lot less challenged, because from an accountability side it sounds to me like it's going to be a lot harder to accomplish with behavioral issues the

way it has been with physical health. Am I making myself clear on that? [LR22]

BETH BAXTER: Yes, and... [LR22]

SENATOR GLOOR: I mean, outcome measures. [LR22]

BETH BAXTER: Exactly. And thank you for asking that question. I believe that the outcome measures for behavioral health, acute behavioral healthcare is very similar to physical healthcare. I mean, obviously, what we do is we work to reduce recidivism because we know that if we can keep individuals in their community, keep them engaged in their family, working, that their overall health is improved as well as their mental health. So we've learned that we engage those activities that keep people, their functionality, to an extent that they can participate in the community. We develop services to really track individuals, you know, to make that tenure that they experience in the community longer and longer because we also know that as people go back into the hospital in an acute state, it often takes them longer if they ever do, are able to get back to where they were before that hospitalization. We know that that takes an extreme toll upon them. [LR22]

SENATOR GLOOR: Can you do this on an outpatient basis, though? [LR22]

BETH BAXTER: Yes, we can. And much of what we do in our system is really on an outpatient basis. Acute care in the public behavioral health system, it's an important, an extremely important aspect of our continuum of care. But we have a much more developed continuum to keep people out of the hospital and to keep them in their community. So a lot of what we do on an outpatient or a community-based process really is at helping people stay out of the hospital and engaged in their community. [LR22]

SENATOR GLOOR: Okay. Thank you. [LR22]

SENATOR CAMPBELL: Any other questions? Thank you very much... [LR22]

BETH BAXTER: Thank you. [LR22]

SENATOR CAMPBELL: ...as always. I'd just like to remind the senators and certainly the folks in the audience that we are using Health Care Cash Funds to proceed with LR22 because one of the imperatives in the Health Care Cash Fund was that we use some of those monies to study and plan for healthcare in the state of Nebraska. And so I'm pleased that we are finally to the point where we have developed a way to do that and to utilize those dollars wisely. So thank you all for coming today. And you will hear from us again. [LR22]