Health and Human Services Committee September 27, 2019

HOWARD: All right. Good morning and welcome to the Health and Human Services Committee. My name is Senator Sara Howard, and I represent the 9th Legislative District in Omaha, and I serve as Chair of HHS Committee. I'd like to invite the members of the committee to introduce themselves, starting on my right with Senator Arch.

ARCH: Senator John Arch with District 14: Papillion, La Vista.

WILLIAMS: Matt Williams, Legislative District 36: Dawson, Custer, and the north portions of Buffalo Counties.

B. HANSEN: Senator Ben Hansen, District 16: Washington, Burt and Cuming Counties.

HOWARD: Also assisting the committee is our legal counsel, Jennifer Carter, and our committee clerk, Sherry Shaffer. And my staff member, Timoree Klinger, will be serving as our page today. A few notes about our policies and procedures. Please turn off or silence your cell phones. This morning we'll be hearing one interim study, and we'll be taking it, obviously, in the order listed on the agenda outside the room. On each of the tables near the doors to the hearing room, you will find blue testifier sheets. If you are planning on testifying today, please fill one out and hand it to Sherry when you come up and testify. This will help us keep an accurate record of the hearing. Any

handouts submitted by testifies will also be included as part of the record as exhibits. We would ask, if you do have any handouts, that you please bring ten copies and give them to Timoree. We use a light system for testifying. Each testifier will be given five minutes to testify. When you begin,; the light will be green when it turns yellow you'll have one minute. And then, when it turns red, we'll ask you to wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly and spelling it for the record, both your first and last name. And each interim study will-- hearing will begin with the introducer's opening statement. After the hearing we'll take testimony...and just a reminder that interim study hearings work a little bit differently. Testimony is not grouped by supporters or opponents, but taken in turn unless we have invited testimony, in which case we'll take the testimony of those invited first. I will note this at the start of each hearing. If the resolution is a committee resolution, I, as Chair, will introduce it and then return to my seat to proceed. We do have a strict no- prop policy in this committee. And with that will begin today's hearing with LR160, and I will hand it off to my colleague, Senator Arch.

ARCH: Senator Howard, welcome.

HOWARD: Well, thank you. OK.

ARCH: Please open our study.

HOWARD: All right. Good morning, Senator Arch and members of the Health and Human Services Committee. My name is Senator Sara Howard, H-o-w-a-r-d, and I represent District 9 which is in midtown Omaha. Today I bring before you LR160, an interim study to assess the mental and behavioral health needs of Nebraskans and the current shortages of services and needs to ensure a robust mental health and behavioral health delivery system. The enter-- the impetus for this interim study was a meeting I had in April of this year with two of my constituents, Tim and Cynthia Heller. You're going to hear from them later, but Mr. and Mrs. Heller talked to me about their experiences and their challenges navigating Nebraska's mental health and behavioral health system. And meeting with the Hellers is absolutely not the first time that I've heard about Nebraskans having issues finding adequate mental health services for their loved ones. I often get calls to my office about individuals who are either having trouble finding services or finding appropriate services. I-- two weeks ago I was invited to speak in Scottsbluff and, in between speaking engagements, I met with a set of families who were talking about how it's really hard to find even adolescent psychiatric services in the Panhandle. There just isn't anything out there for them. And so we know that, across the state, this is a bigger issue. I also get feedback from many providers about the difficulties they experience with issues, such as low provider reimbursement rates and actually getting reimbursed for services that they provide, especially when working with Nebraska's Medicaid

program. To help paint a picture, I've invited a number of stakeholders to tell the committee what they see and what they might need to help build a more robust infrastructure for mental health needs throughout the state, including in rural areas where we know we have a provider shortage. This will include a presentation on current data on where we stand now. In 2016, along with Senator Bolz, I served on the mental and behavioral health task force. This committee released a report that highlighted many of the concerns that we had about the current state of our mental and behavioral health system; and many of these concerns are still relevant today. And so I've passed out a copy of this report for your review, as I feel it-- it's very good background information for all of you. We have invited the director of the Division of Behavioral Health, Sherri Dawson, who's going to talk to us about our strategic plan and the work that they're doing to improve services. She's not here yet, but she will be; I think she's running a little bit late. And through testimony today, it's my hope that we'll have a good discussion and hear suggestions for improving services and other ideas on improving access to mental health services. There's often a lot of emphasis put on physical health and how we need services and access around physical health in our state. But I think it's important to discuss the large piece that mental health plays and well-being as a whole. I'm happy to answer any questions, but there are several individuals coming behind me who have good information to offer and will cover a wide range of topics. I'd

also like us to start the hearing with my constituents, Cynthia and Tim, so they can talk to you a little bit about their experience. I'm happy to answer any questions you may have.

ARCH: Any questions? I don't see any.

HOWARD: All right.

ARCH: So let's invite the family to come on up.

HOWARD: Thank you. Ready?

CYNTHIA HELLER: Yes.

HOWARD: One at a time.

CYNTHIA HELLER: Good morning. My name is Cynthia Heller.

ARCH: Please sit.

CYNTHIA HELLER: That's C-y-n-t-h-i-a H-e-l-l-e-r. Oh, I have to sit? I'd rather stand.

ARCH: Make yourself comfortable.

CYNTHIA HELLER: OK. As I said, my name is Cynthia Heller. I am a resident of Douglas County, Nebraska, and the mother of Devon [PHONETIC] Heller, one of the 48,000 Nebraskans who suffer from severe mental illness. Devon [PHONETIC] is now 22 years old and has been hospitalized and incarcerated several times since he was 18 years old.

One particular occasion I would like to share, because I'll never forget, is the day my husband was called from the Douglas County Mental Health hospital to find out what should be done with Devon [PHONETIC] upon release that day. My husband spoke to the nurse at length and explained we were unable to have him live at home until he was stabilized on meds. And he was told Devon [PHONETIC] was not stabilized but would be released that day. So Devon [PHONETIC] was arrested that day and faced a felony for terroristic threats. That was the solution. We thought he was safe in a locked facility, going to get the proper medications and help he needed. Instead a naive young man was incarcerated with criminals for being mentally ill. This turned into a legal nightmare for us. This is only the tip of the iceberg of what my family and many others have had to experience because we are Nebraska residents, and Nebraska has repeatedly failed myself and several other families. Devon [PHONETIC] has been denied services so many times I've lost track of the actual number. On one of his visits to the Douglas County jail, his front bottom teeth were knocked out by an inmate because Devon [PHONETIC] reached across the table for a salt shaker. He was an 18-year-old kid that had been kicked out of UNO for not attending class and because he started to show symptoms of mental illness. Navigating the programs in Nebraska, if you're savvy enough to find them, is next to impossible. Access to any long-term program is nonexistent or impossible to find. I have been directed to other states, by mental health staff, on several

occasions. If mental health professionals cannot find suitable programs for our mentally ill, how are families supposed to help their loved ones who are suffering and wandering the streets? For three years. I have tried to navigate this system with little to no help. Nebraska has repeatedly-- Nebraska mental and behavioral health has repeatedly fallen in the bottom half of all of these so-called-- know what I'm going to say--

_____: States?

CYNTHIA HELLER: Yeah-- has fallen in the bottom half the states for being the worst when it comes to mental health. I brought my family up in Nebraska and stayed here, and now my husband and I are looking at moving, for our 22-year-old, to a different state so that we can find the right help that we need. So I beg you to take a look at what is going on in this state, because what you're going to find is not very pretty. Thank you for your time, and I didn't cry.

ARCH: Thank you. Please-- just, just a second.

CYNTHIA HELLER: Oh.

ARCH: Are there any questions? Senator Williams.

WILLIAMS: Thank you, Senator Arch. And thank you for being here and telling your story. You mentioned that-- who encouraged you? Was there

someone from the Department of Health and Human Services or that department that encouraged you to look at other states?

CYNTHIA HELLER: Oh yeah. So-- and actually--

WILLIAMS: Could you explain that to me?

CYNTHIA HELLER: So our-- currently in Nebraska, if you have met-- if you have a mentally-- if you're mentally ill and have, say, a drug addiction-- which most of our mentally ill do, OK? They start with mental illness and then they try to self-medicate. We don't have a program that I know of that actually has an on-call, a psychiatrist that's there to work with people. We have no facility that has, unless it's a locked facility that there's a, there's-- let's see-- we have no-- we don't have facilities, long-term facilities with psych, psychiatric and substance abuse.

WILLIAMS: Thank you.

ARCH: OK. Any other questions? Thank you very much for coming.

CYNTHIA HELLER: Thanks.

ARCH: Mr. Heller, would you like to speak, as well?

TIM HELLER: My name is Tim Heller, H-e-l-l-e-r, also a resident of Douglas County, Senator Howard's district. What my wife was referring to was a long-term dual-diagnosis treatment center. All the programs

that we've found are short-term and don't really handle the type of treatment these, these individuals need. We've attended classes and forums. One of the ones that I want to mention that was very, very helpful was Community Alliance. Dr. Jai Sookram directed that program. It's a program for caregivers and parents and families of the mentally ill and chemically dependent. And I would urge you to reach out to him, as part of this, to get some solutions. He has done a phenomenal job and has some ideas, I think, that'd be very helpful. He helped design the Kansas model that was very effective. For those of you that are not familiar with the type of illnesses we're doing with, schizophrenia has hallucinations, delusions, thought disorders, movement disorders, reduced facial expressions, reduced pleasure in everyday life. These people, in order to get those pleasures, in order to reach out and enjoy life, are seeking drugs-- illegal drugs-- in order to get some feeling or to control those hallucinations, delusions, and thought disorders. It's the only help that they see that's available to them. We've got over 8.3 million people in this country with mental illness; it's 3.3 percent of the population. In Nebraska, as my wife mentioned, that's about 48,000 people here in Nebraska that are suffering from that. The public costs to this are that our ERs are filled with acute ill patients waiting for services. Our first line of defense in this situation is our emergency responders. We're tying up people that should be out there handling crime and taking care of the public by having to have CIT-trained

officers, which not all of them are, respond to mentally ill people. Now if you've watched the news anytime in the last 10-20 years, you've seen what's happening on the news with the mentally ill in this country. Nebraska is no exception. You can point back 20 years ago to Von Maur and see what happened there. It still goes on, maybe not to that extreme, but in homes across our state. We've got to do something about this. The breakdown of that mental illness in Nebraska: there's 16,000 individuals with schizophrenia, 32,000 with severe bipolar disorder. And that's just the tip. We've got a lot more that we can do. There is a difference between the criminally insane-- the Nikko Jenkins of the world-- and my son Devon [PHONETIC] who's got mental illness. Nebraska's solution is to put them all in jail together. You're not solving the problem; you're creating better criminals, because the mentally ill are going to come out of a, of a short-term incarceration having lived, slept, and dealt with these other people and learned how to behave from them. That's not going to help us out here in Nebraska. You're creating a bigger problem. I'm looking here at a report card from the Treatment Advocacy Center. Nebraska has a horrible rate; we're rated with a D. That's not satisfactory for our mentally ill in Nebraska. I'm here to advocate two programs that I have found that have been helpful that I believe will work. One is assisted outpatient treatment. It's court-mandated treatment where these people can get help. It's shown to reduce harmful behaviors by 44 percent. These people are four times less likely to perpetrate

violence and half as likely to be victimized. This saves money-- in New York alone 50 percent cost savings, 40 percent cost savings in North Carolina, 40 percent in Summit County, Ohio, and $1.81 for every dollar spent in Nevada County, California. Seventy-seven percent of these people receiving AOT experience fewer psychiatric hospitalizations, 74 percent fewer experienced homelessness, 83 percent fewer experienced arrest, and 87 percent experienced incarceration. This is a viable solution. It has a definite impact on violent behavior. Another option-- another treatment that I've found to be successful is animal-assisted therapy. If you look around the country and around the state, you see an increase in these service and comfort animals that are being brought around. Some people take it to extremes. I'll admit that I saw a lady and a horse with a comfort-- or in a, in a Walmart with a comfort horse, a miniature horse, thankfully, not a full-sized one. But I'm here to tell you that animal therapy can work. They provide a comfort, and they also can reach people in ways that doctors and nurses can't. Animals don't judge. I volunteer for Scatter Joy Acres in Omaha. This is an animal-assisted therapy program. They receive no Medicaid dollars whatsoever. But I've seen it work with the autistic and with the mentally ill. My son Devon [PHONETIC], when we go there, he may sit there and talk to the horse or a camel or a cow, but he is relaxed with no, without drugs, without self-medicating. He will lay down and take a nap with puppies. When he is up all night pacing and doing whatever, trying to control himself,

out there he can relax. This does have a solution. I've seen an autistic young boy who is scared to go out into the world is now actually giving tours at this facility. That makes a difference in a young man's life when they can go from being, you know, unable to communicate with people to actually leading people around a facility and talking about what's going on there. There are opportunities. And when Medicaid is not funding these things and we don't have court-mandated therapy, we're leaving the door open for a lot of problems. I would encourage you to-- I know my time's getting short here-- but to explore these options. I think they have viable opportunities for Nebraska. Are there any questions?

ARCH: Any questions? Yes, Senator Williams.

WILLIAMS: Thank you, Senator Arch, and thank you, Mr. Heller, for being here. You mentioned assisted outpatient treatment. Are there any facilities that do provide that service--

TIM HELLER: Not in Nebraska.

WILLIAMS: --whether it's paid for-- it's just not available.

TIM HELLER: Not in Nebraska.

WILLIAMS: Thank you.

ARCH: I have a couple questions.

TIM HELLER: Please.

ARCH: Is that a day program? Is that what that is, the assistant outpatient?

TIM HELLER: AOT?

ARCH: Yeah.

TIM HELLER: No, it's not a day program; it's court mandated therapy. So these people have to-- if you don't mind me reading.

ARCH: Yeah, that's fine.

TIM HELLER: AOT is practicing and delivering outpatient treatment, and court-ordered, to adults with severe mental illness who meet specific criteria, such as a prior history of repeated hospitalizations or arrest. It's a tool for assisting those individuals most at risk for negative consequences who are not receiving treatment. So there, there's day program part of it. There's also the threat of the legal action that the court has mandated that says you have to do these things. We don't currently have that.

ARCH: OK.

TIM HELLER: So if we get the, you know, if there's that backup for the parents, caregivers that, hey, there's legal action, there's a consequence if you don't do this stuff, that's been our best method of

working with our son that there is that threat of going back to jail or going to jail as a consequence.

ARCH: I see. Have you been, have you been following any of the articles in the paper regarding the discussions between Sarpy County and--

TIM HELLER: Yes.

ARCH: --UNMC and a crisis center, and that type of thing? Do you have, do you have any--

TIM HELLER: I think it's a great start, but it's a start. And as my wife mentioned, we consistently fall at the bottom half of the states for mental health. We're currently looking at moving across the river to Iowa because of the mental healthcare being that much better. I believe Iowa receives a B-minus compared to our D, as far as rankings go. You know, they're ranked much higher. You know, I don't want to move out of the Midwest; I frankly don't want to move to Iowa, for crying out loud. But you know. I don't know that I'm left with a whole lot of choices. You know, we're, we're taxpayers here in Nebraska. We love Nebraska. We'd prefer to stay here, but we've got to do what's best for our family and our son. And that may mean having to relocate to get better mental healthcare, which is a sickness; it's a shame.

ARCH: And what you're, and what you're looking for, for your son, is, is a longer-term treatment program.

TIM HELLER: Right, yeah, so things can be continually managed.

ARCH: Not the, not the episodic, not just a psychiatric visit , not--

TIM HELLER: Not bandaids.

ARCH: Longer, longer-term for severe and persistent,.

TIM HELLER: Right. You know, when he is EPC, in emergency protective custody, that's three days to maybe a week. That's not enough time to get his medication balanced. And we've been fighting that battle for years. And because, you know, if you-- if he's not mandated to take that medication, trust me, he's not going to do it. I've seen him cheek the pills in the hospital, sitting there with the nurse. When the nurse came in and gave him the pills, he cheeked it, tried to throw it under the covers, but he didn't take it. You know, that's not working for us or for anybody else, any of the other 48,000 people in Nebraska who suffer from this. And if there can be cost savings by not having to deal with these emergency incarcerations, by having that backup for the parents, by having that legal action there available, that provides some solutions and can definitely work with cost savings, reductions in the cost of emergency rooms and emergency responders. Let these people do what they're supposed to be doing, not

managing our mental healthcare, before it gets to the point where they have to be involved.

ARCH: Thank you. Are there any other questions? Thank you very much. With a legislative resolutions study, we-- it's not a proponent-opponent-neutral testimony. It is, it is people that want to speak to this. I didn't know if director Dawson-- I wanted to give her an opportunity. I don't see her yet.

WILLIAMS: She's not here yet.

ARCH: So we'll ask, if anybody else would like to, to speak on this issue, to step right up; please come forward. You could provide the blue sheet, if you, if you happened to fill out a blue sheet before-- and you can fill that out later; that's fine. Just want to make sure we get one in. Thank you for coming this morning. Please--

BRAD BEST: Yes, good morning. My name is Brad Best, B-r-a-d B as in boy,-e-s-t. I am currently the superintendent of schools at Heartland, which is Henderson/Bradshaw in central Nebraska. I wasn't really planning to speak as much as to listen today, but I feel it necessary to share a few things and ask the committee for consideration as they move forward. My background-- excuse me-- is 37 years in education, 30 of those in administration. Some of that has been in the Omaha metro area all the way down to class D school in, in rural Nebraska. My, I think, experience as well, in childhood, is that my father was the

director of what was referred to then as the Girls Training School, or YRTC in Geneva, for over 30 years and retired around 1990. And so I grew up in that environment and saw what some of the programming could be and, and some of the challenges, which also involved looking for runaways on Christmas morning until 3 in the a.m in old barns and things like that, probably more so than we spent at home on Christmas Eves. But I think I bring a little bit of a unique perspective to this. What I have seen is a huge change in need. I believe, and, and you've seen in the papers lately, with the challenges that those facilities such as in Geneva and Kearney are facing right now, and I, and I believe this has a trickle-down effect all the way into the public schools. The level of need that these kids have, I believe, has increased dramatically. And I think it has increased consistently since the changes clear back in 2000 and, well, 14 years ago-- LB1083 and Senator-- and Governor Johanns' changes with mental health treatment to try to serve these folks that need that help back in the communities. And while it's a noble gesture, a noble plan, I do think that we have seen an increase in need then back into our communities, and then what we find is the lack of services enabled to be able to handle those situations, especially in rural Nebraska. One of the things that we deal with-- and this is why I am here, I guess, today-- is that in the process of discussing this, please don't lose sight that education is a key component, especially with the youth. And to my knowledge, we have not been well represented in those discussions.

That educational component hasn't been a key player in what, how to move forward. I'm asking for you to at least consider a seat at the table, so to speak, to consider what effect this has on schools across the state of Nebraska-- and not just for those kids and families that are challenged with mental health issues, but also for all of the other students who are maybe in that classroom, trying to learn. And we are dealing with students who are violent in the classroom, disruptions consistently with the teachers, and we have a lack of services; we can't find the support that we need. As an example, recently in, in my own district, receiving foster children into the district, it was more of a, you are receiving this child. We are placing them in your district, just to let you know, but they're going to need a full-time person to follow them around all day because they can't handle the school day. What struck me was, is that I had been advertising for over two months to try to find paraprofessionals to serve the kids that we already had. And now we were being asked to take on another student who was needing that full-time service; and I don't know where that person would come from. I can't hire those people. They aren't there. And that doesn't seem to matter. That student arrived and so what it, this really does is that, for us, we then have to reformat how we are serving all kids in order to address the highest need. And so those students that may have been receiving some services are now not receiving them because I don't have the

personnel to serve those kids. I have to, I have to address the ones with the highest need.

ARCH: Thank you.

BRAD BEST: If it--

ARCH: We're, we're running on a five-minute--

BRAD BEST: Sure.

ARCH: That's the red light there. But, but I want to leave time for questions. Senator Hanson?

B. HANSEN: Thank you, Vice Chair. Thanks for coming, Brad; appreciate it. You mentioned like the need for care has increased dramatically over the years. In your, maybe, professional and personal opinion, why is that?

BRAD BEST: That's the million-dollar question. I wish that people would be able to answer that question. I think that would help us to solve the problem. I do think that it has to do with the societal changes and whether it be self-responsibility, parenting, families that are struggling. We've just seen a dramatic increase in, not just mental health, but just flat out behavior, behavioral issues to where I--and sometimes I don't feel like we have, maybe, the authority that we used to have in trying to deal with some of these difficult cases, but also some of the facilities that handled those highest-level

students are nonexistent anymore or they're full or they're not available to us. One example I would give-- we have a student right now that is placed in a facility in Iowa because there's no place in Nebraska to serve this young lady. They struggled in our district and with the family. They were placed at Boystown. Boystown had her for a period of time, quite a period of time-- two months, and basically said we can't do this. We're not getting anywhere with this child. We cannot serve this child. And so what their solution was-- send them back to us because we don't have-- but they didn't have any place else to go. So they went from us to a higher level of care and they couldn't handle it. So then the only option was to send back to us. That makes no sense. It makes no sense, and I feel bad for the kids.

B. HANSEN: Thank you.

ARCH: Any other questions? I have one. This is at a lower level. Do you, do you have an opinion as to the, the skills that, that the, that the teachers have in classroom management, do you believe that they're-- .are-- I'm sure there's a broad cross-section of skill at that level. Do you think that they are adequately prepared for classroom management of some of the behaviors?

BRAD BEST: I do think we have those resources available, and we do train our our staff on classroom management skills to, to handle unique cases like that. I don't think any additional requirements

would help. I think we have all of those things at our disposal now. We need trained mental health practitioners to work with the schools and to work with these families. An, an article in The Lincoln Journal Star last summer--Riley Johnson-- I would refer back to that, some of you, if you've not read that, that's a really interesting article, talks about some of the numbers since this bill 14 years ago. A third of our counties in the state do not even have a mental health practitioner. And so we have to find unique ways. One of the ways-- we were probably the second district in the state of Nebraska who have contracted with the local hospital. And they have beefed up their mental health departments, too, and then we pay to have these people come out and work with our kids a couple days a week, the highest-need students. But again, that comes back to budget; not all the school districts have that flexibility. And we all know the discussion surrounding school spending. And unfortunately, the money has not followed these people back into the communities.

ARCH: Thank you. Seeing no other questions, thank you very much.

BRAD BEST: Thank you.

ARCH: If someone else would like to speak, please step up. Good morning.

SHINOBU WATANABE-GALLOWAY: Good morning, Chairwoman Howard and members of the Health and Human Services Committee. Thank you for the

opportunity to testify today on this very important issue. My name is Dr. Shinobu Watanabe-Galloway, S-h-i-n-o-b-u W-a-t-a-n-a-b-e G-a-l-l-o-w-a-y. I am the research director at the Behavioral Health Education Center of Nebraska, also known as BHECN. BHECN acts as the state's behavioral health work force development agency. BHECN was established in 2009 by the Nebraska Legislature to address the shortage of behavioral health professionals in rural and underserved areas of the state. We are based at the University of Nebraska Medical Center and have rural hub locations at the University of Nebraska-Kearney, Chadron State College. I'd like to give-- I am here to provide some statistics on our work force supply in Nebraska. These results are the primary analysis we conduct every other year. This is one of the jobs of the BHECN, to provide the most accurate and comprehensive information about behavioral health professional supply in the state. There are some positive trends but, as you heard so far, behavioral health provider shortage is a nationwide problem, including in Nebraska. BHECN uses data provided by the Healthcare Profession Tracking Services [SIC] since 2010. So I'd like to highlight some information comparing 2010 to 2018, which is the most updated data. And the professionals that we cover in this analysis include: psychiatrists, psychiatric nurses, physician assistants-- PAs, psychologists, LIMHP, LMHP--those are the licensed mental health professionals, and also licensed alcohol and drug counselor--LADACS. OK, I'D like to emphasize that results are preliminary; however, the

final numbers would become available in a couple months. OK. Overall there has been an increase in the total number of behavioral health providers in Nebraska, from t2,279 in year 2010 to 2,643 in year 2018, which means increase of 261 people across different behavioral professionals for the entire state. The largest increase we have seen is with LIMHP, licensed independent mental health profession, professionals, 589 in year 2010 to 1,171 in year 2018. Also, we saw the number of psychiatric nurses increased from 72-- 78 to 124 during this period, notably, some of the increases seen in the rural area for these professional psychiatric nurses. The number of psychologists slightly increased from 318 to 369. Trends for the remaining professionals, including psych, psychiatrists, have been very stable during the last ten years. OK. According to the 2018 data, one of the concerns would be aging behavioral health providers. Many of the existing providers are 50 years or older, which means we are expecting some retiring individuals. So the vacancies need to be filled. What to do with that, that is one of the main issues that need to be addressed. As regionwise, psychiatrists in Region 4, the number of psychiatrists in that region went down from 9 in 2010 to 2 in 2018. In Region 5, also we saw a decrease in the number of psychiatrists from 33 to 27 in this period, so that's 18 percent decline. Other regions, psychiatrist numbers have been very stable. OK. I'd like to-- I know my time is short so I'd like to wrap up quickly. We are conducting additional studies to understand the needs of the state in terms of

the behavioral health professionals. For example, we are studying the provisional license-related issues. This is because the conversion rate from provisional license to full license ranges from only 50 percent to a little above 60 percent, meaning many of the individuals with provisional license never get full license. And we are trying to understand the reasons and the challenges these professionals faces to get full license. Other studies we are conducting right now include nursing shortage study, and also, we are paying attention to the role of telehealth, telemental health and how the integrated care, how primary care can work with behavioral health providers. Thank you.

ARCH: Thank you. Questions? Senator Williams.

WILLIAMS: Thank you, Senator Arch, and thank you for being with us and sharing that information. And it would-- it, the piece that I'm missing that I would like you to, to address, is you have documented that we have had some slight increases--

SHINOBU WATANABE-GALLOWAY: Um-hum.

WILLIAMS: --in the professionals--

SHINOBU WATANABE-GALLOWAY: Um-hum.

WILLIAMS: --during that 2010 to 2018 period. How does that compare to what would be the, the needs that are out there to be fulfilled by these professionals?

SHINOBU WATANABE-GALLOWAY: Comparing to national average, even nationwide, we know it's just shortage is so huge. So the short answer to your question would be we are not meeting the needs of the state residents, especially in the rural area. How much we need really depends on what kind of behavioral health models we use and what kind of interventions are available to the families. So I can't really speak to actual numbers because if we start using, maybe, more telemental health, some of the issues may be addressed. So it's not just the number of individuals practicing in here, but how the access to care become available. So that's part of the study of the role of telemental health and integrated care. But if you ask anybody in my similar role here in Nebraska or other states, we can tell you this shortage is so huge, and we are trying to find out the best way to. Increase access to care but we are not there.

WILLIAMS: Thank you.

ARCH: Any other questions? I just have one. You said, you said you'll have your report then completed--

SHINOBU WATANABE-GALLOWAY: In a couple months.

ARCH: --in a couple of months.

SHINOBU WATANABE-GALLOWAY: Yes, the final data.

ARCH: Look forward to that. Thank you.

SHINOBU WATANABE-GALLOWAY: OK, thank you.

ARCH: Anyone else that would like to speak? Welcome.

JOE EVANS: Thank you. My name is Dr. Joe Evans; that's J-o-e, last name E-v-a-n-s, and I'm the clinical director of the Behavioral Health Education Center of Nebraska, or BHECN, as mentioned earlier by Dr.. Watanabe-Galloway. I'm a professor, also, in pediatrics and psychology at the Munroe-Meyer Institute. I'm involved in the training of professionals to become behavioral health service providers in Nebraska, and I'd like to thank Chairwoman Howard and members of the committee for providing the opportunity to testify today, especially related to the behavioral health work force. The University of Nebraska Med Center Behavioral Health Education Center ,in collaboration with UNL and UNO, is utilizing a $400,000 annual appropriation to provide dedicated training experiences for behavioral health trainees in the Department of Corrections and the Department of Health and Human Services' Lincoln Regional Center. In addition to providing over $300,000 in direct trainee stipends, program funds are utilized to supplement auxiliary student training experiences, such as: webinars, topics on civil commitment issues, clinician safety, and specialized in-person training on topics such as combating stress and burnout. The primary goal of this program is to establish a strong pipeline from training programs to employment within Department of Corrections and HHS. Since its inception in 2017-- so its not been

quite two years-- 41 student trainees have been placed in Corrections and also in the Regional Center. Specific placements were 21 at the Regional Center, 1 in Hastings Regional Center, 19 in the Department of Corrections, of which they were 9 psychiatric nurse practitioners, 3 physicians' assistants, 10 master of social work students, 18 counseling students, and 1 doctoral level psychology student. Since then-- and again, keep in mind this is only-- less than two years-- four individuals have been hired by the Lincoln Regional Center and three into the Department of Corrections, so we're making some progress in that direction. Current statutory authority allows for placement of trainees in Correctional Services and the state regional centers. But given the success of this program in establishing a pipeline, it may be prudent to establish expansion of this model to other high need areas, such as county correctional facilities and state-run youth placement treatment facilities, such as Kearney or Geneva. So these are some of the things that potentially could help us with dealing with some of those more, more difficult populations. At present there are 15 graduate training programs in behavioral health in the state of Nebraska. There are two in psychiatry, there's four in psychology, there's one in social work, there's one in marriage and family therapy, six counseling programs and one psychiatric nursing program. At any one point-- this is interesting because there are only, there are over 500 individuals being prepared for careers in behavioral health. Yet our state remains as having major shortages, as

pointed out by Dr. Watanabe-Galloway, particularly in rural areas. On a population based analysis-- in other words per 100,000 individuals, Nebraska has 33 percent fewer providers than national figures comparatively, and in rural areas, we're 65 percent lower than the national averages. So as noted over the past eight years, there's been an increase in the number of licensed professionals by approximately 11.5 percent, or about 33 professionals per year above and beyond individuals who have retired. This is progress, but there are other program graduates now, especially in outstate Nebraska. Where are they? Our data indicate, as she pointed out, 40 to 50 percent of graduates never become fully licensed in our state. Many leave Nebraska others give up due to lack of available required supervision. Some simply can't find jobs at the provisional level because they can't bill for services. And when actually becoming a master's level clinician at the LMHP, or licensed mental health practitioner level, an average of over four years to achieve that status is common. We clearly need to do better. So a recommendation would be that the more we examine our regulatory issues. For example, the number of hours of postgraduate supervision becoming an LMHP, or licensed mental health practitioner, is 3,000 for master's-level clinicians, 2,000 for doctoral-level psychologists. These requirements vary state to state. In 13 states for example, there's no postdoctoral supervision requirement for psychologists. In addition, some supervisory hours need to be face to face, and this can obviously be eradicated, using.

telehealth. So a review of such regulations that impair practitioners from becoming fully licensed is one possible recommendation for improving the state's behavioral well, work force shortages. It's clear that positive strides are being made in the behavioral health work force. In 2009, as mentioned earlier, BHECN was established. During the past ten years, BHECN has joined forces with the 15 behavioral health training programs in the state's universities and colleges in producing additional mental health practitioners. As I ride off into the sunset and go into retirement, I must reflect on how BHECN has had a positive impact in the state. Over the past five years, staff members from BHECN have applied for, and been awarded, five competitive grants from HRSA, the Health Resources and Service Administration, and the Substance Abuse and Mental Health Administration. This year alone, over $2.5 million in federal grants have been allowed, have allowed BHECN to expand its work force development activities, more than doubling the initial type of investment. So my time is running out here, but I will mention that we are specifically looking at working with school mental health. That's a huge issue in our state, as our superintendent pointed out. And we we do know that teachers, during their training, don't get any type of coursework in something like behavior management or in behavior modification. And that's, again, a regulatory thing which, potentially, we need to look at with our our Board of Education. But in addition to that, we have been placing students all over the state,

for, all the way from Scottsbluff to Blair to Plattsmouth and in between. So I think that's something that we've, we've been positive about. Thank you for continuing support for behavioral health training and, particularly, for BHECN. I believe this original investment has provided major dividends and stable funding. It's provided us the opportunity to actually apply for, and get, federal grants to support this activity. We're progressing but we have a long way to go. So I welcome any questions.

ARCH: Any questions for Dr. Evans? Dr. Williams-- Dr. Williams-- Senator Williams.

WILLIAMS: Thank you, Doctor, for being here. And one of the solutions is to not let qualified people ride off into the sunset. I don't suppose that's a viable alternative.

JOE EVANS: Well, when--

WILLIAMS: One thing I--

JOE EVANS: When the [INAUDIBLE].

WILLIAMS: --immediately appreciate is your willingness to actually give a recommendation and then come to us with with some potential ideas in a situation. When you look at those and you look at reducing hours of supervision, hours of training, who's gong to step up and say

those are necessary to meet the quality levels that we, as a state, want to provide?

JOE EVANS: To be perfectly honest, I think some of the, the professional organizations, you know, might object to that.

WILLIAMS: That's why I'm asking the question.

JOE EVANS: Yeah. And I think that's probably to be expected. On the other hand, I'm not talking about getting rid of all those but potentially maybe reducing it, maybe getting to the point where a person doesn't have to put in 3,000 hours; maybe it's, maybe 1,500 is adequate, depending on actual skill acquisition rather than just, just putting in hours. So those are some of the things that potentially, I think, can influence the area. And hopefully, you know, our colleagues in, in psychology and counseling and social work will also be favorable in that direction. Some states have already been doing this.

WILLIAMS: And in your professional opinion, this issue of the provisional license not being moved to a permanent, this would be one way and one help in addressing that.

JOE EVANS: Yeah, that's correct, yes.

WILLIAMS: Thank you.

ARCH: Senator. Hansen.

B. HANSEN: Thank you.

ARCH: I could say Dr. Hansen here, but somebody [INAUDIBLE].

B. HANSEN: I'll take think either one. Do you know, are there any other states that allow provisional licensures to bill for services?

JOE EVANS: We actually can bill for services, with provisional licenses, with Medicaid and some of the BlueCross types of products. But for the most part, almost all the commercial insurers will not panel individuals who are not fully licensed. So that really creates this kind of a doughnut hole, I guess you'd have to say, for, for individuals who maybe qualify but not being able to, to be hired because they can't bill for the agency.

B. HANSEN: OK, all right. Thanks.

ARCH: Thank you. I don't see any other questions. Thank you very much. Please, could I, could I quickly see a show of hands for those who still would like to testify on this? Three, four-- OK. Thank you. Just a reminder of the light system, that we have a five-minutes, and so when it turns red, please try to summarize and wrap up as quickly as you can. Thank you.

DAVE MIERS: All right. Thank you. My name is Dr. Dave Miers, D-a-v-e M-i-e-r-s, and I'm here representing the Nebraska State Suicide Prevention Coalition. I am one of the cofounders of the State Suicide

Prevention Coalition, which we formed back in 1999 following Surgeon General David Satcher's call to prevent suicide, for he declared suicide a public health problem. It was, it was at this time that Nebraska developed its first suicide prevention plan. And over the past 20 years, we have achieved many milestones in Nebraska in the field of suicide prevention, and many lives have been saved. However, we know many lives have been lost and continue to be lost every minute to suicide every day. The alarming fact is that suicide rates continue to increase across our country. And the most recent data, which is always about two years behind-- so the 2017 data indicates that the suicide rates are the highest since the Great Depression. Here in Nebraska, suicide is the number one cause of death for our young, aged 10 to 14, the second leading cause of death for ages 15 to 24. And it has moved up to the ninth leading cause of death for all ages. So for years it was the tenth leading cause of death that has now moved up ninth leading cause of death. So one might ask, well, what does suicide have to do with mental illness? Not everybody with mental illness is suicidal, but we know that, through research, that 90 percent of those who die by suicide have a diagnosable mental illness or would have been diagnosed, most commonly, with depression. Therefore, if we have the services in place to diagnose and treat those with depression and other mental illnesses, we can prevent suicide. In fact, it is taught in our suicide prevention trainings that access to mental health and substance abuse treatment is a

protective factor that prevents suicide. And barriers to those services is a risk factor, an increased risk for suicide. Therefore, to save lives, it's important that we remove the barriers to those needed mental health and substance abuse services that many Nebraskans face. Many individuals who are suicidal do obtain the short-term, acute care services that they need. But there are some who find that long-term treatment they need is not available anymore due to the shortage of regional center beds. Additional regional center beds are needed to help those suicidal individuals with those severe mental health needs. The State's Suicide Prevention Coalition has worked with the six [INAUDIBLE] regions across Nebraska, and we've implemented some gatekeeper training called Question, Persuade, Refer, which has helped educate folks on how to call the National Suicide Hotline and to, how to connect individuals in need to those services. However, there are still times when individuals are in not in immediate crisis and they still need those noncrisis services. It's-- there's times in certain parts of Nebraska where it's difficult to find those services or there's a waiting list. Many times it's these noncrisis services that build into crisis situations that could have been prevented with adequate mental health resource, resources. Training and general needs need to be expanded in our state. The state law requires that school personnel are required to receive one hour of suicide prevention training. It would be beneficial to have this training be mandated to additional work forces, including first responders and any

professional license in the state. In addition, we need to fund this training in Nebraska so that evidence-based training is made available and a system is provided to ensure mandated attendance. Lastly, one area that is often overlooked is integrated care. Many times individuals turn to their family physician for help for mental illness or some-- or individuals are diagnosed with a chronic health condition, who immediately fall into a higher suicide risk category, who could benefit from mental health resources. Integrated care, which means having a mental health resource available in that physician's office, would benefit to the patient,, the physician and help save healthcare costs. Nebraska needs additional mental health resources and would benefit from an integrated mental health system that would allow physicians and mental health providers to exist under one roof and bill, using the integrated codes that exist that we are unable to utilize in our state. So together we can find those solutions. We can help end suicide in our state and in our country.

ARCH: Thank you.

DAVE MIERS: Thank you.

ARCH: Are there questions? Senator Hansen.

B. HANSEN: Thank you for being here.

DAVE MIERS: Thanks.

B. HANSEN: Appreciate it. I'm going to kind of pose the same question that I posed to Superintendent Best about-- I, I think it's-- I hope everyone else here would think that it's rather odd to think that no one cause of death between the age of 10 and 14 is suicide. And I would think only those instances have increased over the years. Why, in your opinion, do you think that is?

DAVE MIERS: The-- a lot of the research is pointing to the lack of connectedness, the technology, that there's a lot of connectedness socially, socially meaning through social media connectedness. But that's not the connectedness that's needed. We need the face-to-face connectedness, that the more connected we can bring our communities together through our families, through our schools, through our churches, through any type of face-to-face connectedness and those face-to-face relationships, that that does reduce substance abuse, violence in general. And what we're seeing is that kids are becoming more isolated to their rooms, to their homes, and. communicating through their, through their devices versus getting together in groups.

B. HANSEN: OK. I think that's some research I've seen, as well,--

DAVE MIERS: Yeah.

B. HANSEN: --that the amount of depression, that the more people spend on electronic devices--

DAVE MIERS: Yeah.

B. HANSEN: --is kind of correlated to depression to some extent.

DAVE MIERS: Depression and anxiety.

B. HANSEN: And I think what the Hellers even mentioned, too, about sometimes getting out face-to-face time, whether it's with animals, whether it's with other kinds of people.

DAVE MIERS: Right.

B. HANSEN: I think we're kind of seeing a little lack of that. And you talk about, also, integrative care, maybe with the family physicians. In your opinion, do you think maybe because the lack of doctor-to-patient face time that we see because of your lack of medical professionals, that may be contributing a little bit? Like whereas maybe you have, you go to your family physician, he's spending a good ten minutes with you, like how's it going, talking about your family, what's, you know, and that gives a person-- can open up-- then maybe we'd see less of that over time. Maybe do you think that could be contributing to some of the problem, too?

DAVE MIERS: That, that could a--I'm sorry-- that could contribute to it. And I, I think a lot of it, too, is that oftentimes, when we're talking to our physicians, they're, they're identifying depression and anxiety, and they're making those referrals, but that individual's

having to drive across town or make a separate appointment. And we're trying some different things. We're replacing psychologists in those physicians' offices, but we can only do it a day or week at a, you know, a couple of days a week at a time. And that's helping, but we're having to, you know, it's always a space issue and that type of thing. So the billing system is not set up to where we can actually have it there all the time. And it's really helpful to be able to have the-- so the physician can just walk across the hall and say [INAUDIBLE], I'm going to introduce you to-- you know, even though they're only able to see them 10 or 15 minutes, they can make that warm handoff and say, hey, this is who I am going to have you start talking to and connect you. In that way, they don't have to drive across town--

B. HANSEN: OK.

DAVE MIERS: --and make that separate connection.

B. HANSEN: OK, I appreciate your opinion.

DAVE MIERS: Thank you.

ARCH: Thank you. Any other questions? Thank you very much.

DAVE MIERS: Yeah, thanks.

ARCH: Thank you for coming.

STACY MARTIN: Good morning.

ARCH: Morning.

STACY MARTIN: Good morning, Chairperson Howard and members of the Health and Human Services Committee. My name is Stacy Martin, S-t-a-c-y M-a-r-t-i-n, and I'm the president and CEO of Lutheran Family Services of Nebraska. LFS has a 125-year history of providing quality human care services that build and strengthen individual family and community life. Our vision is safety, hope, and well-being for all people. Mental health and behavioral health challenges impact all of LFS's services, whether it is ensuring that victims of sexual abuse in our child welfare system get the needed services and supports that they need or work with refugees who need to access trauma-informed care to ensure successful integration into our communities. I would certainly echo many of the concerns already shared this morning. These are very real challenges that face the whole ecosystem and LFS, as well. However, with our limited time today, I would like to spend some time sharing results from a recent evaluation of our Health 360 Integrated Care Clinic, as well as highlight a couple of additional challenges facing LFS and the people we serve. Our Health 360 Integrated Hair [SIC] Clinic, located in the heart of Lincoln at 23rd and O Streets, is a partnership between LFS and Bluestem Health that opened its doors in May 2015. Utilizing a multidisciplinary team compromised-- comprised, excuse me, not compromised-- comprised of physical health and behavioral providers,

Health 360 serves 5,700 clients each year in 2018, and we're on record to have more than that this year. Located in the middle of six high poverty ZIP codes in the city of Lincoln, 90 percent of the clients we serve report living at or below poverty, and 30 to 50 percent of our clients are living with severe mental illness or severe and persistent mental illness. The interrelationship between physical and mental health has long been established. A year-long data collection process, conducted by UNL for Health 360, found clients who participated in integrated behavioral health experienced greater access to care, increased provider referrals, increased levels of satisfaction by both consumers and providers, and greater perceptions of high-quality care. We believe in the integrated healthcare model and are energized by the results of this study. Now that I've shared some of what is working well in behavioral health, I'd like to spend the remaining minutes discussing some of the challenges that we see it at LFS. First is with peer support services. There's been a concerted effort, and understandably so, to create service definitions for peer support services for behavioral health services and the Medicaid program. The motivations behind these changes are laudable. However, the unintended consequences of this policy change have meant that peer support programs have had to change. Because the work of peer support specialists are no longer met by Medicaid Service definitions, there is not an immediately available funding source to sustain the program. And what's more, peer support can no longer stand alone as a support

for our clients and must be a part of a larger treatment plan with the goal of therapy. Some of our clients, such as veterans and active military folks served in our programs, do not need a treatment plan, and this requirement has created barriers, real or perceived, for clients to get peer support services to address their mental health challenges. These new service definitions have had a chilling effect on the clients who participated in our peer support programs, and I would beyond-- add, beyond the written testimony, that this limits the access to other services as peer support is often a conduit into behavioral health services. The second challenge I'd like to highlight is in regards to language accents-- access-- gosh, I'm having a hard time this morning. There are access, accents in medical interpretation, but there's also access issues through medical interpreters. At LFS we believe that everyone should have the tools necessary to understand and be informed of the healthcare that is being provided to them, as well as participate in their own healthcare decisions. This includes the use of medical interpreters for our clients with limited English proficiency. Under Title, under Title VI of the Civil Rights Act, all providers who receive CMS funds for Medicaid or CHIP services are required to provide language services to those with limited English proficiency. Despite this requirement, states are not obligated to reimburse providers for the cost of providing these services. In practice in Nebraska, the managed care organizations vary widely on whether and how they reimburse for these

services. The costs for reimbursement is not sufficient to cover the costs of services; and these of these services are important. Other states, such as Minnesota, have implemented a series of changes to improve access to translator services by establishing a minimum standard for healthcare interpreters and creating a voluntary registry for healthcare interpreters. We encourage the Health and Human Services Committee to look at this and other issues surrounding medical interpreters to ensure access and reduce the disproportionate burden borne to providers to provide these services. Finally, I would like to close my testimony with a report that will hopefully put some of the challenges you've been hearing about in context. Nonprofit organizations are a vital segment of our economy and meet some of society's greatest needs. Nationally nonprofits comprise 5.5 percent of our country's entire GDP, with nearly one in 10 paychecks and jobs generated by the nonprofit sector. What's more, the human services ecosystem touches the lives of one in every five Americans. I've included an executive summary of a report entitled "A National Imperative: Joining Forces to Strengthen the [SIC] Services in America" with my testimony, and I encourage the committee to review the full report, as it considers reforms to our human services system, either in behavioral health or one of the six divisions within the Department of Health and Human Services. Thank you again for this opportunity, and I'm happy to answer any questions.

ARCH: Thank you. Any questions? I don't see any.

STACY MARTIN: All right.

ARCH: Thank you very much.

STACY MARTIN: Thank you.

ANNETTE DUBAS: Good morning, Vice Chair Arch, Senator Howard, and members of the Health and Human Services Committee. My name is Annette Dubas, A-n-n-e-t-t-e D-u-b-a-s, and I am the executive director for the Nebraska Association of Behavioral Health Organizations. We would like to thank Senator Howard for her attention to this important issue. Work force in many of the healthcare professions is in a precarious position, behavioral Health even more so. You heard the statistics from BHECN, and we truly appreciate the work that they are doing to help alleviate these shortages. There is no single solution and it will take time to reverse these trends, but I would just like to highlight a few of the obstacles to growing and sustaining a competent caring and professional work force, as well as some opportunities. When one in five Nebraskans experience a mental illness in any given year, and with suicide rates climbing, especially in our teens and young adults, we cannot ignore this problem. Most of the providers that I know and represent see their calling as a profession-- their profession as a calling, excuse me. They fully understand that this work is important and makes a difference in the

quality of life for their clients. But the payment structure for behavioral health services is fragmented and heavily reliant on public payers. Nationally 62 percent of funding for mental health services and 69 percent of funding for substance use disorder treatment come from public payers, and Nebraska falls well within those ranges and possibly higher. Mental health and addiction services still struggle to achieve parity. Even with private insurance, there are still many limitations on services and rates paid for care. With the rate increase just passed by this Legislature, and we thank you, I have members reporting that they are now able to provide some pay increases, long overdue pay increases, to their staff. With rates that don't cover costs, it's very difficult to pay competitive wages and recruit good people into your organizations, especially in the rural areas of the state. Loan forgiveness programs are important, but it still remains a challenge to recruit, and especially retain, experienced staff. And I think this has been highlighted with the recent issues in, in Kearney and in Geneva. Finding the type of work force that needs to come into those facilities is very challenging. Another challenge in the-- is in the area of regulations and administrative burdens. Providers often say they spend more time on paperwork than they do actually providing care. That may be somewhat of an exaggeration but not by much. When you work with multiple payers who each have their own administrative requirements, it is a challenge to stay on top of things. Authorizations, claims denials, and appeals

take time and resources. Too often the payers are dictating the care that conflicts with the professionals' treatment plans. Many clients have to fail up the system to finally get to where they need the treatments that they need. And so we would support the recommendation that Dr. Evans made in his testimony. The use of telehealth is a promising option, especially in rural and frontier areas of the state, but we need to help providers become more comfortable and confident with the use of this technology. I think by introducing students who are currently in training to more of how the, how telehealth works could certainly help move the needle on our use with telehealth across the state. Costs associated with telehealth have come down considerably and makes it much more affordable for providers, as well as the software required, you know, to comply with HIPPA, that has become much more accessible and affordable, as well. As the current work force continues to age, it is critical that we find ways to fill the pipeline and to encourage people to enter this field. Providing shadowing and mentoring experiences can be very effective. We must figure out how to grow our own. Our young people who grow up in rural Nebraska want to return home if they feel that there are opportunities. Replicating programs like the FARM CAMP in Rushville, Nebraska, where high school students meet behavioral health professions in rural areas and learn firsthand about these careers. They also take classes introducing them to aspects of psychology, mental health treatment, and ethics, for which they receive college

credit. There is no question that the need for behavioral health services is growing. We must find ways to be innovative within a system that is constrained by a siloed and fragmented payment and delivery system. Telehealth, innovative mental programs, and loan forgiveness are certainly steps in the right direction. And I would certainly be willing to answer any questions if I may.

ARCH: Any questions? I have one. Do you see any current barriers right now-- regulations, anything for, for expansion of telehealth, telepsychiatry, behavioral health-- is there anything out there that needs to be addressed?

ANNETTE DUBAS: I, I think it would be good for us to take a look at. I'm not aware of specific-- I think there may be some perceptions that there's some barriers in place, and I know the Legislature has taken some steps in the recent past, you know,--

ARCH: Right.

ANNETTE DUBAS: --looking at being able to make it available to everybody and pay for it, etcetera, so I think it would be a great idea just to maybe elevate that discussion about what, how, how telehealth can be used.

ARCH: Yeah.

ANNETTE DUBAS: And I think a lot of, you know, it's something new. So for those providers who, you know, maybe aren't familiar with technology or how it works, there's just not a level of comfort quite yet in how do they integrate that into their system. But I think-- I know BHECN has a report on their Web site that those who are using telehealth are finding it to be a very effective tool.

ARCH: Right. My experience has been that, as the, as the professionals are coming out of training much quicker to adapt, much, much more ready to embrace, and so that, that's, that makes sense.

ANNETTE DUBAS: Absolutely.

ARCH: But, but I didn't know if there was anything, because it, it shows great hope,--

ANNETTE DUBAS: Yeah, and I--

ARCH: --great [INAUDIBLE].

ANNETTE DUBAS: And I don't know of anything specific. And like I said, I think maybe there's some perceptions out there that--

ARCH: OK.

ANNETTE DUBAS: --there's some, there's some problems, so maybe just some education and some awareness of actually what the regulations are

and how they work. And just training for those already established providers I think could be helpful, as well.

ARCH: Great. Thank you. Thank you for testimony.

ELIZABETH LAY: Good afternoon. My name is Elizabeth Lay; it's E-l-i-z-a-b-e-t-h L-a-y, and I am a deputy county attorney in the Platte County Attorney's office. I've been there for seven years and I think, for six of those now, I've appeared before some committee or another, testifying to the state of mental health in Nebraska and the things that I see from across my desk. I'm particularly moved by the Heller's testimony, as I'm the prosecutor on the other side of that story who's trying desperately to help people and can't find the resources, and end up putting them in jail both for their safety, so to speak, for a limited, for a limited amount of safety for them and for the safety of the public, as well, in, in many situations. In my office I do prosecution. I do all the civil work, which includes the mental health, and I also do prosecutions that are dedicated. I dedicate myself to prosecutions that deal with people who have victims or defendants who have mental illness or developmental disability as a part of their case. And so I see a lot from both sides of the table, both prosecution and criminal, and mental health. The reason that I'm here-- and, and you've heard a lot of general, generalities, and I support so much of what was said today. But from what I see, I see very specific instances in which the system doesn't work. And when it

fails, it fails drastically. And then a lot of times that results in huge public safety concerns and huge concerns for the individuals involved. LRC is still a huge problem. Getting people into the Lincoln Regional Center is still as difficult as it ever was and, in fact, it's becoming more difficult. And because of that difficult process, it trickles down into what we do every day. We have hospitals who don't want to keep people for six months or three months or four months, or whatever it might be, waiting for a bed. So they send them back out into the community before they're ready because they're no longer getting paid because the acuity is passed. But the need for treatment hasn't passed. We see competency placements even are, are also three to four months; the waitlist for a mental health bed is sometimes much, much longer. You can get pushed to the top if the person is violent or very unsafe for themselves, but you have to skip over everyone else in the process, which no one likes to do. Private facilities want to let the vet go if it's going to be a three or four month wait, because they don't want people-- they're not-- you know, private hospitals aren't long-term care facilities so they don't want these people in their home-- or in their hospitals. And so a lot of times they get released to home, which is not the level of care. I object to those when I can, but-- and oftentimes I don't have a resource available for me to fit that need, and so there's no solution to that problem. The root issue is that the needs of tough cases aren't being met with LRC. We have one private staff-secured facility,

which would be kind of a step-down facility from LRC, and the wait to get in there-- we just tried to put someone in there-- was a month. The hospital called me once again, saying, we really need to get this person out of our hospital; what do we do? And I say you just pray, that you please wait. So you're seeing a trickle-down effect from the fact that there aren't enough beds available at LRC. We have people who come to us-- I'm, I'm in the county attorney's office. I have people that come to me that are in desperate need of help, and my only solution is to put them in jail. So there's this huge conversation surrounding mentally ill people in jail. And I try every day; 75 percent of my day is finding resources for mentally ill people. As a deputy county attorney, that's 75 percent of my day. And then when push comes to shove at the end of the day, and I just have to have a safe place for these people to go, it's jail. It's jail. That is the state of that portion of your mental health system right now. That's the state of it in one very quick, quick sentence: the state is. People are at such a loss for resources that prosecutors have to put them in jail, no matter how hard we try. And then, granted, we don't want to keep them in jail so we do go through the whole process of diversion, so to speak. OK, we're going to let you out if you promise to get the treatment that you need. But you're talking about people who can't take care of themselves in a lot of instances. So how are we supposed to let them go? When I can't find the resource, how am I supposed to let them go and expect them to find the resource? It's

just-- that particular part of the system does not work. And the only way that is fixed is for the state to step up and say we're ready to fix it. It's really, really important for you guys to understand that, with LRC the way it is and with no intermediate between them, you are tying my hands. Your tying my hands. And no matter how much I want to do something more for someone, I can't because my, my interest in this problem is public safety. That's my interest in this. And so we're trying to keep people alive. I'm trying to keep people alive. I've had someone in my county commit suicide because the resources weren't there. And do you know how hard it is for me to get that call? Because I put him in the hospital three-- probably one week prior. But there was no room at LRC so the hospital let him go. His parents found him three days later. That is not OK in any way, shape, or form. And it's not OK for that to happen even one time. So a lot of people will say the system isn't broke, and they're right; the system isn't broke all the way down. It's not broken all the way down, but where it really matters at the top and you get that trickle down effect to where it really affects your community resources, it is a problem. Those most dangerous people, those most vulnerable people-- people that I see-- they are not getting the help that they need. They aren't. They aren't, and there's no mincing words on that. That's just where you are right now in the state of your mental health system in Nebraska.

ARCH: Thank you.

ELIZABETH LAY: I would answer any questions that you may have.

ARCH: Thank you. Questions?

WILLIAMS: Thank you, Senator Arch. And thank you, Ms. Lay, for your continued advocacy in this area in front of this committee. Early in our testimony, Mr. Heller talked about assisted outpatient treatment. I would like to know from your perspective as a prosecutor-- we have worked very hard to expand the use of problem-solving courts in our state,--

ELIZABETH LAY: Um-hum.

WILLIAMS: --from a funding standpoint and from an advocacy standpoint. And we have, we are not there yet with mental health courts, but what would be your view of expanding problem-solving courts more into that area?.

ELIZABETH LAY: I I really appreciate that question because it, it has a complicated answer in that I believe problem-solving courts work. I've seen the statistics that drug court really does help a lot of people. There is some issues with the processes that those, the way that those courts are made in each district or in each county. The judges really have to be on board with those things. And a, and I think that, in a lot of instances, judges across the state maybe don't have a lot of experience in those types of alternative solutions, and so maybe they might be a little hesitant to bring those types of

courts in to their counties or their districts, or whatever it might be. And so I think that, you know, in a lot of instances your judge has to be on board with that. And if your judge isn't on board with that, then you're going to have a problem implementing those types of things in your county. You know, in my county specifically, we have implemented an adult diversion program. And then, as a part of that adult diversion program, because of all the prosecution that comes to me that deals with severe and persistent mental illness and developmental disability, I can divert those cases to the adult diversion coordinator. And then that diversion coordinator becomes an additional resource. So that's a way to get around whether-- if you're if your judge doesn't want to deal with problem-solving courts. But adult diversion doesn't work for felonies. You know, we can't divert felonies. Those are very serious charges. And so ,though as a prosecutor I have the discretion in how to deal with that at the charging level, some things just have to stay a felony. And so, you know, I believe that problem-solving courts work. But I think the state is going to have to take a stand and say, you know, if you're willing to, to do these types of things in your county, then we would be willing to help fund things. But then you have to think of the flip side of it, too. Problem-solving courts work, but there have to be resources on the other side that people can partake in. And when those resources are lacking, you're setting people up for failure. And then again, our hands are tied. And I really think that it all comes back

to the fact that we are severely depleted in resources in the state of Nebraska. It starts at the top and it continues to trickle down. In my county alone, we don't have a wait for treatment beds, for example, in psychiatric residential facilities, which I think is phenomenal; that, that's come a long way in the last seven years. But we do have a huge, long wait for voluntary treatment. So someone has to get committed before they can move to the top of the list. So the waitlist is is still four months long. So someone might look at you and say oh we don't have a problem with psychiatric residential beds. Everyone can get in. Well, everyone that's committed can. But when you have a person who wants to voluntarily partake in that treatment or who might be court ordered to do so, they have to go to the bottom of the list and it takes four months. It's a huge time period when you're talking about medical treatment. I mean, ask someone with cancer to wait four months for chemotherapy. See how-- what the responses that you get on that.

WILLIAMS: Thank you.

ELIZABETH LAY: Um-hum.

ARCH: Any other questions? I don't see any others. Thank you very much.

DONNA POLK: Good morning.

ARCH: Good morning.

DONNA POLK: And thank you, Senator Arch and Senator Howard. My name is Donna Polk, D-o-n-n-a P-o-l-k. I'm the CEO of Nebraska Urban Indian Health Coalition. I don't have prepared remarks because I wasn't sure, first of all, if I was even going to come and, secondly, I wasn't sure what I would say. And the Heller family and the school superintendent really have said a lot of things that are so important for you to hear. The system is broken. In fact, we have two broken systems: mental health and the Department of Corrections. I could tell you story after story of people from the native community who have come out of Corrections who were really disturbed, many of them suffering from posttraumatic stress disorder, others from schizophrenia. And we try in vain, most of the time, to find resources to help them because they're just not available from a culturally competent perspective. And that is a part of the core functions of any system of care. You have to have people who are capable of meeting the needs of every individual who presents him or herself. So what are some of the solutions? First of all, you've heard about peer support. It is very important that, that that service be available and that people be compensated for the time and energy that they spend reaching out to people who have had a similar experience that they have had, whether it's addiction or mental health. I think it's important to revise the licensure requirements, and you've heard about that. I was a certified

drug and alcohol counselor in 1985. When licensure went into effect, I decided I could be a mental health-- excuse me-- professional, because that is my academic background. So now I can't do drug and alcohol counseling because I gave up that certification. I thought I didn't need that. We need to take a look at that. We also need to look at how pass-through funds are allocated. Why is it that some programs get really no money to do the services that they need to provide as nonprofits. I am very fortunate that my organization was selected by the National American Indian and Alaska Native Technology Transfer system at the University of Iowa for a demonstration project, that if I can get permission from the Omaha Public Schools, we will be able to provide telehealth access within the school system for Native kids. And in addressing some of the concerns that the school superintendent is, this might be a model that could be used, particularly in rural areas. So I really appreciate the fact that you all are giving people an opportunity to speak, because really we're speaking with one voice. There's a need. You all have the power to make the changes that will help the citizens of this state address their own personal needs ,as it relates to behavioral health, or the needs of their community. And I thank you for this opportunity.

ARCH: Thank you, thank you. Any questions? I don't see any questions. Thank you very much.

DONNA POLK: Thank you.

MICHELE BANG: Hello my name is Michele Bang, M-i-c-h-e-l-e; last name is Bang, B-a-n-g. I'm a deputy chief at the Omaha Police Department. Thank you, Senator Howard ,for the-- and members of the committee-- for your continued leadership and commitment to this important topic. I am here to provide a law enforcement perspective only. I am not an expert in the, in the field so I'm going to defer much of that to them. A lieutenant friend of mine has a saying: mental health is not a criminal matter, but it is a law enforcement matter. I think Devon's [PHONETIC] case and the case that the county attorney, the cases the county attorney presented to you illustrate those perfectly. A vast majority of mental health-related matters that officers deal with are suicidal crisis, suicidal completion, parties causing disturbances that are as a result of a mental health crisis, often because they may not be taking their medication or they have another medical condition that's interfering with their mental health. Parties have drug and alcohol addictions. Some are driven to commit crimes in order to support those addictions or may enter prostitution. But many are simply involved in disorderly conduct, impaired driving, or homelessness. Unresolved trauma and untreated mental health issues drives crime, increasing both the likelihood of being victimized and the numbers of suspects who commit them. Domestic violence is a perfect example of suspects who are traumatized-- unresolved--

traumatized, often as children, becoming suspects; and some of them are violent. And then there is our own mental health as first responders. You know, I wish I could, we, better quantify the number and types of incidents that officers deal with. I can only share anecdotal information at this time. The Omaha Police Department is involved in a number of initiatives that I hope will be better able to measure the scope of the problem and the effectiveness of our initiatives. These initiatives include: increasing the number of officers who have crisis intervention training; embedding mental health practitioners to work side by side with officers as co-responders; better utilizing crisis response teams-- we currently have just started with the Douglas County threat assessment team; development; utilizing peer support services-- all of these are initiatives that are mentioned, have been mentioned here; participating in Stepping Up Initiative to limit the number of parties with severe and persistent mental illness in our jails; and then also hiring a mental health coordinator who happens to be here today, if you have any questions of her, to oversee these programs and identify gaps. Omaha is lucky. We're a metropolitan area with a lot of resources at our fingertips. But I can tell you in Omaha we have a severe issue. None of these programs are going to be successful without the back end mental health services in order to divert these people, to connect these people to. Many gaps that we've mentioned have been mentioned here. They're in your strategic plan. They were in

a 2015 needs assessment that was completed in the Omaha area by a nonprofit, The Behavioral Health Support Foundation, and I'm not going to repeat them in order to save time. Key gaps, though, do involve having step-down care. We commit people, as law enforcement officers, most often due to suicidal ideations, so they may not be severe and persistent mental health issues, such as what Devon [INAUDIBLE] was experiencing. But they have severe depression at that moment and they are in a crisis, and they are then put into a bed, if one's available-- it may be an ER facility. They're stabilized and then they're put out, back into the community, with maybe not enough resources to be connected to. And that week's period between the time they were released from acute care to the time they get outpatient services, that is, that is a high risk period for them to decompensate and then end up back into the system. So there's a number of them that have been mentioned here-- again, I'm not going to reiterate those for you now. We also have some of our severe and persistent mentally ill folks. They are in our areas of town where-- downtown area-- we're trying to develop the north downtown area where Francis House currently is, with a lot of homeless, homelessness issues there. Of course nobody wants to deal with the fact that many of our mental-- or our homeless population are also severely mentally ill. And these are not one and done problems. They need long-term, ongoing, coordinated care with a case manager to oversee that. And of course, again, I'll defer to the practitioners here on how to pay for that, Medicaid

versus, you know, private insurance and all of that. Substance abuse treatment is a ongoing problem. Our drug addiction issues, many of our crimes are related to drug addiction and, again, it's hard to find care, hard to get beds. They have to stay sober or, if they are sober, now they've lost the acuity so they lose their bed, because they are no longer acutely intoxicated. We have law enforcement officers that we struggle to get beds for. We are connected, we have good insurance. And yet we have law enforcement officers with co-occurring disorders, such as anxiety and severe depression, and they're not able to get those beds. And then, lastly, homelessness and affordable housing. We have to have a place for those folks to be stabilized and have a place to live. We all know Maslow's triangle: if you don't have safety, you don't have all the other things you need to build on the foundation, to build on for overall mental health. So I'm here if you have any other questions or--

ARCH: Thank you, thank you. Any questions? I don't see any questions. Thank you very much.

MICHELE BANG: Thank you.

PATTI JURJEVICH: Good morning.

ARCH: Good morning.

PATTI JURJEVICH: Chairperson Howard, members of the Health and Human Services Committee, I appreciate your time today, and thank you for

highlighting this important issue. My name is Patti Jurjevich, P-a-t-t-i J-u-r-j-e-v-i-c-h. I'm the administrator of Region 6 Behavioral Healthcare, one of six behavioral health, regional behavior health authorities in Nebraska. I'm testifying here today, representing the Nebraska Association of Regional Administrators. I've clearly prepared some testimony. I will move quickly through this, and I hope to have an opportunity to address some of the discussion points that have, were, was, were brought up earlier. By history, the behavioral health regions were established through LB302, the Comprehensive Community Mental Health Services Act in 1974. So given that diverse population, resources, and needs of individuals throughout the state, six regions were organized. For your reference I did attach, on the back, the state of Nebraska and how that's divided up by regions. In 1977 then, public policy was expanded, through LB204, to include substance use services. LB1083, the Nebraska Behavioral Health Services Act, passed in 2004, and that provided framework and funds to develop community-based services so that persons with behavioral health issues could be served closer to their home communities, to families, and support systems. This legislation confirms the authority of the regions and the governing boards, the matching fund requirements, procedures, powers, duties, responsibilities. I think it's important to note that, through that reform process, a significant amount of planning was done with hundreds of individuals-- I can speak in Region 6-- hundreds of

individuals to develop and identify services that were necessary to help bring folks back out of the regional center system, help keep folks from going into that regional center system. But I can tell you the funding was not sufficient. So the best, I guess, was done to serve those individuals, but it was with far fewer dollars than were identified that we needed to accomplish that successfully. The responsibilities of the regional behavioral health authorities are delineated in state statute. I'm not going to read all this to you, but it's developing and coordinating that publicly-funded behavioral health service system, integrating and coordinating the services within the system, comprehensive planning for the provision of services, submission of an annual budget to the Division of Behavioral Health to access the funding, initiation and oversight of contracts, coordination of site reviews or audits, and submission of any other reports, as required. The regional dollars in our system are capitated. Federal and state funds are available, based on legislative appropriation, through an annual contract with the Division of Behavioral Health. A portion of that appropriation then is distributed to the six regional behavioral health authorities. Matching funds are provided by the counties. These regional funds are intended to support treatment, rehab, and prevention activities for indigent and uninsured populations with behavioral health needs and, in general, services and supports are provided through contracts between the regions and community-based providers. I do want to note that these regional funds

are the non-Medicaid dollars in the system. So those are, are managed, and responsibility falls into a separate division within the state. So there's two funding streams publicly for behavioral health services and supports. Regions have specialized coordination efforts for emergency housing, youth prevention transition areas, to ensure that systems operate in the most effective manner possible. These efforts include: problem solving; working across various systems to develop partnerships; providing education in the community; advocating for improvements; and understanding the working details of systems to help contribute to their successes. The coordination role provides supports to system partners, as well as to individuals and families. It is important to remember that the specialized coordination function that's provided by the regions is unique in the behavioral health system and is not available for many other kind of organization or entities. Within the limited financial resources available, the regions remain committed to improving the service delivery system in urban, rural, and frontier parts of our state. This includes: maintaining or improving access to core services and reducing wait times; use of technology to address work force shortages; expanding emergency psychiatric services; suicide prevention efforts; diversion alternatives to jail; housing options; medication availability; supported employment; early intervention; medication-assisted treatment; and finding new method to engage our emerging adult population. This is not an exhaustive list but illustrates the

significant amount of work going on within the regions and work that is still needed to improve people's lives. As you are all aware, Medicaid expansion is anticipated to begin October of 2020. With that implementation, there is a $4.35 million dollar reduction to Program 38, community aid for the regions in the FY '21 budget. We respectfully request your support to eliminate the reduction and allow time to monitor implementation of Medicaid expansion and have strategic discussions on how to protect and invest resources in an already underfunded behavioral health system, to ensure a strong infrastructure remains in place. So I thank you for your time. I'm out of time, so with that I'll--

ARCH: OK.

PATTI JURJEVICH: --pause for questions and--

ARCH: Thank you. Any questions? I don't see any questions. Thank you very much for your testimony.

PATTI JURJEVICH: OK.

ARCH: If there are others that would like to provide testimony-- I think we're coming to the the end of our testimony.

HOWARD: Yeah. I know Sheri had to step out for a moment.

ARCH: She's-- she's right here.

HOWARD: Oh, here she is; OK. She's our closer.

SHERI DAWSON: Good afternoon-- I guess it's morning still.

ARCH: Yeah.

SHERI DAWSON: Good morning, Senator Howard and members of the Health and Human Services Committee. My name is Sheri Dawson, S-h-e-r-i D-a-w-s-o-n, and I serve as the director of the Division of Behavioral Health at the Department of Health and Human Services. The Division of Behavioral Health is responsible for administration and coordination of the public mental health and substance use disorder system, and this work is inclusive of the planning, funding, oversight, and technical assistance to networks of services. And those are delivered through six behavioral health regions, four federally recognized tribes, and other nonprofit agencies and organizations providing community-based services. The statewide array of services for children and adults are supported, in whole or in part, with funding received and administered by the Division of Behavioral Health, Medicaid and Long-Term Care, Children and Family Services within our department. Private funding sources such as insurance companies, private businesses, also provide behavioral health services. And it will really take all of us working together as system partners to creatively build out our continuum of care in Nebraska. I recently attended the National Association of State Mental Health Program

Directors annual conference, and one of the opportunities I had was to present about the strategic plan metrics and the data that our division has been able to develop and track over the last few years. And so many states were amazed that, through our system of care work, that we actually had the opportunity, for the very first time and annually now with the system of care, to get data for Behavioral Health, Children and Family Services, Medicaid, and Probation. It's not an easy task but, for us to make data-informed decisions, it's really larger than the Division of Behavioral Health. We really need to look at a systems level. Consistent with our 2016 statewide needs assessment-- I don't know if Dr. Watanabe-Galloway is here, but the UNMC, Public Health, and BHECN assisted us with that needs assessment. 2017-2020 strategic plan-- that DBH funds prevention, recovery, treatment, and support services for over 32,000 individuals a year. People served are without Medicaid and without insurance, or are underinsured, and we have services according to clinical and financial eligibility. The target populations for our division and specific services are adults with severe and persistent mental illness, serious mental illness, substance use disorders, youth with serious emotional disturbances, and those targeted through our prevention activities. So within those parameters, our division must further ensure service provision to the federally designated priority populations. Our division operates unlike Medicaid, We're a nonentitlement, and we have a capped amount of community-based service funding. Our strategic plan

continues to offer direction, based on areas of need, identified through the planning process. The plan addresses the four tenants of recovery, which are: home, health, community, and purpose. Our three goals encompass quality, effectiveness, and, most importantly, the consumer experience. The identification of metrics provided a measurable way for us to gauge progress. And so many people in this room and other system partners are working on this strategic plan together. And when we look at overall how much we would accomplish for those strategies, in May of 2019, 74 percent of that identified work was in process or on track. And we assess that quarterly, and we're on track to do that at 83 percent. I say that because, as a system, we certainly heard today that there are needs and opportunities to continue to grow. But I think it's important to make sure that we give credit to all the people that are working together to make a difference. The strategic plan has-- and the data has really helped us, as evidenced by the new funds that we were able to improve, the safe and affordable housing. We were appropriated additional funds, additional funds for housing-related voucher assistance, including funds specific to women with dependent children, funds to increase the system capacities in short term residential, and secure residential mental health treatment. And we also were funded, based on our study, with a cost model to increase provider rates. So we know that system change is really a journey. And while there is so much work to be done, it's important to build upon our successes that are a result of

the great work by system and consumer partners. I want to highlight a few, knowing that we still have work to do. DBH has served more individuals in the previous year for three consecutive years. There are now 48 Oxford houses, recovery houses providing 356 beds across the state. Eighty-two percent of the individuals discharged from our funded services go to a stable living. Binge drinking, while we are still very high nationally in binge drinking., it's decreased, through great prevention and community coalition work, from 44.9 percent in calendar year '13 to 33.4 percent in calendar year '18. Dr. Miers talked about the suicide rate in Nebraska. And while we look at the vital statistics and the numbers per thousand are coming down, it's still above the national rates and we have continued work to do. The opioid response grants and collaborative efforts are addressing the state's needs to provide medication-assisted treatment. And we started and we had 21 providers of that particular evidence-based practice, and we are now building that work force. There are 54 active prescribers of medication-assisted treatment. We're higher than the national average in persons employed as a result of supported employment. Over one-third of the providers surveyed, there was conversation about integrated services, and about one-third of the practices that were surveyed indicated that they had some form of integration between physical and behavioral health in their studying. Our system of care grant allowed us to have mobile crisis response across the state and 74.8 percent of those youth have been able to

stay in their home. And our adult emergency system partners, we heard some challenges from individuals today. But there is great work being done by a lot of emergency system partners, and having diversion of involuntary treatment, which is at about a rate of 75 percent of those served. Peer support was also mentioned this morning, and it's now reimbursed by both Medicaid and the Division of Behavioral Health. And lastly, the most important voice that we listen to, through our annual consumer survey, are consumers and families. And one of the items we targeted this year on the survey was "I'm better able to deal with crisis." And in 2018, that target was 75 percent, and we were able to meet that. And our teams working on our 2019 results. I'm trying not to repeat too much of what's already been said. But there is a behavioral health work force shortage. And in our DHHS business plan, you will note the initiative to really increase the capacity of the behavioral health work force. Some of the strategies today are probably a little bit of a longer game, when you talk about growing your own and what are those initiatives to bring more interest and have more students and have more people graduate. So in the short term we're going to have to do some mentoring and education, and provide consultation, and work with schools to make sure that individuals that exist in the work force or are graduating have a sense of competency to be able to serve behavioral health individuals. One of the things that I think is really important is to also mention Lincoln Regional Center; that was brought up today. We have had waitlists for a period

of time. Those waitlists primarily have to do with individuals that come to us through the court system for competency restoration. And this past legislative session, there was a bill passed to provide the option for outpatient competency restoration, and so that will be worked on to continue to provide options. One of the great things that have, has happened--Nebraska was one of seven states to receive a SAMHSA grant for looking at competency. That's that waitlist is a problem nationally, and it has brought together a number of the partners that people mentioned today. And they are working on a strategic plan to really divert people from competency to be able to help with that access to services on the front end and how we again can build that continuum for competency. Sorry, I'm dry here. LRC has had, while we have a waitlist, had more admissions in the year before and increased our number of discharges. And over the last several months, our community-based services has worked with the LRC team members since early 2019. They identified 51 individuals that had complex needs that were ready, or almost ready, for the opportunity to be served in the community. But there were barriers-- might have been payment, might have been the guardian, might have been the service combination. And to date, they've worked really hard with providers and the team together, and 36 individuals have been transitioned to the-- a life in the community. Under our leadership with CEO Smith and facilities director Mark LaBouchardiere and LRC hospital administrator Ashley Sacriste, a work plan has been developed to really raise the

bar at Lincoln Regional Center and really look at admissions and discharges and the treatment provided. And so that work plan has focused on rehabilitation and recovery, treatment, safety for patients and staff, and how do we continue to improve and identify performance improvement. So that work is ongoing, and the time for competency restoration and the number of people discharged is being impacted. And I think one of the things I would like to talk a little bit more about, when I'm done reading here, is the role of LRC. We had conversation and thoughts about LRC during testimony today, so I would like to talk about the role that it can serve. We did just have Joint Commission come to the Lincoln Regional Center, and we are reaccredited. There were lots of positive feedback, and certainly there were standards that were not met. None of them are real concerning or were surprises for me. The Joint Commission has really focused on preventing suicides in hospitals and ligature points. And our old buildings have provided us some challenges, so over the next few months we will be working very hard to complete some of the renovations to decrease the risk. We're going to be conducting a statewide comprehensive needs assessment coming up here in the fall and into '20, because our strategic plan we have now sunsets in December of '20. So all of the feedback, all of the stories, all of the recommendations and solutions that were put forward by the testimony today, I appreciated that and have certainly taken note. And stakeholders will be engaged in that process. I can't tell you exactly

what that's going to look like right now because we're still finalizing timing and who's going to help us with that and so forth. But again, it will take all of us to continue to enhance the continuum of care for youth and adults. I would be remiss if I didn't acknowledge that September is Recovery Month and October will bring Mental Illness Awareness Week. Recent national prevalence data reported by SAMHSA states that approximately 16 percent of persons who need substance abuse treatment and 38 to 40 percent of persons who need mental health treatment actually seek and/or get treatment. We need Nebraskans to normalize the healthcare conversation about mental illness and substance use disorders. And I invite you and all of the participants today to join in conversations and celebrations in their local communities. We all need to work together and be champions in supporting and providing the opportunity for recovery. And again, system change is really going to take the power of the individual, local, regional, and state resources working together creatively to find some solutions. So thank you, and I'll answer questions.

ARCH: Questions?

WALZ: I have a question. Thank you.

ARCH: Senator Walz.

WALZ: Thanks for coming today. Sorry I'm late.

SHERI DAWSON: Um-hum.

WALZ: I had an education hearing that I was at, too. So I just have a question about the statewide comprehensive needs assessment--

SHERI DAWSON: Um-hum.

WALZ: --because I don't know much about it. Can you tell me what, what does that tool like? What's the process like? Who's all involved in that?

SHERI DAWSON: Are you talking about the, the one we we did in 2016 or the one that's going to be upcoming?

WALZ: Actually I'm kind of talking about both of them, so--

SHERI DAWSON: OK. So in 2016-- and the needs assessment is quite lengthy, it's about a hundred and some pages. UNMC, Dr. Watanabe-Galloway was our lead, with her team, to do the assessment. She looked at a great deal of data, mostly from the Division of Behavioral Health which is, again, the challenge if you're really trying to get that broader system's view of people served, and where they're served, and so forth. She looked at national, national data. They did focus groups with stakeholders. They also looked at--turn and see here-- the standard SAMHSA, the federally available data. They looked at who's being served, so there is a breakdown on demographics by age, by race and ethnicity, gender-- those kinds of things-- how

the services are currently funded, looked at the estimates of special populations within the behavioral health, such as people that have developmental disabilities, severe and persistent mental illness, homeless. What else did I miss? Most of those areas were covered.

WALZ: OK.

SHERI DAWSON: Um-hum.

WALZ: And that's going to be similar for the upcoming assessment, as well?

SHERI DAWSON: Well--

WALZ: I mean, will you--is that the same type of process? Or--

SHERI DAWSON: Yeah. I mean, I think we're going to-- we want to look at the needs in general. And so I think what will hopefully be different this time than what was available the first time is really being able to get it that cross system data so that we're not just looking at the Division of Behavioral Health. We're also looking at Medicaid, Behavioral Health population, Children and Family Services, what we can get through the criminal justice courts. So we hope that will be different. The processes to get us to share information are complex from a timing standpoint ,but we really want a broader system view.

WALZ: OK.

SHERI DAWSON: Um-hum.

ARCH: Other questions? I just have one.

SHERI DAWSON: Um-hum.

ARCH: And it's probably a little bit of speculation here, but how do you see Medicaid expansion impacting services in behavioral health for the adult population?

SHERI DAWSON: Um-hum. Well, certainly the people that we serve now are-- some of them will be eligible for Medicaid. So there will be an opportunity for people to be paid for differently that are Medicaid eligible. I think also in their system, which is something that our division has paid attention to, was looking at some of the other social determinants or that population health, those recovery tenants, having a purpose in life, so really looking at the opportunity for employment, looking at housing. Some of those factors that will help people be successful is a part of the plan that they have in really looking at the treatment component but also that case management to help people be more successful. So I think that will be different. That will again bring us all together to ensure that we're not duplicating services and maximizing those dollars that get freed up.

ARCH: It obviously doesn't solve any of the issues regarding availability of services, if there are not enough beds, if there are not enough providers, and all of that. I was just interested knowing your, your perspective on that..

SHERI DAWSON: Yeah, um-hum. I think the work force challenge certainly is something that we have to think creatively about. I'll give you an example as we look at the Lincoln Regional Center, and we have nursing students that come. And nursing students no longer have a psychiatric rotation. And so they may be out there for a day or two. And that might be their exposure to people unless they're in the medical hospital, and maybe you have a woman that has postpartum depression or a person with substance use. And so what we're trying to do is, is look creatively at, well, they're all focused on the physical healthcare. And so how do we have the students come to LRC, for example, and do medication education or physical health education or physical assessments with people that happen to have a mental illness or substance use disorder, you know, some of those kinds of things?

ARCH: Not as a formal rotation, but as-- but what--with, with those patients.

SHERI DAWSON: Um-hum, yes. And I think somebody mentioned-- I think it was Senator Dubas mentioned the telehealth and the opportunity that that brings because, again, we're either going to have to continue to

grow the competency of our existing work force. And for those that we do have, engage them in telehealth so that there's farther reach. And I will say-- and this is national in conversations-- that probably behavioral health is slower to engage in telehealth because treatment is so relationship-driven and so that in-person contact is important. For people with substance use disorders, being there to know perhaps if there's alcohol on their breath or, you know, some of those kinds of things make it a little bit more challenging. But I think we have to be open to and creative with and figure out what does that look like. Do we do some sessions telehealth and then so many sessions that are in person? Or what does that look like? But to be open to that. And if I could, I'd like to make some clarifications and talk about a couple of things.

ARCH: Yeah, that'd be-- please, we, we have a couple minutes.

SHERI DAWSON: OK. One of the things with the role of the Lincoln Regional Center-- I think the Treatment Advocacy Center was mentioned that talked about the number of beds that we need. We talked about-- long-term care was a term that was used for people that have longer-term needs, and also step-downs. So once they come out of the regional center, what's that level of care to help them transition to community? In this appropriation, we do have funding for the secure residential that was mentioned. I don't remember who mentioned that. And it does have a waitlist. And there was an RFP that was put out and

we had no takers. And so some of the challenges that we have is also being able to help providers feel competent and also think about value-based reimbursement. Or what is the reimbursement strategy that will look different to serve individuals with those complex needs because, as everybody said, they can stay pretty busy and full and do great work but they may not be the most complex individuals? So in our business plan, again, we have a whole list of opportunities to train and educate and grow the competency. And we will continue to work with providers. But that's an example of-- there is funding, and we really need to engage providers. The Lincoln Regional Center does have waitlists, and I think one of the things that we are going to be working on is for those individuals that get there through a mental health board commitment, that we look at working with the regions in a closer way than we are currently doing, so that individuals have-- or the regions will have a certain number of beds provided to them for those individuals. And in the past when we had that system, they knew their number of beds, and one person was coming in and one person, you know, was going out, and that was fairly successful. So we're going to refresh that and see what that looks like. But we also have to consider that we do have individuals that are in community-based hospitals and just take longer to stabilize with their symptoms. And we'll have to look at the authorization piece. That's one piece of data we're really trying to get. Is it, is it a role issue? In other words, this person could still be paid for. but we know, we really

think they need that longer term care at the Lincoln Regional Center. Or is it opportunities in the community? What does that look like? What does that consultation, what does that service array and wrap around that patient look differently? The department has Dr. Janine Fromm as the executive medal, medical director. She happens to be a psychiatrist. So we'll be working with communities and hospitals and the regional center to really try to sort that through. There also, I think, are drivers of change in integrated care, and I mentioned in the statistics we have about a third of our providers that are in that integrated care. And I think, again, we have the stigma issue that continues to be a challenge and a barrier. And so the opportunity for behavioral health providers, especially those in rural areas, to be integrated into the hospital, their critical access hospital or their physicians' clinic or just really making behavioral health part of healthcare and not having that stigma.

ARCH: Yeah.

SHERI DAWSON: The other opportunity in the emergency system, I would be remiss if I didn't recognize that there are challenges in the emergency system. But I want people to know that there is a pilot in Region 6 that's looking at bed registries to look at where is the open bed. And sometimes it may not be more beds. It could be that a hospital can't accept anybody because they have a psychiatrist that has left or not enough nursing. And they may still have the bed

capacity. but we really need to know more about what are those specific challenges so we can solve that in the overall emergency system. So that pilot is, is happening right now. Also, the mobile crisis response-- I can't overestimate the great work that they do every single day and work with so many partners, including law enforcement, across the state. Plattsmouth law enforcement sent an email-- or a letter-- and they had an individual who they felt challenged with over the last couple of years and really tried to identify what was going on with this person, and thought maybe they had mental illness but couldn't really get them where they needed to go to access treatment. And there was a city event and they were concerned about some verbalizations that this particular person had made. But they were able to connect with the crisis response and also our emergency system manager at the Division of Behavioral Health, and they got the individual where they needed to go. And they sent a very positive note about what's been able to be accomplished. So I do think that ongoing training to connect the dots on who to call and where to call, and that ongoing education with the great efforts, our CIT and threat assessments is something that will continue to be really important, so--

ARCH: Thank you.

SHERI DAWSON: --lots of--

ARCH: Thank you.

SHERI DAWSON: Um-hum.

ARCH: Any other questions?

WALZ: I just have one more question.

ARCH: Sure.

WALZ: Thank you. I'm sorry. I--

SHERI DAWSON: That's OK.

WALZ: Senator Arch was asking you about Medicaid expansion, and I was writing something then. I kind of missed what you-- the whole thing that you said.

SHERI DAWSON: Um-hum.

WALZ: But you said something about their plan includes employment and housing and then something about duplication of services. Can you--

SHERI DAWSON: Um-hum.

WALZ: --talk about the--

SHERI DAWSON: Yeah.

WALZ: --their plan?

SHERI DAWSON: Yeah. Yeah. So in the Medicaid expansion plan they have care management, which is really looking at the clinical services and trying to make sure that people have the services and access that they need. And then they also have added case management which, is really looking at those other kind of social determinants, so more about the housing, more about the employment, food banks, or whatever those other factors are that may not be getting that person through recovery and through treatment. So that is different than what you see in a lot of Medicaid programs across the nation. They focus as a payer of services. So I do think that that will be important. And my point on the duplication is-- for example, right now the Division of Behavioral Health provides housing and employment, not just for people necessarily that are funded by the regions or funded by us, but because Medicaid hasn't been providing that, then Medicaid eligibles can be on those lists.

WALZ: OK.

SHERI DAWSON: And so I'm just saying it's an opportunity, as a system, to think about maximizing those dollars and not duplicating things as we move forward.

WALZ: OK.

SHERI DAWSON: Um-hum.

ARCH: Thank you.

SHERI DAWSON: Um-hum.

ARCH: I don't see any other questions.

SHERI DAWSON: OK.

ARCH: Thank you, Director Dawson--

SHERI DAWSON: Thank you, um-hum.

ARCH: --for testifying today. Senator Howard?

HOWARD: I will be very fast because I know we have somewhere-- we have somewhere else to be, which is my office. I am really grateful that you all took the time this morning to listen. It was two hours, but it was sort of an amalgamation of everything that I learned in a summer with Senator Bolz on the task force. So you all have a copy of the report, and some of the issues-- we're still hearing the same ones, so work force, licensure, loan repayment, gaps in services, telehealth, focusing on integration. But I--there are two people that I really think we should thank. And one is the Hellers, because I don't think we would be having this conversation if 1Tim and Cynthia hadn't reached out to me and said we need to talk to you about this bigger issue. And then I also really think we should thank Director Dawson. She was willing to come in and sort of give us that broad range of what they're focusing on, and in recognition that there are still some

gaps that we need to work on together. And so I think, over two hours, you have seen the entire gamut, from law enforcement to education. I didn't even ask the education person to come, and he just came in and wanted to tell you about his experience. We didn't ask the police officer, the police department to come in. They came in because they saw that this was happening, and they wanted to tell you about their experience. And so I think that just proves that this mental health challenge, or mental health issues in the state, are very broad but they're also something that, with all of us focusing on it, we'll be able to find good solutions. So I thank you for your time this morning. I don't think there are questions, right? Nobody? Nobody? Great. OK, all right.

ARCH: Thank you very much. And this will close the hearing for LR160.

HOWARD: [RECORDER MALFUNCTION] Services Committee. My name is Senator Sara Howard, and I represent the 9th Legislative District in Omaha, and I serve as Chair of this committee. We'll do introductions once Senator Murman is sitting. Assisting the committee is our legal counsel, Jennifer Carter; and our committee clerk, Sherry Shaffer. And today we'll have my staff, Timoree, serving as our page. A few notes about our policies and procedures: please turn off or silence your cell phones. This afternoon we'll be hearing two interim studies, and we'll be taking them in the order listed on the agenda outside the room. On each of the tables near the doors to the hearing room you

will find blue testifier sheets. If you're planning to testify today, please fill one out and hand it to Sherry when you come up to testify. This will help us keep an accurate record of the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. We would ask that if you do have any handouts that you please bring ten copies and give them to Timoree. We do use a light system for testifying. Each testifier will have five minutes to testify. When you begin the light will be green, when it turns yellow you have one minute remaining, and when the light turned red-- turns red, we'll ask you to wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone and then please spell both your first and last name. Each interim will begin with the introducer's opening statement. For the record, after the opening-- this is just a reminder that interim studies are different from bills, we won't be hearing from supporters or opponents. We'll just have testifiers come up in turn-- and you haven't given me any invited testimony today.

HUNT: I have some invited testimony, but I think they're, they're prepared to come up.

HOWARD: Not in a particular order.

HUNT: Yeah.

HOWARD: OK. We do have a strict no-prop policy in this committee, and I'd like to invite Senator Murman to start our introductions.

MURMAN: I'm Senator Murman from District 38, seven counties south of Hastings and Kearney.

WALZ: I'm Lynne Walz, District 15, all of Dodge County.

ARCH: Senator John Arch, District 14, Papillion, La Vista, and Sarpy.

HOWARD: And Senator Williams is gone to a funeral, Senator Cavanaugh is out of town, and Senator Hansen will be joining us shortly. And with that, we'll begin today's hearing with LR135. Senator Hunt's interim study to examine issues related to food insecurity in Nebraska communities. Welcome, Senator Hunt. Sorry, for the delay.

HUNT: No problem. Thank you so much, and it's nice to see all of you again after this long summer. Thank you, Chairperson Howard and members of the committee. My name is Senator Megan Hunt, that's M-e-g-a-n H-u-n-t, and I represent the neighborhoods of Dundee and Benson and Keystone in midtown Omaha's District 8. I'm here today to present LR135, which asks this committee to examine issues related to food insecurity in Nebraska communities. I really appreciate you scheduling this hearing. The idea for this study came about through a conversation I had with my friend Dr. Erin Feichtinger at Together Omaha and Shelley Mann at the Food Bank for the Heartland about food insecurity in Nebraska. We were just on a porch hanging out and it

turned into a whole conversation about food access in Nebraska and everything wrong with it and what we can do to fix it and that's obviously something they have a lot of experience with and I'm a SNAP recipient myself. So as a client, I have experience with that, too. So after that conversation my staff and I looked into what we could potentially get out of a study that looked at food security more broadly and we decided to draft the LR in a way that would allow us to look at food security across all communities in our state in collaboration with clients and producers and advocates and all these stakeholders that we're gonna hear from today. So food insecurity is a term that's used to describe the problem families face when they don't have enough access to affordable and nutritious food whether that's financial or geographic-- you know, barriers to that. Eleven point six percent of Nebraska's population is food insecure according to the Meal-- Map the Meal Gap report from Feeding America. Over 200,000 Nebraskans struggle with food insecurity. That's really hard to reconcile with the fact that this is America's breadbasket. We're working so hard to bring food to everyone else. But even in a state with expanses of farmland and ranches, many families are worried about how to feed their kids. According to a report from the Center for Rural Affairs, enrollment for food assistance programs like SNAP, formerly known as food stamps, is consistently lower in rural Nebraska. So we know that there's people in rural Nebraska who are eligible for these programs but they're not enrolled. Programs like

SNAP have helped fill the gaps for so many families. There are many factors that make it difficult to provide consistent impactful assistance to families in need. And one of those factors is gaps in policy or inconsistent rules and regulations that make it hard for families to have stability and budget for the food they eat. There are a lot of shoulders that need to be pushed to the wheel of food insecurity in Nebraska, certainly, including businesses, charities, faith groups, and government. But we can't put the entire burden of feeding Nebraskans on the backs of charities and churches. Every hungry family, every hungry child is relying on answers from our state government. In 2017, about 14 percent-- that's about 70,000 Nebraska children lived in poverty. And that number goes as high as 52 percent in Loup County. In addition, only 42 percent of eligible seniors are enrolled and receiving SNAP benefits, many of whom are veterans. So it's important that we do not ignore the responsibility and opportunity we have in the Legislature to bring relief to vulnerable children, families, and seniors. Behind me, I'm expecting testimony from seven organizations working on the ground across Nebraska to address food insecurity and ensure that our most vulnerable Nebraskans are able to access the food they need. We have Nebraska Appleseed, Together Omaha, Shelley Mann from Food Bank of the Heartland and Food Bank of Lincoln, Ashley Frevert with Community Action, Center for Rural Affairs, Voices for Children, and Produce from the Heart. Each testifier addresses food insecurity in different ways, from working at

the policy level, to addressing school lunch issues, to delivering produce to food banks, and much more. Each of them has a story to tell that is an important aspect of this conversation. And I want to thank them and anyone else who came here for being here today. Finally, I understand the economic realities of our times and I know that anything we do in the Legislature that has a cost to Nebraska taxpayers is going to take a lot of debate and collective commitment to move forward. So I want to share with you some things to keep in mind. Research shows that every five dollars in SNAP benefits generates almost twice that much in economic activity for the community. Every benefit received is a dollar translated into our local grocery stores and food markets. SNAP can serve as a small but impactful stimulus to local economies across the state. So I'll ask you to remember that supporting people who struggle to gain access to food and nutrition adds to the economy in ways that most, quote, social programs, unquote, don't. That's why I've worked with stakeholders to identify policy recommendations that vary in fiscal impact. So hopefully we can find something that we can all agree is worthy of moving forward. What I hope we can all agree on is that hungry Nebraskans are in need. And as state lawmakers, we share the responsibility of identifying the solutions. Thank you.

HOWARD: Thank you. Are there questions? Seeing none, thank you.

HUNT: Thank you.

HOWARD: Our first testifier.

JAMES GODDARD: Good afternoon, committee. My name is James Goddard, that's J-a-m-e-s G-o-d-d-a-r-d. I'm the director of the Economic Justice Program at Nebraska Appleseed. I'd like to spend my time this afternoon talking about the SNAP program and particularly how it can be improved or further leveraged. It's already a successful program, but there are a number of options under federal law that we could take advantage of that I'd like to spend some time talking about. I'm not gonna mention all of them. There are a number of them, and many of them are quite technical. So I'm gonna to do my best to try to explain them. But I have tried to give you extensive footnotes in the written testimony to some of the material so you can take a look at it on your own if you're interested in doing that. Something just to note at the outset that the way SNAP is structured with the federal government and the way it works here in Nebraska at least is any absence of affirmative legislation by the Legislature on a given option, the default position is the department is going to decide what we're doing with one option or another. And that's true of all the ones I'm about to talk about. So the first one is joint application processing. SNAP agencies are permitted to jointly process applications for other programs including things like Medicaid. So that means we could do combined applications, shared administration, data sharing processing,

and, and otherwise. This was actually the structure that was in place up until, I believe, 2014, where the systems were bifurcated at that point. But there is the ability to actually combine applications and share processes and data. And I think it's worth considering whether the structure that we have where we don't do that makes the most sense right now. For clients, it can often mean that they have to fill out two applications instead of one with the very same information and many of whom are going to be eligible for both Medicaid, SNAP, and other programs. This might make even more sense as Medicaid expansion comes down the pike. Thinking about SNAP is 130 percent limit. Medicaid expansion is about that same limit. So there could be some, some sense in thinking about joint application processing. The second option I want to mention is work requirement disqualifications unless a person is exempt from work requirements in SNAP then they have to fulfill certain hours to be able to stay on the program. If they don't do that, then they receive a sanction for a period of time and lose the support of the program. If the head of household fails to meet the work requirement in Nebraska, the entire household gets sanctioned or loses their benefit, including children. That is an option. It's a choice that, that the department is made to do that. It's not something that we have to do. Only a few states have opted into that policy and it could be modified to only remove support from the person who didn't fulfill the work requirement. The third option is certification lengths-- state lengths, states can determine how long

SNAP households are certified meaning the amount of time households are eligible before they have to resubmit documentation. For seniors and those with disabilities, certification can be up to 24 months; for everyone else it can be up to 12. But the Department has opted instead of, of doing that, to limit it to 12 months for seniors and those with disabilities and every 6 months for everyone else. Those shorter certification periods have shown in other states that more people fall off the program because they have to provide documentation twice as often, they have to respond to that letter, provide that pay stub twice as often so people often fall off the program even though they're still eligible. The fourth option I want to mention is a demonstration project for the elderly and disabled. These are two-- actually I believe that they're, they're waivers that benefit specifically the elderly and disabled. One is called the Elderly Simplified Application Project, or ESAP, and that makes it easier for seniors and those with disabilities to-- easier to apply and recertify by waiving interviews using data matching and extending certification periods all the way up to 36 months. The other option is called the Standard Medical Deduction for the same groups. This is just a way of more easily allowing those individuals to deduct the high cost of medical care instead of forcing them to follow each and every bill that they, that they incur. It's just an easier way to make sure people are being found eligible and receiving the benefits that, that they're entitled to. I see that I'm running low on time so I'm just

gonna mention quickly the, the fifth one. There's more detail in the handout, but in a nutshell states can opt to make SNAP more or less generous for families of mixed status, meaning families with citizens and ineligible immigrants. You can make it less generous by counting an ineligible immigrant's income in the household even though the immigrant is themself ineligible for SNAP. We have chosen to make it less generous for those individuals. As I said before, this particular one especially is quite technical. Be happy to talk more about it in another forum. But in conclusion, there are a number of options that are available in SNAP that the Legislature could take up to make the program more effective. And I'd be happy to answer any questions if I can.

HOWARD: Thank you. Are there questions? There's a lot of information. We really appreciate it. Thank you for testifying today.

JAMES GODDARD: Thank you.

HOWARD: Good afternoon.

ERIN FEICHTINGER: Good to be back. Chairperson Howard, members of the Health and Human Services Committee, my name is Dr. Erin Feichtinger, E-r-i-n F-e-i-c-h-t-i-n-g-e-r, and I coordinate the community outreach and advocacy efforts at Together, a social service agency in Omaha and one of the largest all choice food pantries in the state. I'm here on behalf of our organization to tell you that food insecurity in our

community is real, that it is growing, and that if we are willing we can take positive steps to reduce its impact and eradicate it entirely. Traffic through our pantry has grown steadily over the last three years. In the table on the back of the sheet that you were handed, you will see that growth and that we are on track to serve over 22,000 unique individuals and families by the end of 2019, distributing over 1 million pounds of food in total. More people are relying more consistently on pantries like ours in order to put food on their table. I have heard it said in previous debates over SNAP that churches and charities will make up the difference. As one of those charities, we'll be here to do the work as long as it-- as we're needed. But this is not a sustainable solution to the problem of food insecurity in our community. We can change this trend by making it easier to access and reduce the cliff effect for critical food security programs like SNAP. Time and again I hear from frustrated clients that the system seems designed to keep them dependent on assistance. Contrary to popular opinion, it is difficult to qualify for SNAP in Nebraska. Our income eligibility window is too narrow to help the people who, as one client told me, are always stuck in the middle, always falling through the cracks. We have unique, unnecessary, and redundant restrictions on already struggling populations such as returning citizens with a drug felony conviction. In our experience, those who do-- who fail to qualify for SNAP because of their income are in no less need of food assistance than those who

do qualify. Those who do not qualify are not magically self-sufficient as a result. Rather, they rely more heavily on other forms of assistance in order to afford food for themselves and their families. When we reduce access to SNAP, we are not making people less hungry. We are increasing their dependence. When clients do successfully navigate the maze of paperwork and qualifications to get SNAP, they find that it is far too easy to lose it, largely as a result to the cliff effect. One story I heard from a client was that in order to pay his rent he went to donate his plasma and lost his SNAP as a result of his increased income. That's not income, that's trying to keep your house so that you can stay stable and off the streets. A mother of three that I talked to was looking for more sustainable employment when I spoke with her at the pantry, but she was worried she would too quickly lose the SNAP that she needed to feed her family. We are not encouraging self-sufficiency when we force people to choose between stability now and stability in the future, which is what we are doing when we perpetuate the cliff effect. Every person experiencing hunger in our community is a unique individual with the complexity and stress in their lives same as you or me. They worry about finding work, keeping work, getting to work so they do not have to rely on assistance. They worry about their kids being happy and healthy and whole. They worry about affording medication, they worry about making their money last. Most of all they are proud citizens of this state and they need food which is the most basic of human needs. This is a

complex issue because we are complex creatures, but the solution is spectacularly simple: expand access to SNAP, reduce the cliff effect, and help people build the stability they need to be self-sufficient. Thank you for your time. Thanks to Senator Hunt for introducing this hearing, although it was brought up on my porch. All of you are welcome. [LAUGHTER] You need ideas. And I'm happy to answer any questions that you might have.

HOWARD: Thank you, Doctor. Are there any questions? Seeing none, thank you for your time today. All right, our next testifier. Good afternoon.

SHELLEY MANN: Hi. Good afternoon, Chairperson Howard, members of the committee. My name is Shelley Mann, and I currently serve as the assistant director of the collaborative snap outreach efforts of Food Bank for the Heartland and the Food Bank of Lincoln. I'd like to share some information about food banking and SNAP with you today as you--

HOWARD: Oh, could you spell your name?

SHELLEY MANN: Oh, sorry, Shelley Mann, S-h-e-l-l-e-y M-a-n-n. Hunger exists in every county in the state of Nebraska. Roughly 223,000 Nebraskans are considered food insecure and 1 in 6 of those are children. These Nebraskans struggle to put food on their tables and may not know where their next meal is coming from. Hunger has many faces and its ill effects intersect with nearly every demographic in

our state. People experiencing food insecurity vary in age, race, and location with each facing its own unique set of challenges. For example, 86 percent of U.S. counties with the highest childhood food insecurity rates are rural counties. In the included materials that are being handed out right now, you'll see that I've included a sheet there that has each-- the food and security rates for each county in your individual districts listed out alphabetically so you can kind of look at that and see where you rank. You'll notice that while Douglas County is the highest, the rural counties are really not far behind and some of them are lagging only by a single percentage point. At Food Bank for the Heartland and the Food Bank of Lincoln, we believe that no person should, should go hungry and all people should have access to food regardless of their economic situation. The Food Banks are nonprofit organizations that serve as clearinghouses to distribute food to our partner agencies, like churches, meal provider sites, and we do direct distributions to Nebraskans in need. The 93 counties in Nebraska are divided into two service areas with the Food Bank for the Heartland serving 77 of those and the Food Bank of Lincoln serving 16. Both Food Banks are members of the Feeding America network of more than 200 food banks nationwide. Food banks secure product donations from food producers, the grocery industry, government agencies, and others. And we spend millions of dollars purchasing food to supplement our food donations. The Food Banks distribute food and grocery products through our local network of programs where they are needed.

Those served by the Food Bank include children, families, seniors, veterans and others. The Food Banks take a two-pronged approach to alleviating food insecurity here in our home state. The first is through physical food response. Between the two Food Banks, we partner with 800 local organizations to distribute food including pantries, emergency shelters, schools, and meal providers. We also deliver food directly to communities with high need but limited food resources through our mobile pantry programs. The one day distributions are free for individuals and families and include produce, bakery goods, dairy, meat, and other shelf stable items. Last year the mobile pantry programs distributed the equivalent of nearly five million meals. Additionally, the Food Banks operate direct service programs to help children experiencing food insecurity through our BackPack Program, Kids Cafe, and Kids Cruisin' Kitchen mobile meal provider. The second prong of our work is through our support of USDA food benefits. This is done primarily through SNAP outreach, education, and enrollment. SNAP is a Supplemental Nutrition Assistance Program, formerly known as the food stamp program. The Food Banks are part of a nationwide effort to assist eligible citizens in obtaining this assistance. Food Bank SNAP specialists and their partner helped more than 11,000 households in Nebraska last year apply for SNAP. Eighty percent of those applications were approved for benefits. Not only does this put food on the table of those in need, but it provides localized economic impact of $9 for every $5 in benefits. This helps provide support, not

only for families experiencing food insecurity, but Nebraska farmers and retailers as well. Applying for SNAP in Nebraska can be tricky and lengthy. To apply, someone either has to obtain a lengthy paper application from a DHHS office or they have the option to get on the Internet if they have access there or they can contact someone over the phone. This process has improved greatly and has been streamlined in recent years to help with efficiencies, but it can still be an overwhelming experience and bulky for those not accustomed to navigating these processes and systems. In closing, the Food Banks will continue to partner with state and federal levels of government to support access to food and nutrition assistance to reduce hunger in our state. However, it is important to note that despite our hard work to combat food insecurity in Nebraska the charitable sector cannot solve hunger alone. Though thousands of pounds of food are constantly moving through our warehouse, stores, and trucks, our mission to move the needle for hungry Nebraskans cannot be achieved through rescued and donated food alone. SNAP provides 12 meals for every 1 meal provided by the Food Banks. If SNAP were to go away or be curtailed in any way, the charitable sector is in no way prepared to replace that volume of food needed by vulnerable Nebraskans. I'm happy to answer any questions. Thank you for your time.

HOWARD: Thank you. Are there questions? Senator Walz.

WALZ: Thank you, Chairman Howard. I have a quick question. Do you have a breakout on who's receiving the services through you-- the children, families, senior citizens?

SHELLEY MANN: I do. Yeah. I can get that to you, absolutely.

WALZ: That would be awesome. Thank you.

SHELLEY MANN: For sure.

HOWARD: Do you want to tell us a little bit about the economic impact of SNAP on local communities in Nebraska?

SHELLEY MANN: Sure. So with that when somebody receives SNAP benefits, you'll find if you do a little investigation into-- you know, retailers and, and the money that they're bringing in that a pretty significant portion especially in rural communities of the money coming in the door is SNAP dollars. We know that rural communities utilize SNAP, obviously, and some of these grocery stores would be really hurting if they didn't have those SNAP benefits. So it does provide that local-- you know, just a little bit of stimulus there. So it's important to them.

HOWARD: Other questions? Just, just for, for my understanding, tell me a little bit more about why the Food Bank is advocating for SNAP, because I feel like your work is very different,--

SHELLEY MANN: Sure.

HOWARD: --that it's a different program than SNAP.

SHELLEY MANN: Yeah. If you'll look at the second page of the handout that has your county's on it, I think this is a really good visual. It's a picture of an orange. And if you take a look at that, the tiny piece of that pie is the amount of meals distributed from every Feeding America Food Bank, food pantry, every church you can think of, every homeless shelter you can think of. That is the amount of food being distributed by those organizations and the rest of that orange is what SNAP does. So when we talk about SNAP as something that-- you know, well, this should be provided by the charitable sector, they should be picking up the slack here. You'll notice that even if we were doing five times the work that we're doing we still couldn't keep up. So we think it's really important. Plus, I think it's really good for folks to have access to SNAP and be able to choose their food. The food that comes through our doors isn't really something that we have a lot of control over. You know, what you guys give to a food drive isn't always the things that you most desire. So that's the food that we're able to hand out and SNAP allows them to choose culturally, relevant foods. It allows them to choose foods that are healthier for whatever specific dietary needs they may have.

HOWARD: Senator Arch.

ARCH: I have a question,--

SHELLEY MANN: Sure.

ARCH: --and thank you all for coming. I-- this kind of a technical question. I'm not familiar with the term food insecurity. Is food insecurity synonymous with hunger?

SHELLEY MANN: You know, people use them interchangeably, but personally I, I think, I think there's a slight difference there. To me food insecurity and by the food banking definition is someone who does not know where their next meal will come from. Right? So hunger, I think, is a term that we use really liberally.

ARCH: Yeah.

SHELLEY MANN: But food insecurity is very much a condition that someone's experiencing.

ARCH: OK. Thank you.

SHELLEY MANN: Um-hum.

HOWARD: We did hear from Dr. Feichtinger-- I hope I said that right, that things are getting worse from the perspective of Together. In your perspective, are things getting worse in terms of people needing to use the Food Bank more?

SHELLEY MANN: I think when we talk to our partner agencies we hear really similar stories to Erin, and just that people are, are showing up more and more at the doors. We've been getting a lot of calls to our hotline that we operate for folks to call and apply for SNAP, of people just in very different situations. We're seeing a lot of-- I hate to use this term, but like new poor folks that don't come from generational poverty. They've just lost their job. They're not sure what to do. They've been struggling for a few months. So we're, we're hearing more from those folks than, than ever before and I'm not sure if that's because that's becoming more prevalent or because of our marketing, but definitely.

HOWARD: All right. Well, thank you so much for your testimony today.

SHELLEY MANN: Thanks.

HOWARD: Our next testifier. Good afternoon.

ASHLEY FREVERT: Good afternoon, members of the committee. My name is Ashley Frevert, that's A-s-h-l-e-y F-r-e-v-e-r-t, and I work for Community Action of Nebraska as the executive director. We are the state wide association for Nebraska's nine community action agencies. Our network is the largest anti-poverty movement in the nation with over 1,000 agencies serving 99 percent of counties. Nebraska's agencies serve all 93 counties through innovative programs for children, families, and communities, such as early childhood education

like Head Start, low-income heating and energy assistance, financial and family well-being, such as the new Free to Save Matched Savings program, and nutrition education, and enrollment assistance. In any given year, we serve between 83 and 86,000 low-income Nebraskans. We are established in communities and have over 55 years of proven success in addressing the causes and conditions of poverty. So LR135 is seeking out solutions to reduce food insecurity through SNAP and CSFP, which is the Commodity Supplemental Food Program, and the school lunch program. I am testifying today to provide information on Community Actions' role, how impactful our programs are to communities, and to put into perspective how age, race, gender, geographical location are important factors to consider when we address inefficiencies and gaps in these programs. So as well as SNAP and CSFP, another popular-- population-focused program is called the Food Distribution Program on Indian Reservations, which FDPIR, which is for eligible households living on reservations and in approved areas near reservations. So that's another program that we can consider with this. This can be used as an alternative for SNAP, so they can't have it at the same time and the same month if they have limited access to offices or authorized food stores. About 1,300 receive this-- received this in fiscal year '17. But that's approximately of about 31,000 across the state of Nebraska that indicate that they are American Indian. Research points to Native Americans having higher rates of food insecurity because they do often

have higher rates of poverty amongst their families and communities. Our agencies are intimately familiar with inefficiencies and gaps with SNAP and CSFP. In fiscal year '18, our agencies helped nearly 900 people with SNAP. My next statement, I'm, I'm-- it says thousands of food bags and boxes. Preliminary estimates right now for fiscal year '18 were upwards of 80,000 food bags or boxes were provided by our agencies last year, and those include those CSFP. Our largest concentration of food distribution in Nebraska is in the center of our state in about 21 counties is where we serve the most. So if you look at the back of this page, this front, this front my testimony, you'll see our service area and right in the middle it would be on number 2, it's CNCAP is what we call-- those are those 21 counties I'm referencing. And those are mostly rural counties. And we know from census data that about 50.1 percent of Nebraska's population identifies as female. The fact sheets in front of you, which are attached to my testimony, there are several of them, those are for later. They'll tell you more than 54 percent of SNAP participants are in working families. So we have women and working families in those central areas that are rural that we see who are meeting those SNAP and CSFP type, type assistance. This information shows that Nebraska has great community supports like our agencies working diligently to alleviate this problem, but the inefficiencies and gaps aren't simply coming from how families in need are accessing these benefits or just how to finance feeding those with little and without. The ability to

collectively see these individuals and families as community members and neighbors is imperative. These are nieces and nephews, brothers and sisters, grandmas and grandpas. If we remove the veil of stigmatization and search for truth from the agencies who see truth every day, we can conclude we have a moral and ethical even religious obligation to the health and well-being of our communities because we are all in this together. Thank you, and I'm happy to answer any questions.

ARCH: Are there any questions? Seeing none, thank you very much.

ASHLEY FREVERT: Thank you.

ARCH: Thanks for your testimony. Good Afternoon.

JORDAN RASMUSSEN: Good afternoon, Senator Arch and members of the committee. My name is Jordan Rasmussen, J-o-r-d-a-n R-a-s-m-u-s-s-e-n. I serve on the policy team at the Center for Rural Affairs. I'd like to elaborate a little bit more upon what Senator Hunt referenced in her opening remarks about what, what SNAP is used for or how SNAP is utilized in our rural communities and the impact it has not only on our residents but that, that actually utilize SNAP in our communities as a whole, so. During 2017, 52.3 percent of Nebraskans who receive SNAP benefits had household incomes below 100 percent of the poverty line with a net income of about $2,400 for a family of four, of four. In our rural counties, more than 22 percent of our households earn

less than $25,000 annually so about in line with that, that, that net income mentioned previously. This-- we've seen a decrease or a lowering of the income in our rural counties over the last couple of years. While Nebraskans who participate in SNAP have incomes in line with national figures, overall participation rates fall far below our national trends. Nebraska ranked 39th in SNAP participation in 2016 with 76 percent of eligible SNAP households participating. Nationally, 83 percent participate. When you break that down and look at it based on rural-urban residency, there's a further variance that emerges. According to five-year averages, in 2017, 8.8 percent of the state's households enrolled in the program. In rural counties, that was 6.4 percent were enrolled in SNAP. Yet, the percentage of rural Nebraska households enrolled in SNAP is particularly concerning when compared to the percentage of households at or below 100 percent of the federal poverty level. In the state's rural areas, 11.6 percent of households are at or below the poverty line. This figure does not account for those who may be currently eligible for SNAP with gross incomes of 130 percent of poverty before deductions. I'd like to share a little bit about a report that was released by USDA recently that talks about how SNAP has impacts on our communities beyond that $1.70 investment that comes back into the community. Prior-- between 2001 and 2013, the SNAP program expense-- or spending grew exponentially and really solidified its place as the largest USDA program in the nation. The impact of this investment in a rural community is multifold. The report found

that for every $22,000 in SNAP redemptions during this-- during the recession, an increase in one rural job resulted. In 2010, the rural Nebraska counties of Cherry, Sheridan, and Dawes saw the state's greatest levels of SNAP spending per capita increasing their access to food necessities and employment. This analysis also identified a glaring gap in rural Nebraska's ability to utilize and multiply the benefits of their SNAP dollars as 36 out of the state's 93 counties have fewer than 4 SNAP retailers. And as I was talking with Ashley previously, a lot of those SNAP retailers are our, our convenience stores and so not necessarily providing access to healthy foods for, for those that are eligible to spend their SNAP dollars there. Nationally, when we look at the data of those redemptions and impact on employment, it resulted in our urban areas, it only resulted in .4 job increase. So that impact in our rural counties is really important. The report also affirms that what we've observed in rural Nebraska, SNAP dollars are spent immediately in local grocery stores and retailers keeping these community assets for all of our residents. Moreover, SNAP purchases stimulate employment in the food processing and distributing industries which are concentrated in our rural areas of the state. There are further radiating impacts of SNAP participation, including improved health outcomes for children and elderly. As prospects of Nebraska's agricultural economy remain bleak and our rural incomes remain stagnant, the need for nutrition assistance in Nebraska's rural communities will continue to increase.

We ask the Legislature to continue to look toward the mitigation of the cliff effect and raising the federal poverty level eligibility or look to broad-based categorized eligibility opportunities. The Legislature has a responsibility to respond and recognize the value and importance of SNAP for our residents and our state. Thank you for your time. I'll take any questions.

ARCH: Any questions? Seeing--

JORDAN RASMUSSEN: Thank you.

ARCH: --thank you very much.

JULIA TSE: Good afternoon, my name is Julia Tse, J-u-l-i-a T-s-e, and I'm here today on behalf of Voices for Children in Nebraska. I'm here to speak specifically about school meals and how they impact childhood food insecurity. I've said this multiple times to this committee before but although child poverty rates in Nebraska have largely recovered since the recession, in fact, new census data released yesterday shows that we're actually at the lowest rate we've ever been since data has been collected. The data on food insecurity has only, has only continued to, to increase and has not since recovered since the recession. So in 1946, Congress authorized what we know today to be our school lunch programs thanks in large part to testimony from military officials then who reported that 40 percent of their recruits were turned away for reasons related to poor nutrition. Since then,

schools-- school meals have been an effective buffer against hunger and its effects. Federal child nutrition programs provide funds for all meals served in participating public and nonpublic schools during the school day. The two key school meal programs are the National School Lunch Program, NSLP, and the School Breakfast Program, SBP, which reimburses schools for each meal served. Children in households with income less than 130 percent of the federal poverty level receive free school meals, and children above that and up to 185 percent of federal poverty are eligible for reduced price meals which is no more than 30 cents for breakfast and no more than 40 cents for lunch. Nearly 45 percent of Nebraska students are eligible for free or reduced price meals. And to my testimony, I have attached some additional information about those reimbursement rates, meal costs to students, and our rate of students eligible for free or reduced price meals over the course of a decade, which you'll see has only-- has been increasing. I would offer three areas of priority as this committee considers how Nebraska can maximize school meals to reduce child hunger. First, an issue that is much more directly related to the work of this committee since school meal related bills are generally a reference to the Education Committee, is that under a process called direct certification, schools and states can certify children eligible for free school meals with less paperwork by using existing data that we have on children from low-income households. Data held by DHHS is matched with school enrollment data to verify

children who are categorically eligible for school meals due to their participation in a number of programs including SNAP, FDPIR, Medicaid, TANF, or ADC in Nebraska. And although, although this is an area where reforms in public programs under the jurisdiction of this committee, many of those identified by Mr. Goddard and Dr. Feichtinger, would have a spillover effect in reducing school meal paperwork for nutrition staff and families and making sure that children who are eligible for those meals actually receive them. Second, we would suggest that there needs to be an increase in meal participation for students. This would also have an effect in strengthening the financial viability of offering both breakfast and lunch for more schools. School breakfast has been linked to improved attendance, lower levels of hyperactivity, fewer disciplinary referrals, and even fewer visits to the school nurse. Unfortunately, Nebraska has consistently struggled in this area with one of the lowest breakfast participation rates in the country for several years. In the most recent year, we were 47th. Innovations that reduce barriers to participation for school-- students and parents, such as offering breakfast in the classroom, or a grab and go option, can give every child the best start to their school day while also helping schools achieve economies of scale in their food service programs, which is essentially-- or which is particularly essential for smaller and rural schools. Last, we can also work to ease school meal debt for families and districts. You may have seen media coverage in the last few years

about the alarming practice of lunch shaming, which is what happens when a student is unable to pay for their meal and the school responds in a way that publicly shames them for that. The media reports that we've seen have ranged pretty wildly including throwing away the meal in front of that student, refusing to serve the student at all, forcing students to wear a stamp on their hand, forcing students to do chores before they can eat. This troubling practice comes with significant debt that districts must carry. In 2018, Senator Walz introduced LR393, an interim study to examine this very issue across Nebraska. After surveying 77 districts-- I will finish up and just thank Senator Hunt for her commitment to this issue and the members of this committee for their time and consideration. Thank you.

ARCH: Thank you. Any questions? All right. Thank you very much.

JULIA TSE: Thank you.

ARCH: Anyone else care to testify?

MIKE SHAMBAUGH-MILLER: Good afternoon, my name is Mike Shambaugh-Miller, S-h-a-m-b-a-u-g-h hyphen M-i-l-l-e-r. I'm here today speaking for my nonprofit. I'm a professor at the university. I, of course, have to make it clear that I'm here as the ED of my nonprofit, not in my role as an employee of the university. I am the executive director of Produce From the Heart. We are a nonprofit hunger relief and environmental impact organization. In addition, I'm also a member

of the Lincoln Lancaster County Food Policy Council, the University of Nebraska's Chancellor's Commission on Sustainability and Resilience and a contributor to the United Way of the Midlands' recent study on health-- healthy food access in the metropolitan region. I'm also the former director of the Rural Policy Research Institute's GIS program at the Med Center and the former rural outreach coordinator for the Food Bank of Lincoln. I want to thank Senator Hunt for pursuing this interim study into an extremely important but nearly always overlooked crisis in our state. I also want to thank you for the opportunity to speak on an issue that holds particular importance for me as an individual. As I grew up on food stamps throughout my childhood. And again while on active duty in the military. I understand personally the power of hunger and the damaging effect it can have especially on families, children, and the elderly. The testimonies of those who have come before me and the state's own research revealed a striking and shameful status of food access inequality in our communities. You've already been made aware of these statistics and I'm gonna come at things from a little bit different angle. I'm not here to talk about a current program SNAP. I'm here to talk about food waste in the state and the potentials that it provides for us. Even, even as a leading agricultural state, Nebraskans waste up to 40 percent of the produce grown in this state. This waste occurs all the way from the field to our homes and is influenced by many economic policies and social cultural practices. The amount of waste produced alone, and this is

just produce waste alone, could fill up Memorial Stadium four times at a minimum every year. Some numbers show it could fill up Memorial Stadium seven times a year. If we look at food waste overall, so all types of food that is still edible good food, we could fill up the stadium 17 times. We also have to take into consideration considering this waste, we are also wasting the water, the fuel, and the labor that was involved in the production of that produce and that food. Environmentally speaking, organic matter is the largest percentage of landfill waste in the state. And as I tell my students, it becomes a one-to-one ratio, one pound of organic matter decomposing in a landfill will turn into one pound of methane gas in the atmosphere, thus driving climate change. The need and possibility for produce rescue, as we term it, is rapid growth-- shows rapid growth in the state. Our organization in the first year collected just 5,000 pounds of produce from one farmer's market and one farmer. Last year we collected over 150,000 pounds of produce just four years later working only with three farmers markets, four farmers, and one transportation warehouse. So we know it's out there. But that's what leads me to the two requests that I have of the Legislature. First off, is we have insufficient data about the amount of waste out there. Three years ago a interim study was suggested and was to be pursued by Senator Kolowski. But unfortunately, we ran into the realization that the Department of Agriculture does not have numbers on the amount of food waste. And they also don't have numbers on the number of small

agricul-- small produce growers that we have in this state. And so we need to have better numbers on exactly what's being grown so we know how much is actually being wasted. Our other recommendation and in the papers we have provided is that the Legislature examined the possibilities of some type of tax credit preferably tax credit or a tax break for farmers who do donate their produce to organizations such as ours or to food banks. It's been proven in other states. There's eight now that have pursued different forms of tax credits that $1,000 of a tax credit brings in over $4,000 worth of produce to go to organizations such as food banks and pantries. The big problem is transportation. The food's out there. We just have trouble getting it to where the people are who need it. Be happy to take any questions you might have.

ARCH: Questions from the committee? I don't see any. Thank you very much.

MIKE SHAMBAUGH-MILLER: Thank you.

ARCH: Anyone else care to testify? Senator Hunt, would you like to close?

HUNT: No, thank you.

ARCH: Senator Hunt waives close. And this will close our interim study on LR135. Thank you very much. We'll take a five minute break and be back.

[BREAK]

HOWARD: And we will open the hearing for LR173, Senator Quick's interim study to examine the health concerns related to the public use of and secondhand exposure to electronic nicotine delivery systems and other products. Welcome, Senator Quick.

QUICK: Good afternoon, Chairman Howard and members of Health Human Services Committee. My name is Dan Quick, D-a-n Q-u-i-c-k, and I represent District 35 in Grand Island. I've introduced LR173 to continue the important conversation we've been having about dangerous e-cigarettes devices, and the secondhand effects of aerosol vapor they produce. Last session, you joined me in raising the age of purchase from 18 to 19 for electronic nicotine delivery systems, or ENDS devices, and traditional tobacco products in Nebraska. There are now at least 18 states where you have, where you have to be 21 to purchase e-cigarettes and tobacco products and Pennsylvania is expected to pass a bill soon. My hometown of Grand Island raised their age of purchase from 18 to 19 before the state's changes go into effect. They also included e-cigarette devices to, to their existing prohibition on smoking tobacco in public places. Now at least 20 states and over 600

cities have included e-cigarette devices in their smoke-free laws. In my testimony about LB149 last year, I stressed how dangerous these ENDS devices can be and how harmful they are particularly for our children. Unfortunately, we are now seeing that play out across the United States. In just the last month, the CDC has been investigating an outbreak of vaping-related diseases that has caused at least 11 deaths and left hundreds of people in the hospital. And who knows how many other people were misdiagnosed before they figured out the cause. Meanwhile, Congress has investigated JUUL labs for their marketing tactics towards children which included school programs encouraging youth to use their product. And the FDA has sent JUUL labs a warning letter telling them to stop marketing their products as safer than traditional cigarettes which appealed to children and teenagers. It's safe to say that we are having a national conversation about these products and their dangers. I am proud that Nebraska has been a leader on this issue. However, our work to protect our children is not done. Today we will hear from experts who can explain not just the dangers that face the users of these products but the secondhand dangers that face the people around them. These ENDS products let off an aerosol vapor that contains chemicals and nicotine that can being inhaled by others exposed to the product. As public policy makers it's important to keep our constituents safe and we should modernize our policy to reflect these advancements, advancements in technology. Here's what we know about ENDS devices and secondhand aerosol vapor they produce:

many of the chemicals found in vapor products are carcinogens such as nicotine, polyethylene glycol, formaldehyde, benzene, nitrosamines, and methanol glycol. Researchers have shown that people exposed to secondhand e-cigarette aerosol can absorb nicotine. And have found tobacco specific nitrosamine in urine samples of people who were exposed to secondhand aerosol from e-cigarettes. This can be especially dangerous for sensitive groups of people such as children and women of reproductive age. Exposure to nicotine during adolescence when brain development is at a critical period is associated with long-term changes in attention and cognition, mood reward seeking behaviors, and other aspects of brain development, which is what we've also heard from our teachers. Using nicotine during adolescence can also increase the risk for future addiction to other products. Even if some elements of e-cigarettes like [INAUDIBLE] flavors are safe or harmless in their intended use, they have not been determined to be safe for use in e-cigarettes. Fundamentally, e-cigarette aerosol is not harmless. E-cigarette aerosol vapors contains just not nicotine but other harmful substances like heavy metals and ultra fine particles that can be inhaled deeply into the lungs. We know that children who are exposed to vaping begin to see it as it-- as normal, not dangerous, and even healthy. And we've learned that including e-cigarette-- including cigarettes and clean air policies has helped reduce the rate of traditional smoking including vapor products into clean air policies will help reduce the prevalence of people vaping

and help children avoid these products. You should have received a letter from former Senator Don Preister, and I'd like to thank him and his colleagues who worked on, who worked on legislation towards passing the current Nebraska Clean Indoor Air Act expressing that the legislation was intended to cover future product and advancements and technology changes. We as a body need to look at changes we can make to modernize our statutes and protect the intent of the original policy. I hope you will ask the experts behind me good questions, and I look forward to working with all of you to keep our clean-- to keep our air clean and our kids off and away from these dangerous devices and products. Thank you.

HOWARD: Thank you. Are there questions for Senator Quick? Seeing none, thank you, Senator. Our first testifier. Good afternoon.

TERESA ANDERSON: Hi. Good afternoon, Chairman-- Chairperson Howard and members of the Health and Human Services Committee. My name is Teresa Anderson, T-e-r-e-s-a A-n-d-e-r-s-o-n. I am the health director of Central District Health Department in Grand Island serving the residents and visitors to Hall, Hamilton, and Merrick counties. I'm here to testify today on behalf of Friends of Public Health in Nebraska. Thank you for letting me tell you our story about vaping in the city of Grand Island. It's a short story with very little drama, but with a really happy ending as far as the story has gone thus far. Early this summer we were contacted by Grand Island City Councilman,

Chuck Haase, who is also the president of our Board of Health. He told us of his experience at a restaurant where he and his wife were dining. Directly next to them was a couple and both were vaping. He told me how concerned he was when he saw the white vapor floating toward them as a couple exhaled from their cigarettes. Why would we allow folks to breathe in whatever is in that vapor, he asked, adding we need to do something about this. And I totally agreed. So the health department provided him and the city attorney with the science-based research on vaping. That science tells us that aerosol that users exhale from e-cigarettes can potentially expose bystanders to harmful substances including nicotine and heavy metals such as nickel, tin and lead, volatile organic compounds, cancer causing chemicals, flavorings such as diacetyl, a chemical linked to serious lung disease, and ultra fine particles that can be inhaled deeply into the lungs. We are fortunate that Grand Island had already had a Smoking Regulation Act. It essentially made it unlawful to smoke in places of employment or in any public place. Amending that ordinance to include vaping was a simple process and I have included that amended act in this written testimony. Our environmental health supervisor and I attended the council meeting where the amended act was on the agenda. We were armed with additional testimony and anticipated a rigorous debate with the pro-vape crowd. We were surprised to find that there was absolutely no one there and no opposition to that amendment. The city attorney did an excellent job

of taking the information we had provided and delivering a concise and accurate description of the potential danger of secondhand and thirdhand exposure to vaping. Before we knew it, the City Council had voted unanimously to pass the vaping amendment. Following this, we wrote an op-ed that was published in the Grand Island Independent, and we praised the City Council for its prudent action, which I have included in this written testimony as well as a news release that was sent out to the effective-- prior to the effective date, date for the vaping amendment to take place. Our health department is written into city code for enforcement of the Smoking Regulation Act. And past experience with this-- with that Act told us to anticipate backlash to, and reports of vaping violations related to the addition of vaping. I am here to tell you that aside from a few phone calls requesting clarification from businesses and a couple of Facebook posts in favor of free vaping we have not received negative feedback from the public. What we have seen is an increased awareness of the dangers of vaping and we have seized on the opportunity to educate the public on the epidemic of youth vaping especially. Unfortunately, our efforts have been aided by the onslaught of vaping illnesses and deaths in our state and across the nation. We are aware in Nebraska that as of yesterday noon there were five confirmed cases and another four probable cases of vaping related illnesses in our state. And that's because we're looking for them now. I can also tell you that we have new forms that we're using for investigation of respiratory

related hospitalizations which I think will lead us to even more reported incidents of vaping related illnesses. Central District Health Department has taken the stand that inhaling either firsthand or secondhand anything other than clean air can be problematic and should be avoided. Until and unless science proves otherwise, we will continue to promote a vape-free environment. And since I still had the yellow light, I just want to add that when you're looking at research there are different ways and there are-- it's all over the place. There are those that are funded by the tobacco industry or by the vaping industry and they're going to tell one story. And then there are the peer-reviewed, science-based articles that tell us the truth. I have provided Senator Quick with many of those articles and I would be happy to share any of those articles with you. You're going to hear that vaping is not bad and that it's not harmful. And-- well, according to the research that I did, that simply isn't true. Thank you for your time today and I'm available to answer your questions.

HOWARD: Thank you. Are there questions? Senator Murman.

MURMAN: Just one quick question. What's thirdhand exposure?

TERESA ANDERSON: Oh, I wanted to explain that. Thank you for asking. Some of the research that I was looking at was when, when the exhalation of the vapor hits say this table and let's say this is a table at a restaurant-- I'm so glad you brought this up, because then

I, I come into the restaurant after the vaping people have left, after the folks who were vaping have left, the residue stays on the table. And one of the ingredients that stays on that table is nicotine. So I take my little six-month-old Joanna [PHONETIC] granddaughter and set her on my lap, she puts her hands on the table and starts patty caking on the table and the nicotine on the table-- it's absorbed through her skin and into her system. And we know that nicotine is a poison to anyone, certainly for an infant or a young child the dose would be very small to cause some impact health wise.

MURMAN: OK. Thank you.

HOWARD: All right. Other questions? Seeing none, thank you for your testimony today.

TERESA ANDERSON: Thank you.

HOWARD: Our next testifier. Good afternoon.

TODD WYATT: Good afternoon. I'm-- my name is Todd Wyatt, T-o-d-d W-y-a-t-t. I'm a professor and a scientist at the University of Nebraska Medical Center. I have adjoint appointments in the College of Public Health in the Environmental Health Department, as well as in the College of Medicine in the Pulmonary Division of Internal Medicine. I am here speaking for myself as a scientist with specialized knowledge in environmental pathology. I do not speak officially for the University of Nebraska. One of the things that I

wanted to do here is direct your attention to the handout material, and I thought I would take my time here to, to walk you through the slides that I prepared rather than just read a preprepared statement to you. And I've been studying cigarette smoke exposure in my laboratory here in Nebraska for about 25 years. I'm particularly interested in chronic obstructive pulmonary disease which is the third leading cause of death in the United States now. This is primarily caused by cigarette smoking. And a few years ago we became interested in asking questions about what relative harm could happen to the lungs from traditional vaping devices. And more recently we focused in my lab now on, on a specific device called JUUL, and I want to tell you a little bit about that if you're not very familiar with it. JUUL has entertained a meteoric rise in its popularity and its market share in a very short time period. Two major reasons for that is that JUUL has an extremely high concentration of nicotine making it much more addictive. But more importantly, the nicotine form in JUUL is a modified version. It's called technically a benzoic acid salt of nicotine. What this chemical modification does, it makes the nicotine in JUUL mimic much more closely the form of nicotine that is removed from setting fire to tobacco, which is referred to as a free-acid nicotine. The reason this is important is this quickly and easily moves through the lipid membrane of cells that are a normal safety barrier to toxins in our environment. And it moves so fast that, that it enters the brain similarly to normal nicotine and, therefore, is

very gratifying to a smoker. So the high concentration and the quick absorption of this product is something that's, that's very attractive to, to individuals who are dependent on nicotine. Now another reason why we focus on JUUL is, is that the other versions-- there are thousands of different liquids that are on the market and hundreds of different devices. So any of the research that we would come up with in our lab on a specific product wouldn't easily be translatable to large numbers of people to help improve public health. JUUL, because of its market share now, has emerged as a single item that we can study specifically and, and has a large impact on the most people. There's a lot of talk about harm reduction in vaping and, and this is a hypothesis and it really needs to be studied. It's one of the things we hope to do in my laboratory. There are-- the common sense would tell you that normal cigarettes have thousands and thousands of, of, of toxins in them and compounds and components. And that's true. Over 7,500 compounds have been identified to date in cigarette smoke. JUUL has just five ingredients and once it's vaporized from a coil heat source it can-- those ingredients can be changed into somewhere between 1 and 200 compounds that have been identified. So the question of whether or not harm reduction is accomplished through vaping versus compared to regular cigarette smoke, this has not been fully answered and we do need to do more studies. The one thing that I do in my lab that's unique is that we don't study exposures as individual things because humans don't just do one thing. We have a lot of different

exposures. Alcohol is one of the biggest ones that we study with regard to lung health. It's clear that people who smoke cigarettes, and studies have demonstrated this clearly, they smoke heavily. Heavy smokers drink heavily. And people who have alcohol-use disorders, as many as 95 percent of those people, smoke cigarettes. So alcohol and smoking goes hand-to-hand. Very interestingly enough in this last calendar year, a study came out from Canada that studied high school students and there is a significant increase in the onset of alcohol use in high school students who vape. We are interested in this-- my lab asked the question the combination exposure of vaping and alcohol consumption since this appears to be real world behaviors. What does this do to the lungs? And we surprisingly found out that the unique synergy of alcohol and vaping appears to injure the lungs in a manner that either individual exposure does not. So we-- I, I stress that we need a lot more research to, to be able to find out reproducible and, and, and correct facts related to this. Comparison work is very important to com-- to directly compare the injury from-- between cigarettes and vaping. But I want to point out that human disease pathogenesis takes a long time. Smoking related lung injuries don't occur in a short period, they occur over decades. And so this will be an important aspect to, to future research. I, I thank you for your time, and I'd be happy to answer any questions you might have.

HOWARD: Thank you. Are there questions? Senator Arch.

ARCH: Thank you for coming. Is, is JUUL the product, the device, or both?

TODD WYATT: JUUL is a specific device used-- that uses a specific product in its proprietary replaceable disposable pods.

ARCH: OK. So are, are there other devices that would take a JUUL pod or is it-- is, is JUUL proprietary for both the device and the, and the pod?

TODD WYATT: To my knowledge, the different products that are on the market design-- they're, they're disposal and, and some have refillable pods. JUUL does not, that they, they purposely design them to be independent of each other so that they can market their own, their own products.

ARCH: All right. Thank you.

HOWARD: Senator Hansen.

B. HANSEN: Thank you, Chairperson Howard. Thank you for coming today. Just a couple of questions about the slides. Is this based on research, or this kind of more on an opinion type presentation?

TODD WYATT: These are studies I've conducted in my laboratory.

B. HANSEN: OK, that's what I was wondering. OK. And do you know of any other studies out there, because I'm trying to, trying to get a handle

on all this kind of stuff, because I know this, this came up last year, is e-cigarettes and JUUL the same thing?

TODD WYATT: In the Venn diagram of e-cigarettes, JUUL would be a-- one component. The generic term that, that is currently being used is electronic nicotine delivery device that would encompass any form of nicotine delivery that's accomplished through electronic means.

B. HANSEN: OK. Because I think-- from my understanding I think, the components or the ingredients used in JUUL are sometimes different than what are used in like what are classified as e-cigarettes or nicotine levels are a lot higher in JUUL compared to e-cigarettes.

TODD WYATT: That's exactly correct.

B. HANSEN: OK. All right. So there is a difference between the two?

TODD WYATT: Well, there, there are indeed differences there. As I mentioned out in my presentation that many e-cigarette vaping products may have less than 20 milligrams per milliliter of nicotine. Whereas, the, the introductory JUUL product was almost 60 milligrams--

B. HANSEN: OK.

TODD WYATT: --per milliliter. It's extremely high nicotine.

B. HANSEN: And so when we use the term vaping, what does that include? Does that include like all of it, like everything, like JUUL and

e-cigarettes, or is it just-- there's so much terminology out there and it seems sometimes a little bit vague and people just kind of use them intermittently and--

TODD WYATT: That's exactly right and they, they, they seem to be interchangeable to a lot of individuals. The-- I, I think that generically people do lump JUUL in with vaping. The process is, is-- generally the term vaping is used to differentiate this from traditional tobacco-- pyrolized or burn tobacco, inhalation, and smoking.

B. HANSEN: OK. And one more question. I-- and whenever I try to make decisions when it comes to matters like this I try to at least look at the data or look at research as best I can. And so I see some research out there like previous testimony that is seems like it is backed by tobacco companies to some extent and there are some that are not that show that the exhaling or the, the vapor that's produced by e-cigarettes is not harmful at all. And then I see other research that says that it is.

TODD WYATT: Um-hum.

B. HANSEN: And so it's hard to get a grasp on this sometimes about what to believe and what not to believe. And so if-- and I don't know if it's so much of a question, but I would be open to any kind of research that you might have.

TODD WYATT: Well, I, I share your concern about that because it's difficult for, for me and this is-- I'm presumed to be an expert. The definition of harm, I think is a central notion here, many studies at this stage and many published reports related to what is in JUUL or what is in any other specific vaping liquid focuses on an analysis of the chemical contents. And there is not enough research that documents yet what do those components when vaporized due to biological systems. We have the tool box to answer these questions because we've been studying cigarette smoking for 100 years. We can study this at the molecular level, the cellular level, preclinical animal models. But more importantly, given enough time and enough users who come down with enough diseases, the science of epidemiology can make accurate statistical analysis of whether or not a disease was caused by a specific substance.

B. HANSEN: OK. And that's kind of where I think where I feel like we're at right now when it comes to vaping is like it's almost like the infancy stage, we don't really quite have enough research right now. It's more of a-- and not hearsay, but what people, what people are coming down with. And so I'm trying to figure out the amount of government control, if there should be any, of what our steps are as legislators to combat any kind of public health issue, if there is one. And so right now it's hard to kind of get a grasp on anyone when the research isn't quite out there yet on a whole bunch of stuff.

TODD WYATT: I, I don't want to be unclear. The public health issue is about nicotine addiction in children.

B. HANSEN: Um-hum.

TODD WYATT: That's certainly something that I, I, I think most of us should be very concerned about. If no-- if you are not using nicotine, there's really no, no-- there should not be anyone advocating a nonnicotine user to start using nicotine.

B. HANSEN: Um-hum.

TODD WYATT: But my questions are, we simply do not know the answer of someone who's been smoking conventional cigarettes for many, many years if indeed switching to a vaping product will result in less injury and less subsequent disease. We don't know the answer, but those are studies that can be done and in my opinion should be done.

B. HANSEN: OK. Great. Thank you. Appreciate it.

HOWARD: Senator Arch.

ARCH: Thank you. Words do, terms do make a difference. And, and I have read like water vapor and I've read aerosol. Do you, do you make a distinction between those as far as what's produced as a result of vaping?

TODD WYATT: Absolutely. Anything can be aerosolized. This-- the term generically meaning that it's, it's a particulate in the air. Vaping, because it generates a liquid vapor, it does have physical characteristics different from some say pyrolized tobacco smoke which can dissipate and remain airborne for longer periods of time. Again, there, there are physical differences and there are chemical content differences.

ARCH: Because water, water vapor to me sounds like steam. Yeah, I mean-- you know, your tea kettle produces water vapor, right?

TODD WYATT: [INAUDIBLE]

ARCH: Aerosol-- aerosols sounds like something that comes out of a can. But, but-- you know, so I mean to me it-- it's-- it makes a difference whether that's water vapor or whether that's aerosol. What you're saying is there's a lot of chemicals in that [INAUDIBLE]--

TODD WYATT: Certainly, steam, steam as long as it is generated from pure water is, is going to be--

ARCH: Right.

TODD WYATT: --water in steam form. But that's not true for the products that are vaporized and, and exhaled.

ARCH: Thank you.

HOWARD: Senator Murman.

MURMAN: Thanks a lot. I've heard-- I guess because it's a vapor that it's taken more deeply into the lungs. First of all, do you know if that's true? And then also, if that's the case, I've also heard that your lungs or lungs don't heal themselves because of that also as well as they do with like smoking cigarettes.

TODD WYATT: Well, your, your first question, what we know about deposition of anything that you inhale, it's governed by the size of particles. So whether it's a droplet of, of, of any form of vaporized material in liquid form or whether it's a small dry particle. The size governs how deeply it enters your lungs. And these, these are well-established concepts that we can, we can study and should study. The nature of the injury is, is, is something that, that needs to be studied in the context of that. There, there is-- there are both chemical and physical properties to, to lung defense. I'd like to add that it's-- the FDA has approved many flavorings that are contained in these products for oral ingestion, but they have not been-- they were never studied in terms of inhaling them. Many pyrolized or vaporized modified compounds that are involved in flavorings can be reduced into what we call reactive aldehydes. And we know that reactive aldehydes are very damaging to the lungs because they engage in things called covalent bonding or covalent modifications which are somewhat very stable and changing the proteins that exist in the lungs. One of the

things I'm very interested in my laboratory is a lifetime of having modified these proteins in your lungs resulting in something of a storm of continued inflammation. How does the body and naturally try to fight back and repair itself and respond to that? And unfortunately, that's the manifestation of this disease I mentioned, chronic obstructive pulmonary disease. It's a disease of remodeling where the body is attempting to repair itself. But under continual injury for years, it remodels in an aberrant way. And as you grow older you have a great difficulty in breathing, you have a horrible quality of life, you just can't do the things that others can do. Particularly, the tragedy is, is one of the most expensive things we have in our healthcare system is treating people with existing chronic obstructive pulmonary disease that can result from these types of inhalation injuries. When they get a viral infection or bacterial infection, they're not like you or I and can get over it in a short period of time or with the help of antibiotics. Oftentimes, people with COPD have to be hospitalized and sometimes even have to go on a ventilator from, from a simple exacerbation of disease. The injuries are real, but they are greatly understudied with regard to vaping.

MURMAN: So the jury is still out as to whether it, number one, it goes more deeply in the lungs. And number two, how quickly-- or if it does, if the lungs do heal themselves.

TODD WYATT: I, I would imagine that each product would likely produce different physical characteristics and there would not be uniformity to the, to the delivery of the deposition. And it would also be related to the dosage and the amount used and the frequency of use. But also be related to two other things: the health state of the individual and their ability to actually clear things they breathed, but also all of us have different genetic polymorphisms that express different levels of defense about the environmental things that we inhale.

MURMAN: OK. Thank you.

HOWARD: Any other questions? Thank you, Dr. Wyatt. Last time I saw you, you exclusively talked about mice. So this was considerably better than that.

TODD WYATT: Give your mother my regards.

HOWARD: I will. Thank you. Our next testifier for LR173.

SARAH LINDEN: It's hard to roll that chair.

HOWARD: Good afternoon.

SARAH LINDEN: Good afternoon. Good afternoon, Chairperson Howard and members of the Health and Human Services Committee. My name is Sarah Linden, S-a-r-a-h L-i-n-d-e-n, and I'm the president of Nebraska Vape Vendors Association. There was some discussion from previous

testifiers that I want to clarify and address the recent misleading news stories on respiratory illnesses caused by vaping. But I first want to answer Senator Hansen's question about what is vaping? THC can be vaped, nicotine can be vaped, anything that is essentially turned into a liquid or a liquid that's heated and turned into a vapor can be vaped. So sometimes when they talk about vaping, they're not actually even talking about nicotine vaping. Some of the results from the CDC study on youth vaping includes THC vaping. So you kind of have to-- that term can be misused and it can be misleading because we don't actually know what these people are vaping. So that goes to these respiratory illnesses. We've all seen the headlines that vaping is causing these respiratory illnesses. Well, it's not nicotine vaping that's causing these illnesses. So the New England Journal of Medicine released a study two weeks ago in which 84 percent of those with the respiratory illness admitted to using black market THC cartridges. They acknowledged that the other participants who were sick were either unable because they were incapacitated or they may not want to admit to using illicit drugs. Presence of Vitamin E acetate was found in most of the black market THC samples tested. Vitamin E acetate is an oil used to thin THC distillate. Because THC as a compound when it's distilled down to a liquid is very, very thick. So you wouldn't be able to vape it unless you mixed it with something thinner. And that's used in those black market THC products. Vitamin E acetate, while Vitamin E we use as a beauty product for our skin, it's not good

to inhale because it's an oil. Our bodies are made up of water and they do not take in oils well, especially into the lungs. So what happens is that oil coats the lungs and the lungs react trying to get that oil out, and I'm oversimplifying because I'm not a medical professional, but they become inflamed and that is what causes the lipoid pneumonia that you're reading about. The reason nicotine vapor products aren't causing these illnesses is because there are no oils. And I wanted to correct something that Senator Quick said earlier, that propylene glycol is a carcinogen. That's actually not true. Propylene glycol is what's used in medical inhalers so they wouldn't give a carcinogen to people with asthma in a medical inhaler. So it's absolutely not true. But the ingredients in nicotine e-liquid is all water soluble so that means that it dissolves into the body, it dissolves into water. I wanted to show you an example of pouring a bottle of e-liquid in a bottle of water to show you that it dissolves, but I'm not allowed to have props so you can try that one at home. The FDA told state officials two weeks ago and this is the most recent update is in your packets that I handed out that lab tests found nothing unusual in nicotine-vape products which were collected from sick patients. The New England Journal of Medicine also acknowledges that in the 12 years e-cigarettes have been on the market in the U.S. there have been no related reports of pulmonary illness or deaths linked to the use of e-cigarette products. NBC News, which I have another article in your packets, did their own independent

investigation and released the report just this morning. And this is really scary. They commissioned one of the nation's leading cannabis testing facilities to test a sampling of THC cartridges both legal products purchased at dispensaries and illegal products purchased on the black market. All of the black market THC products contained myclobutanil. I might have said that wrong. It's a fungicide that can transform into hydrogen cyanide when burned. Officials at the CDC were under fire by public health officials for releasing generalized warnings advising the public to stop vaping. Recently, they changed their tune and are telling the public to continue vaping and do not return to combustible cigarettes. I'm almost-- I'll close with this here, nicotine vapor products have been regulated by the FDA since August of 2017 for their ingredients, marketing, labeling, and other features including tamper-proof seals. THC products are not yet federally regulated as they are not currently legal nationally. I'm happy to answer any questions that you guys have about vapor products. What is an e-cig? What is a vape product? What is-- we want to work with you and help your guy's understanding of these products so that you can regulate them with sensible regulation, but with the clear understanding of what actually is and is not true. So I thank you for your time, and I'll open it up if you have questions for me.

HOWARD: Thank you. Are there questions? Senator Hansen.

B. HANSEN: Thank you for coming today, too.

SARAH LINDEN: Thanks.

B. HANSEN: And I think in the essence of the nature of, of the LR173, we're talking, I think, more about not so much what vaping does to the individual who inhales it. I think anytime you inhale a chemical, it's probably not the best thing in the world no matter what it is. But in the essence of the study, we're talking about, the secondhand exposure to other people whether it'd be children or adults. And that, in my opinion, when I think of where government steps in, is when you're behavior then affects the civil liberties of somebody else, which is the nature of the study. So do you think or do you know of any studies that show or maybe just your opinion about secondhand exposure to vaping or e-cigarettes to other individuals?

SARAH LINDEN: Um-hum. So there are two studies done and one of my colleagues is actually gonna come up after me and cover this exactly. But one of the studies showed that there is actually no harmful contaminants in secondhand vapor whatsoever because it dissipates very quickly into the air and that it's actually no different than standing on a street corner breathing regular air. Like, it's actually more harmful to stand on a street corner because you get the pollutants from cars. The other study just talks about how the particles are broken down. And there's such small particles and why they dissipate

quickly. Whereas, cigarette smoke lingers in the air and doesn't dissipate. So I can-- he's gonna pass out the actual studies. So if it's OK, I'll just invite him up and he can talk more about it and then give you the studies so you can review them yourself.

B. HANSEN: OK. Thank you.

SARAH LINDEN: Do you have other questions for me though?

HOWARD: Sure. Are there other questions? Seeing none, thank you for your testimony today.

SARAH LINDEN: Yep. No problem. Thank you.

HOWARD: Our next testifier. Good afternoon.

ERIC JOHNSON: Hi. Good afternoon, everybody. My name's Eric Johnson, E-r-i-c J-o-h-n-s-o-n, and I'm here to give a little bit of a talk about some of the science behind all of this. I'm not gonna pretend like I completely understand what's in all the studies that are there. Those are probably a little bit above my pay grade. But I kind of wanted to start out by saying that if somebody would come up to you 20 years ago and said, I'm gonna be able to provide you a product that will be significantly more effective than any other product that's on the market to help people quit smoking, not only is it going to be 95 percent more safer than smoking, but it also will clinically be able to not be harmful to anyone else around them. I mean, none of us would

question from it, we'd, we'd jump on that. That would be a public health panacea to a number of different issues that we have both from a funding perspective of public health and also from the human part of it with the suffering that people go through, through COPD and all of the other issues that go with that. One of the things that we wanted-- I wanted to start out with is the first one here that says the Royal College of Physicians says that e-cigarettes can prevent almost all the harm from smoking. Now this is the Royal College of Physicians, this is one of the leading medical institutions in the United Kingdom. In the late 1950s and the 1960s, they were the ones who were the first to come out and say, smoking is bad for you, do not smoke. Now there's some of the first that are coming out saying, hey, if you smoke switch to vaping because it is much, much, much safer for you. So when we start talking about whether something is dangerous for you or not it's important to put things into perspective. That while this may be-- it may, may be much, much, much better than smoking. Is it still harmful for you? The jury is potentially out on that. Right now, so far what we've seen is there actually is no available data that shows any harm. There's nothing so far. And that's really important. When we start talking about-- you know, whether or not it harms other people, the two studies that you see right here-- and I think I just gave away somebody's-- one of these that ended up having my notes on it, crap. So--

HOWARD: Everybody look at theirs.

ERIC JOHNSON: --we'll go ahead and go with the conclusion. And so if you, if you go to the first one, SRNT, right, which is the characterization of the spatial and temporal dispersion differences between exhaled e-cigarette mist and cigarette smoke. What they're basically breaking down here for you is that, that the-- and this is the most important part here, e-cigarettes with particle concentrations returned rapidly to background values within seconds, within seconds. However, however, unlike e-cigarettes test devices tested such temporal deep variation was dependent on room ventilation rates and whatnot. The cigarettes increased with successive puffs returning to background levels after 30 to 45 minutes. So when we start talking about is this gonna be dangerous to people around you, because of that water soluble ability it disperses almost instantly. So we don't have that danger to other people that we're talking about. This doesn't become a concern for other people around you. When we start talking about whether things are dangerous, I think that it's important for us to put things into perspective. You know, we, we hear about heavy metals and other chemicals that are in there. And one of my other colleagues is gonna talk about that here in a minute, too. But when we talk about science, and we can present you with the science that shows that this is actually not bad. Like it's not what it's being made out to be both in the media and in the people that,

oh, my gosh it looks like smoking so it must be smoking. It's not that. And when we make something into something that it is not, we literally push people back to the thing that we're trying to pull them away from. It is incredibly important for us as a community to make sure that we differentiate ourselves from between the tobacco that's actually out there is actually harming people and the product that is not harming people. Right now one of the things that we're seeing in our vape shops is significant drop in sales. We're seeing people that are going back to smoking because of the headlines that we're seeing, because we're seeing people say, oh well, it's the THC products but they bury that way down in the article and they say vaping instead. Why do they do that? Because the honest truth is that if you said tainted illegal drugs kill six is not gonna to give you a headline. Nobody's gonna click through from that. But the reality is, is that once you end up telling people, hey, it's THC cartridges. Well now, people not only are finding out, hey, if my vaping is OK, but I've still got those cartridges in my car because I didn't know that they were bad for me. When we differentiate between the two, we help encourage people to stop doing the bad behavior and pick up something that's much better for them. And by telling people that it's OK to do this in public and say, you are safe, like they do in England. They actually tell you in front of their hospitals, they have a sign, it says, please no smoking. However, if you would like to vape or enjoy your ENDS, please do so. In a hospital, you know, that's important.

That's-- that tells you something. So I think that as you consider this, please look at all the available evidence that we're giving to you, and I hope you guys will make an educated choice on it. And please feel free to ask us any questions at any time if you have any further questions.

HOWARD: Thank you. Are there questions? Senator Hansen.

B. HANSEN: Question, sort of a comment. On one of the studies that you provided, I-- the three that you provided here, in so much-- I don't know for sure if it was peer-reviewed study or not, but this one that had your writing on it is probably yours.

ERIC JOHNSON: Oh, it's probably mine,--

B. HANSEN: Yeah.

ERIC JOHNSON: --you probably got mine maybe.

B. HANSEN: Looks pretty legit and I think it's, it's not too bad. I'm kind of a data nerd and I like a lot of research papers. The other ones look pretty good, too. I'm just gonna take this other one with a little grain of salt, the one that you provided to us because of the funding that it came from. The work is supported by Fontem Ventures BV, the manufacturer of e-cigarette products used in the study. So I'm just personally gonna take it with a little grain of salt because if it's one of the studies that want to make e-cigarettes.

ERIC JOHNSON: Right. Absolutely.

B. HANSEN: I think Blu, is that what they make? So--

ERIC JOHNSON: Yeah.

B. HANSEN: But the other one looks pretty good. So I appreciate you giving us information though. This is kind of what I'm looking for. I'm gonna try and make good educated decisions as, as legislators about how we're gonna affect other people's lives.

ERIC JOHNSON: Yeah, and I--

B. HANSEN: I appreciate it.

ERIC JOHNSON: --think that's a great, that's a great way to take it is-- you know-- obviously, look at where the source is coming from. You know, take that, take that as a, as a caveat to everything that we do. One of the things that I would really encourage all of you to do when you hear people talk about, oh, it's so dangerous, and this that, and the other thing, have them give you the studies so you look it over because you're gonna hear a lot of people saying it's dangerous, but in a lot of ways what we're talking about here is kind of lemmings. You know, it's like, oh, we, we know it's dangerous. We know that it's bad. Well, I mean to paraphrase Tommy Lee Jones in, in Men in Black-- you know, 1,500 years ago we knew that the Earth was the center of the universe. Five hundred years ago we knew the earth was

flat. Imagine what you're gonna know tomorrow. Right now everybody knows that vaping is bad. Well, if you do your homework, you'll find out that that's not really true. And now you'll know the truth, not what everybody thinks they know.

B. HANSEN: Right. Thank you.

ERIC JOHNSON: Anything else?

HOWARD: Senator Murman.

MURMAN: Yeah. I'm, I'm gonna ask a question for a friend. You mentioned THC and, and the previous-- or-- and the previous testifier--

ERIC JOHNSON: Yes.

MURMAN: --mentioned THC. If I'd go to a dispensary in Colorado and buy THC and vape it, would that be safe?

ERIC JOHNSON: Honestly, I've never had them myself. I honestly-- really I haven't. And as, as Sarah said previously, they did do the studies with-- MSNBC said that they did studies on that and that the ones from the dispensaries-- I'm correct-- is that correct Sarah?

SARAH LINDEN: We're fine.

ERIC JOHNSON: The dispensary ones were fine. It was the illegal ones that ended up being the problem. So you know, again, we're back into

that Venn diagram as Dr., Dr. Wyatt said earlier. You know, vaping exists as a, as a giant box that has all of these different types of doing things in it. You can vape THC, you can vape CBD, you can vape caffeine, you can vape nicotine. You know, how you handle that and where you get your products very much matters. Safe tested products that have been in the marketplace for a long time now with no obvious health problems are beneficial to our communities. They do a good thing. This stuff that you find, the THC that comes off the streets on the other hand, those are dangerous. They're absolutely very dangerous. And by banning vaping you're not gonna ban those. Those are still gonna keep coming in. Those cartridges that they get are easily available from Alibaba, which is a Chinese e-commerce site. And you can just get them shipped here. And then they'll do the same thing they've been doing in Wisconsin, which is where they have a little room and they process the marijuana, they distill it down, they put it into the little cartridges they got from China, they box it up and then they go out on the streets and sell it. And so-- you know, we're, we're not part of that system and you wouldn't ever take away syringes because someone was out there shooting up heroin. You would take that syringe and still, still use it for other good purposes.

MURMAN: OK. Thanks.

HOWARD: Any other questions? Seeing none, thank you for your testimony today.

ERIC JOHNSON: Great. Thank you.

HOWARD: Our next testifier. Good afternoon.

DAVID BOARDMAN: Good afternoon, Chairperson and members of the committee. My name is David Boardman, that's D-a-v-i-d B-o-a-r-d-m-a-n, and I am the regional manager for Generation V here in town. And first I'd like to talk about, talk about a couple of names that come up a lot when, when the discussion is on the safety and efficacy of e-cigarettes. First is Dr. Stanton Glantz, he's a professor of medicine and cardiology division at the University of California San Francisco. He graduated the University of Cincinnati in 1969 with a degree in aerospace engineering, then a PhD at Stanford University. The topic being computer modeling of heart tissue. Glantz has no medical or scientific qualifications at all pertaining to smoking cessation research though it's often reported that he did postdoctoral work in cardiology. However, this was Stanford's Department of Applied Mechanics and this is part of the Department of Mechanical Engineering. They don't study medicine there. So another name that comes up quite a bit when it comes to e-cig research is Dr. Konstantinos Farsalinos, and he is a cardiologist and research fellow at the Onassis Cardiac Surgery Center in Athens, Greece, at the

Department of Pharmacy University of Patras, Greece, and the National School of Public Health Greece. He specializes in echocardiography and in smoking and tobacco harm reduction, reduction research. He has been conducting laboratory clinical and epidemiological research on smoking, tobacco harm reduction, and e-cigarettes as princi-- principal investigator since 2011. So we've heard a little bit today about some of the harmful things that have been reported to be found in vaping in e-cig emissions and to speak explicitly to the claim that-- excuse me, potential-- potentially dangerous levels of formaldehyde were detected. You can cite one study that was actually done at the Portland State University in January of 2015 where the research was conducted using machines meant to replicate drawing on a vape device not human subjects. So as a response to this study when it was released, Dr. Farsalinos trying to replicate the study's findings where they said it was-- there were no amounts of formaldehyde detected when the device was fired at 3.3 volts on a 2.1 uncoil or about 5 watts. But then potentially dangerous levels equal to that of a potato, which they left out of the study, but were detected when the device was fired at 5 volts on a 2.1 uncoil or 12 watts. So the tank that was used in that study was something called a CE4 top coil atomizer. A manufacturer-- or the manufacturer of which recommends the voltage between 3 and 4 volts which in the study when they fired it at the manufacturer's recommended rating, there were no amounts of formaldehyde found. But that same manufacturer issued a warning with

the product saying an explicit warning that if used at high wattage which they detailed as equal to or higher than 4.5 volts, the coil would burn. As a response to this study, Dr. Farsalinos wrote his-- or on his study that he did to try and replicate their findings, that in his personal experience the use of top coil atomizers had-- he tried to use a very similar one in his study evaluating plasma nicotine levels from e-cigarette use. Unfortunately, it was impossible for most vapors to use the top coil atomizer and puff at their preferred conditions due to what's called a dry puff where it would burn and get you back to that sensation of actual combustible tobacco rather than vaping. Only a small minority who are taking very short puffs were able to use this atomizer at 9 watts. Now to reference that study that said they found formaldehyde in there, they had fired that device at 12 watts so a human subject could not take but a very short pull at 3 watts below where they found trace amounts of formaldehyde equal to that of a potato. So now if you look at the National Center for Biotechnology Information they cite the most common source for formaldehyde exposure is the combustion process be that in manufacturing traditional combustible tobacco, or otherwise. There's also been some said about diacetyl, which actually Dr. Farsalinos was the one who published his study in September-- on September 1, 2014, in Nicotine and Tobacco Research and concluded that potentially unsafe amounts were in 74 percent of e-liquids he tested in 2014. As a response, the vape industry being a self-policing industry awaiting

regulation from the FDA responded by using safer flavorings at the cost of some juice tasting not as good because it's that-- provides that buttery flavor resulting in lost sales and even forcing some e-liquid companies out of business. And the amount detected in Dr. Farsalinos' study was found to be 100 times lower than that in traditional cigarettes. Now another thing that gets talked about a lot is, oh, excuse me, that's my time, but I'd be more than happy to answer any questions.

HOWARD: Thank you. Let's see if there are questions? All right. Seeing none, thank you for your testimony today.

DAVID BOARDMAN: Thank you.

HOWARD: Our next testifier for LR173. Good afternoon.

JENNIFER SVOBODA: OK. Good afternoon, Chairperson Howard and members of the Health and Human Services Committee. My name is Jennifer Svoboda, J-e-n-n-i-f-e-r S-v-o-b-o-d-a. I am co-owner-- excuse me, of Big Red Vapor. We opened our only location in Lincoln six years ago this week with the intention of making a safer alternative more available to the smokers in our community. This industry was a consumer-driven solution to the tobacco problem. The misleading and false information about vapor products circulating is a risk to public health. Smoking is the leading cause of preventable disease and death. So to demonize a product that's 95 percent safer, as we heard from Mr.

Johnson earlier, is irresponsible. It's a public health tragedy that 45 percent of adults in the U.S. incorrectly believe that vapor products are just as harmful as cigarettes. Studies make clear that vaping is a safer alternative to smoking and also show that the flavors that smokers when they switch to vaping the flavors that they use are crucial to their success in switching. My favorite flavors were and still are the fruit flavors. And I'm not alone. Only 3 percent of adult vapors who are switching from tobacco products actually vape on tobacco flavors. So can you imagine telling an alcoholic that they need to drink nonalcoholic beers instead of soda to quit drinking. I would hope we wouldn't do that and for the same reason we shouldn't tell adults who are trying to quit smoking that they can only use tobacco flavored product if that makes sense. And that's just kind of in response to some of the recent stuff in the news with knee-jerk bans and stuff going into place. But on the subject of alcohol, according to Youth Risk Behavior Surveillance, alcohol use is a greater risk to teens than vaping is with 29.8 percent of teens reporting use. And yet we haven't seen any bans on fruit or birthday cake flavored vodkas or anything like that. So if we aren't, if we aren't debating bans on cigarettes which kill 480,000 people a year or on alcohol which kills 88,000 people a year, it doesn't seem very logical to start banning flavored vapor products which to date has killed nobody. Bans create an influx of black market products which as we've seen recently are not regulated so there's no

regulation at least to unsafe products. There's no age limit. There's no oversight There's nobody carding. And so it'll lead to more sickness and death among both teens and adults. We're hoping to work with this committee and the Legislature as a whole to come up with some solutions to teen vaping that don't impede the rights of adults. And we've come up with a few solutions that would be workable that have maybe been tried in other places and been successful. One example of that is limiting the nicotine content of juices. We could limit it to 20 milligrams. That's what they've done in the UK. They haven't seen the same usage by the problem with teens trying to use vapor products in the UK as they have here and their limit is 20 milligrams. It seems like teens kind of like the, the buzz that they get from the 50 milligram products like JUUL. So if we can limit the nicotine content in it, it's still effective for people trying to quit. It's pretty rare that people who are smokers need anything stronger than 20 to be able to switch. So lowering the nicotine content is a thing that is a logical solution that would also curb that, that urge the teens have to get a buzz from it. We can also limit the flavored vapor products to adult only stores which data shows have a better track record of checking IDs and refusing sales to minors. We can require ID scanners. We could get rid of closed pod systems that are like JUUL. JUUL's a closed pod system. You can't refill it. You use it once and throw it away. And I see I'm running out of time here, so. Because of their stealthy design we can use purchase tracking to eliminate

[INAUDIBLE] purchases, install vapor detectors in school bathrooms, increase penalty for possession by minors, and for procuring to minors. So we're hoping that we can work together with the Legislature to develop solutions so that we don't squash the biggest public health opportunity that we've had so far in our lifetime. Thank you.

HOWARD: Thank you. Are there questions? Seeing none, thank you for your testimony today.

JENNIFER SVOBODA: OK. Thank you.

HOWARD: Our next testifier for LR173. Good afternoon.

AUTUMN SKY BURNS: Hi. Good afternoon, members of the Health and Human Services Committee. My name is Autumn Sky Burns, that's A-u-t-u-m-n S-k-y B-u-r-n-s, and I live in Papillion, Nebraska. I am a former smoker and I was occasionally still smoking when e-cigarettes hit the market in Nebraska about ten years ago. About the same time we did the Clean Indoor Air law, which we've mentioned. You have the letter from Don Preister. My first interaction was, a tobacco company sent me a coupon for a dollar starter kit. So I could go in to the gas station, it was MarkTen, which isn't really around anymore, and I could trade that coupon which the tobacco company is very limited in what they can send, they can't send a dollar pack offer, but the e-cigarette companies could. So I am an old school person. I still read real books and I don't like electronic things so I pass it off to a friend and

then I noticed a lot of my friends were talking about how awesome it was that there was a get around the Clean Indoor Air law because it wasn't really smoke, right? And they would say, oh, it's just harmless water vapor. My background's in public health so I kind of doubted that but there wasn't much research. About five years after that, so five years ago I took a job at our hospital working in community and public health specifically managing a community coalition of about 65 organizations that are working on the negative impacts of commercial tobacco in our communities in Sarpy and Cass County. One of the first things I said was, what are we doing about electronic smoking devices? Yes, words are important. And by using the word vapor we have disguised what this is. It's just another alternative to smoking. The product might look different when it's coming out of your mouth, but it's still nicotine. That's what we're talking about is nicotine addiction. It doesn't matter what method you're using, this is nicotine addiction. I know it looked mighty, mighty, mighty appealing. I haven't smoked in over five years, and the last year the proliferation of advertising has made me think several times about picking up an electronic smoking device because nicotine addiction is like any other addiction, it lasts for life. I got a cigarette when I was in my teens by a babysitter. That set up my brain, my neural pathways for addiction for the rest of my life. Because research isn't there and our community work has to be evidence-based-- yeah, there's not a ton of research. I mean, we have the Surgeon General's report

for 50-plus years saying smoking kills and people still smoke because it takes a long time for social norming to change. The rates and use that we're seeing are comparable to what we were seeing in the 50s with smoking because doctors used to say that smoking was OK. They'd prescribe it to people with bronchitis and say it would help with asthma, it would help with clearing up your, your, your airway especially if it had menthol in it. We know now that's a bunch of not truth. I have some-- and I've-- you've seen, I've went way off of this because I've heard people talking. And I keep getting angrier and angrier and that's not fair because I do want a better public health solution. I'm on the Board of Health for my county. I'm not here representing them, but that's how much I care about what's going on in our community. Our having all the-- excuse me, the police departments are coming to us. The schools are coming to us. It's a public health issue because my 14-year-old is being exposed to secondhand aerosol in his classrooms at school. He's 14. We have schools in our community removing bathroom door stalls because they don't know how to deal with it. It's not included in the Clean Indoor Air laws, so they're not really breaking any laws. If I was to sit in my office all day and spray hairspray at my coworker, I'm pretty sure they would figure out a way to stop me, right? That's what it is, it's aerosol. And, yes, it may be less harmful than cigarette smoke, we don't know. But I-- that's what I keep hearing is arguing over, well, it might be a little bit safer-- it's not air, it's not clean air and that's what we should

care about. I am all for adults who want to quit but that's not really what this was about. If you read LR173, we're talking about the public health effects on pass it on people who are not using the product. The people who are sitting in the office whose coworkers are exposing them to this toxin. I appreciate what the people are doing who are trying to get people to stop smoking. It does kill six million people a year. It does. But we have to think about our kids, our elderly, our adults. Our community is-- and I know in Sarpy and Cass County, we are having a lot of problems especially with our youth. So as a government and [INAUDIBLE] have to come together and-- you know, come to you and say, what can you do? Adding it-- you know, making sure that clean air is utmost responsibility, you know, and this product is not air. So maybe less safe or more safe, we don't know yet, but it's not air. Does anybody have any questions?

HOWARD: Sure. Are there questions? Seeing none, thank you for your testimony today. Our next testifier for LR173. Good afternoon.

NICK FAUSTMAN: Good afternoon. I'm Nick Faustman, N-i-c-k, F as in Frank-a-u-s-t-m-a-n. I'm the Nebraska government relations director for the American Cancer Society Cancer Action Network which is the nonprofit, nonpartisan advocacy affiliate for the American Cancer Society. ACS CAN is pleased that Senator Quick has introduced LR173. Our organization advocates for comprehensive smoke-free workplace laws to protect workers and the public from harmful effects of secondhand

exposure and to create communities that support tobacco-free living. The use of electronic cigarettes or e-cigarettes, regardless of their content, should be prohibited in all workplaces and including restaurants and bars to protect against secondhand exposure to nicotine and other potentially harmful chemicals to ensure the enforcement of existing smoke- free laws are not compromised, and to ensure that the public health benefits of a smoke-free law are not undermined. Everyone has the right to breathe clean smoke-- or I'm sorry, clean smoke-free air and no one should have to choose between their health and a paycheck. With that said, there are a couple of main points I would like to make about this issue this afternoon. First, is that e-cigarettes are not safe. They contain chemicals such as propylene glycol, nicotine, tobacco-specific nitrosamines, metals, volatile organic compounds, and polycyclic aromatic hydrocarbons. It's only common sense that they be prohibited under the state's Clean Indoor Air Act in order to protect the public and preserve the intent of the act. Second, the state's Clean Air Act should be comprehensive and apply to all e-cigarette products, not just those containing nicotine. And so with that in mind, ACS CAN recommends the definitions that are attached to the handout there that you should have received from Timoree. In the interest of saving time I will not read those into the record, but that is what we would recommend for inclusion into the Nebraska Clean Indoor Air Act. The Legislature can protect the intent of the Act by incorporating these definitions into statute

as early as this session. I did want to address a few things that were said earlier. There seems to be-- with all of these news stories happening over the last several months, there seems to be a developing understory that there is a difference between black, quote unquote, black market products and products that are sold in stores currently. But I'll remind you that none of these products have been reviewed by the FDA. None of them. So to draw a clear distinction between the two is rather difficult in the, in the opinion of my organization. As far as my organization has heard, the FDA-- neither the FDA nor the CDC have drawn back on their warnings to the public regarding use of e-cigarettes. I have not heard that. Additionally, the FDA has not approved any of these products as cessation devices. And, in fact, just a couple of months ago they sent a letter to JUUL warning them to tone that down. And if we have individuals here who are retailers of e-cigarettes claiming that they are cessation products, I think we know folks at the FDA who would like to talk with those individuals about those claims. So another testifier said let's keep things in perspective and then stated that none of these have been claimed as harmful. But our own Surgeon General, in fact, has claimed that these are harmful. That they contain these, these chemicals that I read earlier and others in fact. I can't speak to what happens in Greece or the United Kingdom, Ireland, or whatever European country that may have been cited earlier. But what I can tell you is that our government right now is undergoing a study of all of the different

illnesses and deaths that have occurred that have been linked to e-cigarette use. And they have not been specific to only THC oils. I have seen articles that have claimed that. I have also seen articles that have claimed they have been linked to nicotine. And I've seen articles that have claimed that they've been linked to nonnicotine products. But the bottom line is that the CDC is undergoing an investigation and a review. They will make their, their findings known hopefully sooner rather than later. I also heard another testifier say that they have not claimed any, any lives. But just yesterday, I read that the number of, of cases of illnesses is up to 530 confirmed and with 11 deaths. Now I can't, I can't specifically tell you where those have happened. I know that they've been all over the country in different states. The article that I read yesterday indicated that they were in Georgia, I believe, Florida, Georgia. I know there's been some in Minnesota, Wisconsin, and other states. There were a lot of ideas put forward by a previous testifier, but remember that this study is about the, the Nebraska Clean Indoor Air Act. And the intent of that Act is to preserve and protect clean air for the general public.

HOWARD: Thank you. Are there questions? Seeing none, thank you for your testimony today.

NICK FAUSTMAN: Thank you.

HOWARD: Our next testifier for LR173. Good afternoon.

BRIAN KRANNAWITTER: Good afternoon. I'll be brief. My name is Brian Krannawitter. I'm the government relations director for the American Heart Association. I'm here today submitting testimony regarding LB173 [SIC]. And thank you for the opportunity to--

HOWARD: Could you spell your name first?

BRIAN KRANNAWITTER: Sure. It's a-- first name is Brian, B-r-i-a-n, last name is spelled K-r-a-n-n-a-w-i-t-t-e-r.

HOWARD: Thank you.

BRIAN KRANNAWITTER: And just a couple of points that have kind of been brought up with respect to the CDC and I, I just literally checked on their Web site as my colleague from American Cancer Society said, at least as of 1:00 p.m. Eastern, they had not withdrawn their warning if you will regarding e-cigarettes. And they also posted on there, there's been 105 lung injury cases from 46 states and 12 deaths have been confirmed from 10 different states. So I just want to give you the latest information. What I had as a handout, it's just a 101 we call it from HA, describes what is vaping, was is, was is e-cigarettes. It gives examples of what they look like. It talks a little bit JUUL. You can use it refer to it on questions regarding e-cigarette products. Vaping is the act of inhaling and exhaling the aerosol often referred to as vapor which is produced by an e-cigarette

or similar device. The term is used because e-cigarettes do not produce tobacco smoke or rather an aerosol often mistaken for water vapor that actually consists of the fine particles. Many of these particles, and this has been talked about before, contain varying amounts, varying amounts of toxic chemicals that have been linked to heart and respiratory diseases and cancer. I should also point out from the Surgeon General's Web site, it states, quote, even breathing e-cigarette aerosol that someone else has exhaled poses potential health risks. And that is on the Surgeon General's Web site if you go to e-cigarettes.surgeongeneral.gov. That's where I found that from. With respect to statutory changes as it relates to the Clean Indoor Act, it makes sense to include all cigarette-- all e-cigarettes as the FDA has stated, even e-cigarettes labeled as nicotine free could still expose users to toxic chemicals known to cause serious health effects. Also, just from a practical enforcement perspective, [INAUDIBLE] enforcement, it makes sense as well. And I also do believe if you look at-- for example, the Lincoln Public Schools' tobacco policy, and I think even Grand Island tobacco policy, it doesn't distinguish between e-cigarettes that contain nicotine and those that do not. It just refers to e-cigarettes. That's all I have this afternoon. Thank you for this opportunity to testify, and I'd be happy to answer any questions.

HOWARD: Thank you. Are there questions? Seeing none, thank you for your testimony today.

BRIAN KRANNAWITTER: Thank you.

HOWARD: Is there anyone else wishing to testify for LR173? Seeing none, Senator Quick, you're welcome to close.

QUICK: Well, thank you. I think we've heard a lot of interesting and educational testimony. One thing I did want to clear up that was about the polyethylene glycol. According to our information that it is a carcinogenic, but it says via ethanol oxide, which I can't explain what that means, but it says it can cause breast cancer and uterine cancer. So I just wanted to clarify that. You know last week, I know I had the opportunity to testify in the public health districts and I talked a lot about preventative care, preventative-- prevention and how we can save-- that saves us the cost in the long run. And I think we need to really pay close attention to what we're doing with, with, with this and make sure that, that we're doing what's best in the best interests of our constituents. And I think what we're seeing out there in our schools is really troubling for me. You know, my whole object last year was to make sure we get it out of the hands of our children. And I still believe that 21 was the right age. We passed 19, but I still think that's important to maybe address that at some point. I know that's not part of this study, but I think the Clean Indoor Air

Act is another part of that because our children are still exposed to those secondhand-- exposed to secondhand or maybe even thirdhand as we found out. And so I think that's an important thing for us to try to figure out. I can tell you that I have witnessed personally someone in my family who used to smoke and I'm not advocating for smoking or vaping or any other thing but they used to go outside to smoke and now they vape in front of their children, right with the children in a room, and I think that's a dangerous thing that can happen. I know the Clean Indoor Air Act won't address that but I think more education for our public will help address some of those issues along with what happens out in the public. I think-- I know if I had my grandchildren out with me at a restaurant and someone's vaping I'm probably gonna move to another place or go to another restaurant because I don't feel I want to expose them to that, to that problem or that issue. I can tell you firsthand experience my grandparents on my mother's side both smoked. My grandmother died at-- as I-- when I was a senior in high school and my grandfather passed away right after we were married. My wife and I were married and before we had our first grandchild. So they never had the opportunity because of a lifetime of smoking and a lifetime addicted to nicotine. And I think that's what we're trying to address here is the, is the fact that people-- whether there's other harmful, harmful chemicals in the, in the-- in vaping products, there's still nicotine in a lot of these products. And we're trying to address the fact that we're seeing people-- or we're seeing children

who never vaped before becoming addicted to nicotine. And, and that can also happen with-- you know, it worries me that that can happen with secondhand exposure as well. So I hope this is something that we can look really closely at this next year and see if there's something that we think that we can do. I think the original intent of the law was to make sure that we kept up with, with progress and to make sure when new technical devices come out or whatever-- whether other form of tobacco use comes out that we address that in-- and include that in the Clean Indoor Air Act. So with that, thank you very much. And I look forward to working with you.

HOWARD: Thank you. Are there questions-- any final questions for Senator Quick? Seeing none, this will-- thank you, Senator Quick, this will close the hearing for LR173. Have a good weekend.