HOWARD: 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 this committee. I'd like to invite the members of the committee to introduce themselves, starting on my right with Senator Murman.

MURMAN: I'm Senator Dave Murman from District 38: Clay, Webster, Nuckolls, Franklin, Kearney, Phelps, and southwest Buffalo County.

WALZ: Lynne Walz, District 15, Dodge County.

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

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

CAVANAUGH: Machaela Cavanaugh, District 6, west central Omaha in Douglas County.

B. HANSEN: Ben Hansen, the best district, District 16: Washington. Burt, and Cuming Counties. No offense to my--

HOWARD: Woah, this got awkward.

[LAUGHTER]

HOWARD: Also assisting our committee is our legal counsel, T.J. O'Neill, our committee clerk, Sherry Shaffer, and our committee pages today are Angenita and Nedhal and they're amazing. A few notes about our policies and procedures; please turn off or silence your cell phones. This afternoon, we'll be hearing five bills and we'll be doing two gubernatorial appointments 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 green testifier sheets. If you are 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. If you are not testifying at the microphone but want to go on record as having a position on a bill being heard today, there are white sign-in sheets at each entrance where you may leave your name and other pertinent information. Also, I would note if you are not testifying but have written testimony to submit, the Legislature's policy is that all letters for the record must be received by the committee by 5:00 p.m. the day prior to the hearing. Any handouts submitted by testifiers will also be included as part of

the record as exhibits. We would ask if you do have any handouts, that you please bring ten copies and you give them to a page. We do use a light system in this committee. Each testifier will have five minutes to testify. When you begin, the light will be green. When the light turns yellow, that means you have one minute. And when the light 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. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters of the bill then from those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given an opportunity to make closing statements if they wish to do so. We do have a strict no-prop policy in this committee. And with that, we'll begin today's hearing with the gubernatorial appointment of Brent Heyen to the Commission for the Blind and Visually Impaired. Welcome, Brent. Good afternoon.

BRENT HEYEN: Thank you.

HOWARD: So we were hoping you could just tell us a little bit about yourself and, and sort of your work-- your experience with the Commission for the Blind and Visually Impaired.

BRENT HEYEN: Well, I grew up in a-- or out in the country near Syracuse, Nebraska, where I, of course, went to school. I first started receiving services during my junior year in high school. Of course, back then, it was Services for the Visually Impaired, not the Commission for the Blind. And at that point, I not only started receiving vocational rehabilitation, but also during the summers-- for a couple of summers, I started attending their WAGES Program, which stands for Work and Gain Experience in the Summer, which of course for me, was the first job that I had ever had at that point. So of course it was, you know, a pretty life-changing experience for the better, of course. And as I grew up, I eventually became a counselor for that program where I worked with blind youth. It's usually a six-week program and eventually-- I mean, of course, I eventually became a teacher, which you can say that was kind of, you know, an experience that really kind of helped with that. I have continued to work with WAGES through the years. I also was the chairman for the committee that found-- that made the-- set up the, the anniversary celebration that we had for the Orientation Center for the Blind, which I did attend, actually, between my senior year in high school and my

freshman year in college. I, at that point, was-- we created an alumni association. Unfortunately, that was a bit short lived, but I was elected as president of that, where we raised money to help support the orientation center as well as to give graduates of the orientation center just an opportunity to reach out to other graduates so they can continue to learn and to grow and really just not feel quite so alone, especially for those who are out in the boondocks, so to speak; out in, like, western Nebraska, that sort of thing. You know, I've just-- throughout the years, I've been able to give back in what ways that I can. And I, you know, look forward to hopefully, being that I'm confirmed, to have the opportunity to do that again.

HOWARD: That's wonderful. Thank you. Let's see if there are any questions from the committee. Are there questions? Senator Williams.

WILLIAMS: Thank you, Chairwoman Howard. And thank you, Mr. Heyen, for being here. What is your vision for the group that you're dealing with, the commission? What, what do you see as the main purpose and what you could be doing for your state?

BRENT HEYEN: Well, my main purpose would be to help with the vocation-- vocational rehab-- excuse me, the vocational rehab-- I can't talk today-- the rehabilitation of the blind in Nebraska, which not only includes people who are partially sighted such as myself, but those who are totally blind-- to help them to get the skills to be successful in life so that they can work at the same level as their peers, something that thankfully, you know, through the training that I've received and have been able to do myself. I currently work as an assistant general manager of a hotel here in town so--

WILLIAMS: Thank you. You're a great example of what can be done with the commission. Thank you.

BRENT HEYEN: Thank you.

HOWARD: Any other questions? Seeing none, we very much appreciate your willingness to serve on the commission. And we will, we will send your confirmation to the floor to be considered by our colleagues. Thank you so much.

BRENT HEYEN: Thank you.

HOWARD: Thank you. All right, this will close the gubernatorial appointment for Brent Heyen and open the gubernatorial appointment for

Kimberly Scherbarth for the Commission for the Blind and Visually Impaired. Welcome, Kimberly. Good afternoon.

KIMBERLY SCHERBARTH: Good afternoon.

HOWARD: So we were hoping you could just tell us a little bit about yourself and your interest in serving on the commission.

KIMBERLY SCHERBARTH: OK. Well, I am from Kearney, Nebraska. I've had the opportunity to receive training from the Nebraska Commission for the Blind and Visually Impaired. I actually also went through the training center in the summer of 2015 to early 2016 and had the opportunity to gain skills that I needed so that I could return to the workforce. I currently am working now at the University Nebraska-Kearney in disability services for students. As far as, like-- I'm-- was your question also about my vision for the--

HOWARD: Sure. We'd love to hear your vision for it. That's wonderful.

KIMBERLY SCHERBARTH: OK. Well, for me, I am a very big proponent for individuals gaining skills that they need, even at a young age. I've had the opportunity to, like Brent, work the WAGES Program, also Project Independence with younger blind children in Nebraska, for your independence with older blind individuals, and just sharing the skills that I've learned so that their everyday life can be like mine; better, having the skills to do the things that I want to do and give back.

HOWARD: That's wonderful. OK, let's see if there are any questions from the committee. Senator Cavanaugh.

CAVANAUGH: Thank you. Thank you for being here. I'm interested-- would you mind sharing a little bit more about what you do in your role at the university?

KIMBERLY SCHERBARTH: I oversee the lab and testing center where students come in who may have some type of accommodation, specifically for testing. I'm actually serving right now as an interim TRIO disability advisor, where I'm also helping students get set up with the accommodations that they may need to be successful in college and beyond.

CAVANAUGH: What is TRIO?

KIMBERLY SCHERBARTH: It is a, it's a federal program that helps students who may be from one of three categories. They may experience some type of disability, they may be a first-generation student, or they may come from a lower socio-economic status. And there's-- they have a lot of supports that are built in for them. Like, there are a bunch of, like, foundation courses that teach them basic things like study skills. There are peer mentoring programs. There just are a lot of things to help the students succeed who may not have a background where their parents have been a previous college student or they just don't have those supports outside of the university.

CAVANAUGH: Thank you and thank you for your willingness to serve on this commission and sharing your experience.

KIMBERLY SCHERBARTH: Sure.

HOWARD: Any other questions? Senator Arch.

ARCH: Thank you. Question: you, you and Brent both referenced skill training. What, what is available-- what types of skills are available for training there?

KIMBERLY SCHERBARTH: Well, at the training center in Lincoln specifically, you receive training on orientation mobility so if you're using the long white cane, skills training, also, in-home management, cooking, learning to do things nonvisually that you may have been doing previously with vision. Let's see, Braille; that's a-- I'm a big proponent, proponent for Braille. This summer, we're going to be having a Braille program for kids on campus. But let's see, shop just basic things like fixing things around the house, learning to do things that you may believe that you don't have the ability to do because of vision loss, but kind of gaining confidence in your ability to do anything within reason, just with alternative skills.

ARCH: All right. Thank you, thanks. That's educational for us. Thank you.

HOWARD: Seeing no further questions, we appreciate your willingness to serve and we'll send your confirmation to the floor for consideration by our colleagues.

KIMBERLY SCHERBARTH: All right, thank you.

HOWARD: Thank you so much. All right. This will close the gubernatorial appointment for Kimberly Scherbarth and open the hearing

for LB893, Senator Bostelman's bill to change provisions relating to emergency care providers and provide for community paramedicine and critical care paramedics. Welcome, Senator Bostelman. Good afternoon.

BOSTELMAN: Good afternoon, Chairwoman Howard and the Health and Human Services Committee. My name is Bruce Bostelman. That's B-r-u-c-e B-o-s-t-e-l-m-a-n and I represent the best legislative district, 23. I am here today to introduce LB893, which provides for community paramedic and critical care paramedic practice and discipline of training agencies; removes limits as to where they can practice their already approved scope under medical supervision; eliminates obsolete provisions; and changes provisions relating to the State Trauma Advisory Board. LB893 is supported by the recommendations of the Nebraska State Board of Health and Nebraska Rural Health Advisory Commission as well as unanimous-- unanimously, approval of those recommendations by the Emergency Medical Services Board. I would note that the director's report of the 407 credentialing review outlines how this proposal is supported by the Technical Review Committee and Board of Health and meets all of the necessary statutory criteria. LB893 grants EMS Board the statutory authority to create a process for licensure and certification of critical care and community paramedic practice by adding it to our current framework of EMS programs and licensure classifications. It will also update statutes by removing antiquated phrase "out-of-hospital." Critical care transportation has developed over the last few decades to involve a larger scope of practice for paramedics. Yet current paramedic education does not include the necessary knowledge and skills to manage patients in need of critical care. The International Board of Special-- Specialty Certification does not believe paramedics should work in a critical care environment without being certified specifically in that field. And the legal risk is much greater without validation of clinical-- of clinic competency. Research, according to the findings of the Nebraska State Board of Health, shows that paramedics currently deliver medical care using equipment and medications at a level above their education qualifications and for which they are not certified. Also, it shows that patients requiring transportation and needing critical care performed will continue to grow and this development of guidelines and standards are necessary for the public safety. Essentially, current education and certification programs do not prepare paramedics for roles and critical care transport and so additional specialized education and credentialing is necessary for safe practice in critical care environment. Not to mention, Nebraska is a geographically large rural state. This is even more evident when you consider how much we,

as a state, rely on our paramedics and critical care specialists. Numerous states have made policy adjustments to EMS personnel involved in critical care transport. According to the International Association of Flight and Critical Care Paramedics, these include nearby states of Colorado, Iowa, Kentucky, Michigan, Montana, Oklahoma, and Wisconsin. Critical care transport paramedics are not currently recognized in Nebraska, yet they are-- yet there are no statutory limitations or restrictions on critical care transport since it's not a recognized or regulated occupation. This leads to patients being potentially at risk due to lack of oversight, minimums or certification, credentialing, education, and licensure requirements. LB893 would simply recognize and provide that needed oversight for critical care paramedic practice and require completion of a certif-- certification application with the EMS Board. Mobile integrated health community paramedic programs have been increasing more and more throughout the past decade. These programs are designed to meet individual community healthcare needs. Services provided may include helping those with chronic diseases and posthospital discharge follow-ups to prevent readmissions, helping navigate patients to the related healthcare destinations such as the urgent care or primary care instead of the emergency room, provide assistance to nonurgent 9-1-1 callers, and using telemedicine practice to facilitate patients at home with healthcare providers. To begin the community paramedic practices, these EMS services will be required to obtain the required approval from the Nebraska EMS Board and Nebraska Department of Health and Human Services prior to any provider beginning mobile integrated healthcare community paramedic services. To obtain this approval, the EMS service will have to submit an application that will show the need of community healthcare in their territory, outline the details of what services will be provided, provide for how EMS personnel and other healthcare professionals will gain the education required on patient care for their services and how medical oversight of the program will be provided by the physician, by the physician medical director. I have handed out an amendment for LB893 for your committee's consideration, which contains language that all stakehold-- all stakeholders have agreed upon. This is a result-- as you know, we had the bill three-parted and then we've met since then. So this is language clarifying some of the areas the people, the stakeholders had concern so it's for your consideration for that purpose. Essentially, LB893 will provide education and training requirements to critical care practice that is already being performed across the state by EMS service providers and save money by preventing unnecessary visits to the hospital emergency rooms for patients whose need could be just as well taken care of at home with a community

health component. Therefore, I ask for your support of LB893 and its advance-- advancement to General File. There will be experts of this subject matter following me and I will be glad to answer any questions. Thank you.

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

B. HANSEN: Thank you. You put in-- you put me in a bind here, Senator Bostelman. His district is where all my family lives. So maybe your district is a better one. [LAUGHTER]

BOSTELMAN: Need I say more?

B. HANSEN: No, it's not. So can you, like, maybe just talk a little bit more about the change with the nurse, the registered nurse?

BOSTELMAN: I think the nurses and Dr. Smith will be following behind me and I'll let them answer those questions.

B. HANSEN: OK, thanks.

HOWARD: Other questions? Will you be saying to close?

BOSTELMAN: Yes, I will.

HOWARD: Wonderful. Thank you.

BOSTELMAN: Thank you.

HOWARD: All right. We'll invite our first proponent up for LB893.

JAMES SMITH: I feel like I'm in a kid's chair, kind of low. Good afternoon, Chairman Howard. My name is Dr. James Smith and that is spelled James, J-a-m-e-s, Smith, S-m-i-t-h. I'm a board-certified emergency medicine physician and chairman of the Nebraska State EMS Board. I've been authorized, along with fellow board member Dr. Mike Miller, to speak on behalf of the Nebraska State EMS Board to offer testimony in strong support of LB893. I want to thank this committee and its members for taking up this legislation and especially would like to thank Senator Bostelman for introducing LB893 and for his ongoing support of EMS in the state of Nebraska. I will also offer testimony today from the perspective as a medical director for two critical care flight services, an ALS 9-1-1 service, three volunteer BLS services, an EMS training agency, as well as a practicing emergency physician in rural Nebraska. First of all, as an EMS Board

member, I can tell you that from our experience, a large portion of the disciplinary actions we take care-- we take at the board level are relative to standards care provided during-- substandard care provided during transportation of critical or injured patients. We have recognized there's a huge disparity in the quality of care among critical care transport agencies, which must be corrected to protect the lives of our patients. This can only be done by-- accomplishing through first, recognizing critical care as a level of licensure; secondly, establishing education requirements; third, requiring those providers to obtain critical care certifications; and lastly, development of supporting rules and regulations. Make no mistake, people are dying in Nebraska due to lack of critical care transport oversight and the board urges you to support this initiative. Relative to community paramedicine, as an emergency medicine physician with 32 years of practice experience, it disheartens me to continue to care for patients in my emergency department whose visit and potential hospitalization could have been prevented if they would have been evaluated earlier by a trained, qualified healthcare provider who could have identified their impending decline and subsequent now emergent visit to my ER. Our vision would be to allow certified community paramedics throughout Nebraska to be utilized to go into these homes, which paramedics do already on a daily basis. But instead of being called for an emergency, they could identify patients that may require an expedited visit to the provider's office or referral for a higher level of in-home care to prevent their decline. You may hear today that this is already being done in Nebraska by home health and visiting nurses. But there is a huge shortage of these providers who, in my region, can only see a limited number of patients due to extreme distances from their offices or cannot treat those patients who do not qualify for traditional services. How wonderful would it be if someone who actually lives in that community could travel just a few miles or even a few blocks to bridge this gap? I've included an article from the Omaha World-Herald dated September 14, 2019 in your packet in which the Dean of the University Nebraska College of Nursing, Juliann Sebastian, states through data obtained through the Nebraska Center for Nursing, latest workforce reports put the current nursing shortage in Nebraska at 4,062 and estimates that the number to grow to 5,436 by 2005, an increase of almost 34 percent. We have to bridge this nursing shortage and utilize community paramedicine and trained providers as a model that has been proven to be successful and already used in many other states. There are also a few other changes in LB893 that are noteworthy. We have recommended the removal of "out-of-hospital" as the term is simply antiquated. No other state

uses this verbiage and certainly, it's inaccurate as many hospitals already utilize EMS providers and have done so for decades. However, related to these changes made particularly on page 24, where it prohibits an EMS provider to practice their scope unless they are acting under the supervised-- supervision of a licensed healthcare practitioner. In the previously quoted article, Catherine Todero, dean of Creighton's University College of Nursing, highlights the even greater nursing shortage in rural Nebraska, "yet rural areas face greater changes with supply. Most of the growth in nursing-- 88 percent-- have been concentrated in metropolitan areas. Eighty-four of the state's 93 counties have fewer registered nurses than the state average of 1,300 per 100,000 people. Five counties have no registered nurses or licensed practical nurses." Lastly, a recommended change is to provide for disciplinary action against training agencies by the EMS Board. We currently have no mechanism to ensure our training agencies are successful in producing EMS providers that are qualified, competent, and able to obtain licensure. Our volunteer squads often spend thousands of dollars educating their volunteers only to have them incapable of obtaining certification. This provision would allow the EMS Board to provide process improvement plans from agencies with poor pass rates and even ultimately revoke training agency licenses if they fail to improve. I want to thank this committee for your consideration of LB893 and would be happy to answer any questions.

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

MIKE MILLER: Honorable Nebraska Senators of the Health and Human Services Committee, thank you for the opportunity to provide testimony this afternoon regarding LB893, a bill important to the future of emergency medical services delivery in Nebraska. My name is Mike Miller, spelling of my last name is M-i-l-l-e-r. I am a paramedic, EMS instructor, registered nurse, working in emergency medicine for 35 years. The last 17 years, I've worked at Creighton University, where I currently serve as assistant professor and EMS education program director. I address you today as a member of the Nebraska Board of EMS and the EMS Board's designee to the Nebraska Board of Health Credentialing Review Program process. I would like to ask for your support of LB893. The bill seeks to address three main goals: (1) remove-- removal of the reference "out-of-hospital" throughout much of the EMS Act; (2) the ability to formally regulate critical care paramedics through certification; and (3) the ability to formally regulate community paramedicine. It is important to share a brief

history of how these initiatives have come before you today. In April of 2016, the Nebraska Board of EMS, with several other Nebraska EMS stakeholders, participated in a facilitated strategic planning process, followed by two years of listening sessions throughout the state. Several strategic initiatives have developed from this work, including a new EMS Practice Act approved by the Nebraska Legislature in 2018 and subsequently signed by the Governor. Rules and regulations have been developed and a public hearing was completed on January 30, 2020, with no opposition. The goals above were removed from LB1034 and the EMS Board was encouraged to engage the credentialing review program's process. Following a lengthy Technical Review Committee process and action on behalf of the Nebraska Board of Health, the Board of Health unanimously approved the EMS proposals. Subsequently, Gary Anthone, Chief Medical Officer and Director of Division of Public Health- Department of Health and Human Services, in a report to the Legislature, supports changes outlined in the proposal. It is also important to note the Nebraska Board of EMS has unanimously supported these initiatives and continues to do so. The board is an all-volunteer group of subject matter experts committed to protecting the well-being of all Nebraskans through safe and evidence-based EMS practice. Comprised of EMS personnel, three board-certified emergency physicians, a physician assistant, RNs, and educators representing paid, volunteer, urban, rural, basic life support, and advanced life support agencies, collectively, the board has over 400 years of medical experience. Goal number one: removal of the reference "out-of-hospital" throughout much of the EMS Act. The term "out-of-hospital" is an antiquated term. Paramedics have been working in a multitude of healthcare settings for many years in Nebraska and beyond. When I arrived in Nebraska nearly 18 years ago, paramedics were providing care alongside physicians, nurses, and other healthcare professionals in Nebraska emergency departments. Paramedics are healthcare professionals licensed in Nebraska with a defined scope of practice. LB893 recognizes the reality that exists in Nebraska. We need paramedics in a multitude of healthcare settings to best serve patients. Nationally, this has been recognized in the 2019 National EMS Scope of Practice document, which states: paramedics work in a variety of specialty care settings, including but not limited to ground and air ambulances, occupational, in-hospital, and community settings. Goal two: the ability to formally regulate critical care paramedics through certification. Tertiary care centers will continue the need for and likely increase critical care transport services. Medical advancements are making care more complex and sophisticated. Educated, certified, and credentialed EMS critical care transport

providers are capable of providing additional procedures currently not addressed in the paramedic-level scope of practice. Without a robust critical care transport infrastructure in Nebraska, the health and well-being of patients in our state are at risk. Currently, there is a lack of regulatory oversight for the specialized services being performed when critical care transports are necessary. It is impossible to quantify substandard care because the practice is not regulated. Therefore, there are no safeguards in place to assure minimally-competent providers. Over the past few decades, healthcare has advocated for a culture of safety. Safety involves process evaluation and improvement with oversight and minimum standards. Existing EMS personnel and services are poised to continue to deliver these services and bridge emergency scenes and critical access hospitals with the specialized care they need. The International Board of Specially Certification, as you've already heard, does not believe that paramedics should work in a critical care environment without being certified. The legal risk and potential harm to patients is exponentially increased without validation of clinical competency. LB893 helps us establish minimum standards for those involved in critical care transports. If I may?

HOWARD: Yes.

MIKE MILLER: Quickly, sorry. Goal number three about community paramedicine: the concept is not new. Programs began in many areas of the country in 2004; 93 percent of states have community paramedics or plans to implement them. The majority of community paramedic programs focuses on admission/readmission avoidance, 81 percent; manage frequent EMS/ED users, 72 percent; and chronic disease management, 72 percent. Collaborative partners in a community paramedic program sees hospitals, physicians, paramedics, home health agencies, and others working together in order to make this happen. I'll leave the rest of the comments on community paramedic for you to read in, in my report. The bottom line here is that over the past two years, the EMS board and EMS stakeholders engaged the credentialing review program process to seek changes in scope of practice and formally recognize and regulate critical care and community paramedic personnel. An interdisciplinary Technical Review Committee, following months of meetings with testimony, recommended to the Nebraska Board of Health support for both proposals. The Nebraska Board of Health unanimously voted to support the proposals with subsequent support of the Chief Medical Officer and director of Department of Health in DHHS. I am asking again for you and your colleagues in the Legislature to support

LB893. And we'd like to thank Senator Bostelman for his leadership and ongoing support of EMS through the introduction of LB893. Thank you for allowing me to share my views and I'm happy to answer any questions that you may have.

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

WILLIAMS: Thank you, Chairwoman Howard, and thank you for being here today. So the end of your testimony, what you talked about there, so it is fair to say that this has gone entirely through the 407 process and been fully approved through that process; is that correct?

MIKE MILLER: Yes, sir. Senator, it has.

WILLIAMS: Second thing, with-- with your education and with your teaching at Creighton, could you just give us a brief overview of the education, the additional education and credentialing process that would be required?

MIKE MILLER: Sure. So there are separate educational aspects to what was-- is proposed here. On the critical care side of things, the educational guidelines that are largely set by the International Board of Specialty Certification, there is no other national entity that has done that for this level of EMS provider; outlines a curriculum. At the university, just to speak for my own program, that program is roughly around 120 to 130 hours in total, which includes required clinical time in a critical care environment within a hospital. It is actually a very accessible program as well. In fact, it's accessible online with the exception of a weekend or so on our campus in order to do an invasive skills kinds of lab to actually put into practice many of the skills that they're taught as part of that particular education. There are also other programs throughout the country that are accessible as well that exist in many states.

WILLIAMS: So the accessibility to the education that would be required for this certification is available across the state, roughly 120-plus hours to do--

MIKE MILLER: Correct.

WILLIAMS: Thank you.

MIKE MILLER: And to add to that, this is not necessarily requiring additional education. There could be people that are already practicing in this domain. The key here, at least in our vision as we

look at this, is to make sure that they have demonstrated that they have the knowledge and abilities to safely practice at this level. And that could be done by an examination process that exists for the International Board of Specialty Certification as well.

WILLIAMS: Thank you.

MIKE MILLER: My pleasure.

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

MIKE MILLER: Thank you very much.

HOWARD: Our next proponent testifier for LB893.

DAVE HUEY: Good afternoon, Senators. My name is Dave Huey, D-a-v-e H-u-e-y. I am the first vice president for NEMSA, Nebraska Emergency Medical Services Association. We're an association made up of volunteer and paid or career EMS providers across the state of Nebraska. We are in support of LB893 and I'm handing out testimony that I was prepared to give, but a lot of it has been covered already. I'm also a paramedic that worked for a department that did critical care transports but wasn't certified and a department that also did community paramedicine visits, you know, in our community as well. So I've had experience with both, good and bad. I'd just like to say that, you know, we were part of the group that went through the 407 application, you know, and approved it as well and, you know, totally support it. NEMSA is grateful again to Senator Bostelman for his work and his efforts on this. We feel that, you know, this is a bill that needs supported to help further the critical care paramedic certification as well as the community paramedicine program. The Nebraska Emergency Medical Services appreciates the committee's consideration and urges you to advance LB893 and I'll take any questions at this time. Thank you for your time.

HOWARD: Thank you. Are there questions? Seeing none, thank you for your testimony today. Our next proponent testifier for LB893. Good afternoon.

MARTY FATTIG: Good afternoon. Senator Howard and members of the Health and Human Services Committee, I am Marty Fattig, M-a-r-t-y F-a-t-t-i-g, and I am the CEO of Nemaha County Hospital in Auburn, Nebraska. And I am here today in support of LB893, which will make

changes to the EMS scope of practice in Nebraska. Critical care transportation has developed over the past three decades to involve expanded scope of practice for paramedics. Educational programs have been designed recognizing that paramedics need additional preparation and ongoing education to prepare and maintain advanced critical care during interfacility transports, including performing advanced clinical patient assessments and providing invasive care beyond the scope of advanced prehospital care. Specialists trained with demonstrated competency are essential to the quality delivery of critical care of transport. Current paramedic education, based on national educational standards and guidelines, does not include necessary knowledge and skills to manage critical care patients during a high-risk transfer. And as was stated earlier, Nebraska is a geographically large rural state that relies upon critical care specialists to care for critically ill and traumatized patients. Currently, there is no framework in Nebraska to verify education, certification, licensure, or credentialing for personnel functioning in a critical care role. Ensuring public protection and safe quality medical care is paramount. I support the Nebraska Board of EMS in the development of statutes and regulations to formally recognize and provide oversight for EMS personnel engaged in the critical care transport. This process will entail the successful completion of a Nebraska Board of EMS-approved certification application and the requirement to make application to Nebraska licensure unit. Community paramedicine programs have been on the rise for the past decade. According to the Mobile Integrated Health Care and Community Paramedicine 2nd National Survey, forward-thinking EMS agencies designed the programs to meet individual community healthcare needs following the Institute of Healthcare Improvement's Triple Aim of improved patient care experience, improved population health, and reduced per-capita cost of healthcare. This is accomplished by identifying gaps in healthcare specific to a community. Programs are not meant to compete with existing services being provided. I recommend the Community Paramedicine Program be recognized in statute and/or regulation. Community paramedicine programs with formal associations with hospitals have been piloted in Nebraska, but because community paramedicine is not a recognized-- is not recognized, no service can be officially accepted. Advancing the community paramedicine proposal may prevent gaps in healthcare, potential return visits to the emergency room, and/or admissions or readmissions to hospitals, resulting in more effective care and reduced costs for patients and the entire healthcare system. LB893 begins the process of updating the scope of practice for EMS professionals to what is

required in today's healthcare environment. I recommend that you direct the Nebraska EMS Board to develop regulations to implement these necessary changes to the EMS scope of practice. I would also recommend that the committee refer to documents created through the 407 process for more detailed explanation of these recommendations.

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

MARTY FATTIG: Thank you.

HOWARD: Our next proponent testifier for LB893.

JERRY STILMOCK: Madam Chair, members of the committee, my name is Jerry Stilmock, J-e-r-r-y, Stilmock, S-t-i-l-m-o-c-k, testifying on behalf of my clients, the Nebraska State Volunteer Firefighters Association and the Nebraska Fire Chiefs Association in support of LB893. Everything that I could have said has been said, but particularly I wanted to take time out without too much delay in thanking Senator Bostelman. He has taken this to the forefront, recognizing the issues regarding EMS, particularly volunteers. I think it's meritorious at a public setting to say that to him. Also to the members of the Board of EMS, you've heard from two of them. There's another member I know for sure in the audience to-- to also identify, Ann Fiala. These three members and the members of the EMS Board have gone to great lengths. Most recently you've heard of the, the, the strategic plan that was the first of its kind by the Board of EMS, the two years of talking across and listening, but most importantly across the state. And this is just one of the initiatives to come out and we're anticipating many more. In terms of the volunteers, the thing that Senator Bostelman and Dr. Smith both commented upon was the disciplinary nature and the kind of the one-way ticket on training agencies. Right now, the Board of EMS, Department of Health are only able to-- the Department of Health and Human Services only have a exit ticket, if you will. They don't have anything in between to try to have corrective measures. And that's one of the items that is contained within the bill that's presented to you. We think it would be very helpful. You've heard me say before and it bears repeating that when a volunteer takes time out of their family life, their work life, to go to training sometimes upwards of six months, many in the room that are active volunteers in the room, they've done this. They know it. You know, 120 to 168-- 160 hours depending on the training agency. It's critically important that the educators. And for the most part, they are wonderful, dedicated individuals as well, but to make

sure that the education that those volunteers are receiving is paramount because it all falls back to patient safety. And I want to express that to all the members of the committee. We'd ask you to advance LB893. To the senators, I thank you.

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

MURMAN: Yes, thanks for coming in and testifying.

JERRY STILMOCK: Yes, sir.

MURMAN: How would the volunteer departments work together with the certified? Would-- would all the volunteers be certified or a certain number of them?

JERRY STILMOCK: The-- you raise a good question, Senator, because, because the volunteers in many areas are overworked. Can I say overworked? Do I say overvolunteered? But it's-- it's-- it's in areas like-- OK, how much more can Nebraskans expect the volunteers to do? So I think it would be a select area, a select group, sir, that, that they wanted to participate in some additional care within the community, the community paramedic part of it that-- let me give you an example of what I've been told, Senator. So somebody needs a postsurgical update to make sure that the vitals are being taken. Rather than that, that person having to drive to the hospital, the surgical center, or perhaps a doctor's office, that volunteer EMT or volunteer paramedic would be able to come to the home in a 15 half-- 15-minute or a half-hour setting and accomplish what might otherwise take three or four hours. I think that's the way I understood it, sir. It would only be some people that would be engaged in it, sir.

MURMAN: OK, so follow up, the volunteer that would do it wouldn't necessarily be certified then.

JERRY STILMOCK: Yeah. I don't believe so. No, sir. They would be recognized. They'd have to be approved by their medical director who's authorizing that activity in a home. But it would all flow through another cog. A so important cog of all of this is the, to whom I've just mentioned, the medical director. An active medical director is critical to the activity of that department. So the medical director says this is something that we want to do in the community. Then it would be authorized and they would be able to go into the home without the certification. The other part of what I heard, Senator, was for the certification that we heard this afternoon. It would be for those

areas of-- specifically a paramedic that would be involved in a very difficult transportation, transportation of a patient that needs that higher level of paramedic care. And that would be where I understood where this certification would come in, sir. So that would only be at the paramedic level for a specific type or classification of individual for air or ground transportation, sir.

MURMAN: OK. Thank you.

JERRY STILMOCK: Yes, sir. Thank you.

HOWARD: Other questions? Seeing none--

JERRY STILMOCK: Very good.

HOWARD: --thanks for visiting with us today.

JERRY STILMOCK: Thank you, Senators.

HOWARD: Our next proponent testifier for LB893.

RALPH MOROCCO: Good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. I'm Ralph Morocco. First name, R-a-l-p-h, last name, M-o-r-o-c-c-o. During the summer, I served as camp director for the Mid-America Council's Camp Cedars. Camp Cedars hosts about 1,500 Scouts between the ages of 10 and 17 and a number of leaders from 21 on up to-- well, I'm going to be 70 this year so some of us are older. Our camp sessions run a week long and over five weeks during the course of the summer. One of the services that's required to be offered as part of our national accreditation is a health lodge where we provide care for a range of incidents that occur at summer camp: encounters with poison ivy, cuts, scrapes, bruises, falls, medical problems like allergic reactions to peanuts in the dining hall or potential problems like a water sports accident or a concussion from a fall from the climbing tower or for those of us who are older, heart attacks or broken bones. In Scouting's finest traditions, we plan to be prepared. As such, we would like to employ a licensed emergency medical technician who is trained to deal with the wide range of problems that come up at a summer camp over many weeks with a wide range of ages. Unfortunately, the Department of Health and Human Services advises us that an EMT cannot function outside of an emergency medical service, a hospital, or a health clinic licensed by the state of Nebraska. The Department of Health and Human Services has advised us that LB893 will provide more flexibility, allowing us to

employ an EMT so long as he or she works under protocols established by the department or under protocols developed by our own camp's medical director. In the meantime, we have been advised to seek licensure as a basic life support, nontransport emergency medical service. So we would support LB893, which I believe will help summer camps like our own deliver a better quality of emergency care to those who might need it. That's all I have. If there are questions, I'd be happy to answer them.

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

RALPH MOROCCO: Thank you.

HOWARD: Our next proponent testifier for LB893. Good afternoon.

NIKI EISENMANN: Hi, good afternoon. Good afternoon, Senator Howard and members of the Health and Human Services Committee. My name is Niki Eisenmann, N-i-k-i E-i-s-e-n-m-a-n-n, and I'm here to testify in support of LB893 on behalf of the Nebraska Nurses Association. LB893 establishes the community paramedic, critical care paramedic, and strikes "out-of-hospital" in the Emergency Care Providers Practice Act. The Nebraska Nurses Association believes that all Nebraskans deserve access to safe, quality healthcare from all care providers in the healthcare team. The environment in which healthcare is delivered is constantly changing and we support healthcare team members to function to the full extent of their education and training. Services provided by our fellow public health, home health, and visiting nurses may be complemented with trained community paramedics. Paramedics also help our emergency nurses and critical care nurses with the provision of necessary care to patients with emergent life-threatening illnesses. Striking "out-of-hospital" really does not change the scope of practice in this bill. These are still emergency care providers with a specifically delineated scope as established by Nebraska Administrative Code. We believe our emergency care providers will complement the role of the registered professional nurses in the delivery of excellent healthcare to Nebraska citizens. The American Nurses Association encourages nurses to work with community paramedics to provide patient-centered care in our communities. With this, we encourage our emergency care providers to work closely and collaboratively with nurses in the regulatory process should LB893 become law. We believe there should be minimum educational standards, specific identification of roles as well as interdisciplinary cooperation. The Nebraska Nurses Association supports LB893 to provide

access to healthcare services for all Nebraskans and further believe the services rendered by those should be safe. NNA is concerned with the role confusion and oppose the language as proposed in Section 16 of LB893 identifying all types of emergency care providers with the exception of emergency responders functioning in the role of community paramedicine. We do, however, support the paramedic functioning in this role and only the paramedic with the appropriate education and training. We feel this will ensure clearly-defined roles with the community paramedic to the public with appropriate accountability for safe practice. The paramedic has the appropriate training and background to add further education and training specific to providing patient care services to clients in our communities. The Nebraska Nurses Association wishes to thank you for your time and attention to the healthcare needs of our citizens and for your consideration to support LB893.

HOWARD: Thank you.

NIKI EISENMANN: Thank you.

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

NIKI EISENMANN: OK. Thank you.

HOWARD: Our next proponent testifier for LB893. Is there anyone wishing to testify in opposition to LB893? Is there anyone wishing to testify in a neutral capacity to LB893? Good afternoon.

JANET SEELHOFF: Good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. My name is Janet Seelhoff, J-a-n-e-t S-e-e-l-h-o-f-f. I serve as executive director for the Nebraska Home Care Association. Our members represent home health agencies across the state and we wish to testify in a neutral position regarding LB893. Members of our association have no concern with removing the references to "out-of-hospital" for emergency services from the law, as it's understood that emergency medical services providers need to be able to stabilize and transport patients in a variety of settings. Members of our association attended the Technical Review Committee and Board of Health meetings last year that involved the 407 review process. Members shared comments and presented testimony in those meetings focused on ensuring appropriate care, safety, and well-being for Nebraskans to remain independent in their home and communities. When a community paramedic is responding to a

call in the home or community and determines that a client's needs are different than stabilizing and transporting to a hospital, urgent care, or facility, then the role of that paramedic ought to be to help connect the clin-- the client with a professional or other resources such as licensed, trained, and operating under the respective scope of practice to meet the patient's needs. It's the desire of our home health agency members to work collaboratively to integrate services such as public health, home health systems, and primary care providers. Referring the client to those appropriate resources is a recommended course of action. Our members also support working in collaboration with the appropriate stakeholders to directly educate Nebraskans and their family members or other caregivers on maintenance and preventative care. Home health professionals provide case management, long-term chronic disease management, wound care, physical and occupational therapy, and other specialized services. Any services provided through a community paramedicine program for Nebraskans in their homes must complement home health services and not be services that are outside the scope of practice of nurses and therapists, nor outside the requirements of home health agency licensure. Licensure assures that standards of operation are met with oversight from a governing body; services provided are defined with personnel qualifications, policies and job descriptions, background checks, orientation and training requirements, and competencies. Licensed agencies must ensure that patient rights are communicated and upheld and that the reporting requirements for abuse, neglect, and exploitation are being completed. Licensure requires that agencies have policies defining criteria for admission, discharge, and transfer, patient care policies and procedures, documentation protocols, a comprehensive infection control program, an emergency preparedness plan, and a quality assurance performance improvement program that is integrated into all aspects of home health agencies' operations. Patients have an extensive medication reconciliation at mit-- at admission and also as changes occur. A multidisciplinary plan of care is developed in conjunction with a certifying physician. The agency is required to communicate all of the patient's plan of care to all providers who write orders for the patient documentation, background checks, orientation and training requirements, competencies as well as patient rights and the reporting requirements for abuse, neglect and exploitation. As our state moves forward with implementation of a community paramedicine program, our home health agency members intend to work collaboratively with the EMS providers and other stakeholders to help ensure that the more than 50,000

Nebraskans continue to receive home health as well as companion services and other nonmedical care. Thank you for your consideration.

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

JANET SEELHOFF: Thank you.

HOWARD: Our next neutral testifier for LB893. Good afternoon.

GARY ANTHONE: Good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. My name is Gary Anthone, G-a-r-y A-n-t-h-o-n-e, and I am the Chief Medical Officer for the Division of Public Health within the Department of Health and Human Services. I'm here to testify in a neutral capacity on LB893, which amends the Emergency Medical Services Practice Act and related statutes. In 2019, the department's Credentialing Review Program completed two evaluations for the emerg-- emergency medical services profession, one for critical care paramedicine and the other for community paramedicine. The credentialing review process determines the need for regulations of professions who are seeking a new credential or a scope of practice change. Recommendations are received from a Technical Review Committee, the Board of Health, and the Director of the Division of Public Health upon completion of the review process. The critical care paramedicine application received recommendations approving the application by all three bodies. The community paramedic application received recommendations approving the application by the Board of Health and the Director of the Division of Public Health. The Technical Review Committee had a majority vote to also recommend approval. Final reports can be found at the link in your testimony paper. The department has recommended the following changes to LB893. Section 16, Section 23, and Section 30, Item 12: for consistency throughout the bill, change "community paramedicine" to "community paramedic". Section 18: this section establishes the licensure classification levels before and after December 31, 2025. The section referring to emergency care providers prior to December 31, 2025, should include community paramedic and critical care paramedic. Section 33: Item 3 should be reworked to add clarity to the section. We recommend removing the section that was added and replacing it with "in a setting other than emergency medical service." Because this section is referring to licensed healthcare practitioner, lines 23-25 should be deleted. Item 4 should be added with the following language: "a registered nurse may provide for the direction of an emergency care provider in settings other than an emergency medical service." DHHS

understands that Senator Bostelman has drafted an amendment that would make these changes to LB893. If this amendment were to be adopted, DHHS would support this bill. DHHS would like to thank Senator Bostelman for sponsoring this legislation and for his support of emergency medical services in Nebraska. Thank you for the opportunity to testify today. I'd be happy to answer any questions.

HOWARD: Thank you, Doctor. Are there questions? Have you had the opportunity to see the amendment that Senator Bostelman shared with us?

GARY ANTHONE: I have not yet, no, Senator.

HOWARD: Thank you. I'm sure he'll share it with you. And then once we know that it's OK, would you share that with us?

GARY ANTHONE: Yes, sure.

HOWARD: All right. OK. Any other questions? Seeing none, thank you for your testimony today. Our next neutral testi-- testifier for LB893. Seeing none, Senator Bostelman, you are welcome to close. And while he's coming up, we do have four letters in support: Laura Ebke, Platte Institute; Marc Harpham, City of McCook Fire Department; Rodrigo Lopez, Children's Hospital and Medical Center; Julie Wihelmson, self. No letters in opposition. No neutral letters. Welcome back, Senator Bostelman.

BOSTELMAN: Thank you, Senator Howard. A couple things: I'd like to thank everyone who came to testify today. I really appreciate those testifiers coming here. Some of them drove quite a ways to be here today. And I would also like to answer a couple questions. Senator Murman, they both would have to be certified. They would have to be certified.

MURMAN: Who, who did you say would have to be certified?

BOSTELMAN: The volunteers you were talking about would have to be certified.

MURMAN: OK. They'd have to--

BOSTELMAN: Yes.

MURMAN: --all the volunteers would have to be.

BOSTELMAN: The ones who are actually performing those services that practice.

MURMAN: OK. Thank you.

BOSTELMAN: And the other thing, we did coordinate our amendment. We did talk with legal at DHHS. So I will-- I will also share with Dr. Anthone the information as well. I would like to thank you for this afternoon, for the opportunity to discuss LB893. It is an important bill that will grant the EMS Board the statutory authority to have a process in place for licensure and certification of critical care and community care paramedic practice. Granting the EMS Board the authority to oversee licensure of community paramedic practice will prevent unnecessary visits to the hospital emergency rooms and serve those in the community with care that can take place at home or via telemedicine. With that, I'd answer any questions you may have.

HOWARD: Thank you. Are there questions? Seeing none, this will close the hearing for LB893 and it will open the hearing for LB1002; Senator Bostelman, a bill to change provisions relating to wholesale drug distribution for emergency medical reasons. Welcome back, Senator Bostelman.

BOSTELMAN: Thank you. It was a long trip to get here. Good afternoon, Chairwoman Howard and the Health and Human Services Committee. My name is Bruce Bostelman. That's B-r-u-c-e B-o-s-t-e-l-m-a-n and I represent the Legislative District 23. I am here today to introduce LB1002, which amends Sections 71-7436 and 71-7444 to change provisions relating to wholesale drug distribution for emergency medical services. Section 71-7436 allows for the transfer of prescription drugs to alleviate a temporary shortage between (1) holders of a pharmacy license (2) healthcare practitioners and (3) hospitals. LB1002 adds EMS to that list to simply continue a practice that had been done previously in Nebraska for many years. This bill also clarifies that this practice does not include the regular and systemic sales to emergency medical services, but the alleviation of a temporary shortage due to usage while transporting a patient to the hospital. When advanced life support EMS units first started functioning, they were able to restock the medication and supplies they used during transport of the patient at the hospital emergency rooms and bill the patients that required them. With a change in federal statutes, this practice was no longer allowed and they began to restock at the hospital pharmacy. In January 2019, a new interpretation of the, of the statutes deemed the hospital pharmacies

had no legal authority to sell to EMS. This required EMS to purchase and restock their units from wholesale drug distributors only. The issue is that these distributors are not local or do not always have the necessary supplies in stock and on hand, causing back orders. This results in EMS providers having to constantly be waiting for necessary medications and supplies. On top of that, distributors, in most cases, require a minimum purchase, i.e., by the case, causing EMS to order more than what is needed and spending money on medications that will not be used due to expiration dates. That is why this practice is being able to restock just one-for-one at hospital pharmacies. We'll save our service providers time and money as well as keeping our state's volunteer EMS in service and properly stocked with medication. I have an amendment for the committee's consideration that includes agreed-upon language by all stakeholders. Taking this action will be a big step in assisting our state EMS providers with the logistical and financial difficulties they currently face. Therefore, I ask for your support of LB832 [SIC] and its advancement to General File. I would be happy to answer any questions and there will be subject matter experts following me.

HOWARD: That's great. Can you tell me what the amendment does?

BOSTELMAN: So the amendment-- basic-- the amendment allows for the EMS units to be able to use a hospital pharmacy to, to receive those medications that they use up basically during that transport.

HOWARD: OK. Are there questions? Seeing none, will you be staying to close?

BOSTELMAN: Yes, I will.

HOWARD: All right. We'll invite our first proponent testifier for LB1002.

JOEL SACKS: Good afternoon, Senator Howard and other senators. I'm Joel Sacks, J-o-e-l S-a-c-k-s. I am the fire chief of Ponca Hills Department that has provided advanced life support service since 1981. I am a former paramedic and have been in emergency medical services for 45 years. In the early years of advanced life support in Nebraska, supply restocking was very simple. When we transported a patient to a hospital, we were able to restock our supplies on a one-to-one basis. If we used it, we were able to acquire it and the hospital would bill the patient for what we restocked. Insurance regulations changed and hospitals no longer could bill the patient, but we were still able to

purchase our medications and supplies from the hospital. This made it very easy for small departments and larger departments for restocking medications. February 4, 2019, we received a communication from our medical director detailing a change at Nebraska DHHS that prevented hospital pharmacies from selling us medications. I was directed to a wholesale supplier, multiple telephone calls, emails, communications, forms. When they found out we were a small user, they pretty much didn't return my calls. That leaves us purchasing from our current supplier that requires a minimum purchase. For example, if we need to purchase fentanyl, which is a Class II narcotic, we have to order a minimum of 10. And those will expire before a smaller agency will use all of them. And the other issue with the wholesale supplier; I got on their website yesterday and fentanyl, in the form that we use, is back-ordered for three to four weeks. So if we are out of a medication due to a transport, we won't be compliant with state EMS statutes for carrying the necessary medications. Approval of this bill will allow us to once again restock necessary medications from the hospital on a one-by-one basis in emergency situations where we run out of a supply or are not able to get a supply in, in a timely fashion. I ask your support of this bill and thank you for your time. And do you have any questions?

HOWARD: Thank you. Are there questions? Seeing none, thank you for visiting with us today.

JOEL SACKS: Thank you.

HOWARD: Our next proponent for LB1002.

RHONDA MEYER: Good afternoon, Senator Howard and senators of the Health and Human Services Committee and Senator Hansen for supporting our region. My name is Rhonda Meyer, R-h-o-n-d-a M-e-y-e-r. I'm a volunteer paramedic and firefighter for Blair Volunteer Fire Department. I am also the EMS chairperson for the Nebraska State Volunteer Firefighters Association and supporting both agencies. As Joel Sacks had stated, approximately ten years ago, we were prohibited from exchanging any supplies or medications from our local hospital. That was a change that they made because of expenses. But we did pay for those medications and we'll continue to pay for medications that were a one-to-one swap in those situations. Our call volumes for our community were over 900 last year. And many of those, over 750, were EMS runs; many of those don't require medications. When you look at the amount of inventory that you have to keep in order to supply them, it could be a large number depending on if you are a paramedic service

versus an intermediate service, an advanced service versus a nonadvanced service. Currently, there are 20 different medication classes that are-- that we are able to carry as a paramedic service; once again, depending on the service. So when you look at the volumes of those medications, each one of those does contain an expiration date associated with them. Some medications have an expiration within six months. Some of them last two years. But when you look at the quantities that you have to purchase in order to supply those with a minimum amounts that you used-- if there's 20 different classes of medications, I may only use three classes of those medications; maybe it's the paralytic that I need for a rapid intubation of a patient. You have to buy that currently from-- Boundtree is our current vendor-- because they're very limited to those. It costs over-- around $1,100 to buy 25 vials of those. How frequently will we use that in a year? Probably three times and the expiration of that-- so we just spent $1,000 for a vial that probably costs $25 to replace. Once again, you have that large volume. There are other items, as with our EpiPens, which luckily, with the state-- they did change the statute to where we can get them as an IM injection now, rather than having to buy the $600 for a package of two. So we can buy the epinephrine in vials, but once again, those vials are coming in packs of 10 to 20 for those medications, which do expire. And if we could have that one-to-one exchange, it eliminates that need to wait for reordering to restock versus having to keep an inventory on hand. Another thing that's occurring when I'm having to buy a quantity of ten, 30 other services are having to buy a quantity of ten of those medications. And then we have shortages from our drug companies of these medications. Now I have, sitting on shelves, all these medications that are expiring, yet we can't obtain from the vendor, as Joel can't with his fentanyl. And so now we have a limited access to those. We have medications that are expiring. We're spending money to a company that's making income from that when we need it for our patients and we are not able to have it for our patients. So if we could do that one-to-one exchange with the hospital, we would have a general source. We wouldn't have all these vials sitting on shelves, which we have to then secure because we do require licensure through our medical director to carry any medical pharmaceutical medications that are prescription strength. We also require a DEA licensure if it is a narcotic that we keep on our units. So we do have a control system within our, our organizations in order to take care of those. But having that accessibility to the inventory and not having to wait for a week in order to get those supplies when they're reordered, which can impact your services on what you have available to you and to our

community when they are in need-- so if I have an allergic reaction and I have to give out an Epi shot because they're in severe respiratory distress, I want to have one right away to replace that. So it would be in coordination with our local pharmacies. Once again, we look at the cost of going to take a prescription to Wal-Mart and get that filled out or to Walgreens and get it filled versus going to the local hospital to get that filled. The cost of medications in hospitals, because they buy in bulk, they can obtain the quantities of those medications in order to replace us. If I go to get a medication from my local pharmacy in Tekamah, Tekamah may not carry that medication. So I can't just go take a prescription there and get it changed. I then have to go to Blair or to Omaha in order to get that. And when we look at our rural communities out in the distance, they don't have the easy accessibility to that. But if they were at the hospital with the patient-- I use my Epi, I use my lidocaine, I use my amiodarone, then they can just do that one-to-one exchange in order to have it accessible to them. So there are many reasons why this would very much benefit our rural services. Still, we would pay for those medications. Many of these people that use large quantities, they will continue to use their retailers that they have, that Boundtree that they utilize. But for lots of small organizations, the costs associated with that, especially with the number of runs that they have, they don't have the finances to support that when they can just do that one-to-one exchange. Thank you.

HOWARD: Thank you. All right, are there questions? Senator Hansen, do you want to check on your district, make sure it's still the best one?

[LAUGHTER]

B. HANSEN: Pretty sure it still is.

[LAUGHTER]

HOWARD: Thank you for being with us today.

RHONDA MEYER: Thank you.

HOWARD: All right, our next proponent testifier for LB1002. Good afternoon.

ANDREW SNODGRASS: Good afternoon. Thank you for the opportunity for me to take the time to speak with you today. My name is Andrew Snodgrass, A-n-d-r-e-w S-n-o-d-g-r-a-s-s. I am the paramedic manager for the City

of Nebraska City, Nebraska City Fire and Rescue. I'm here today to speak in support of LB1002, introduced by Senator Bostelman. But first, a real brief history on the problem: on November 27, 2013, the Drug Quality Security Act was enacted by Congress as a part of the Affordable HealthCare Act. And what this did, it permitted the FDA to regulate and monitor the manufacturing medications-- was, was its initial attempt. Title II of this law is the Drug Supply Chain Security Act, which is a subsequent act of it. It was created to identify and track prescription medications in the US to ensure that the medications being manufactured and received followed an appropriate chain. They weren't being counterfeit, if you will, or manufactured incorrectly to harm our patients. In that act, there's different provisions that are enacted at a different timeframe. In October 27, 2019, the latest act or the latest provision was enacted. And in the simplest form of that, it said the, the FDA regulated the pharmaceutical companies to set what the minimum quantity they want to sell. So before, as been mentioned, if we needed a vial, we could order one vial of medication or however many needed. Now as the pharmaceutical companies have set their bare minimum of what they will sell, some in cases of 30 or higher, we are unable to purchase the appropriate malware, required to purchase higher cost and higher quantities that we will not use. This will only affect, typically, advanced life support ambulances in our state that are typically at the paramedic level and carry a wide range of medications. For departments like mine who have lower run volume and have to order more medications which costs us more, we end up either throwing them away after expiration or when we do have the opportunity to take them off the shelf and put them in the ambulance used, we have such a short duration left before they expire that we don't gain a benefit off it. Furthermore, before the November 27, 2019 was enacted, we were only given about two to three-week notice from the pharmaceutical companies of what their minimum order would be. So in Nebraska City, we have an approximate annual budget line item of $30,000 for medical supplies. With this provision of the DSCSA, the Drug Supplies Security Act [SIC], I have estimated that this current fiscal year, that budget line item will be expended by 20 percent purely for the fact that I have to over order medications to meet the minimum quantity set by manufacturers. This also does not account for the increased waste and disposal fees that we'll have to follow. What LB1002 gives us is an option to be able to purchase in smaller quantities from other sources. I have spoken with various departments around the state and in my area and this-- we are on the same situation. This is not a Nebraska problem, this is a national problem. However, speaking with

these other departments, we have explored various options that are-- communicated with other options that we'd like to see. And the two that we have is the one that, that is specifically addressed in this bill, is to purchase through hospitals or another option-- pardon me-- is working through a co-op type of system with other departments as a buying power. We could share supplies, if you will. While the intent of the Drug Quality and Security Act is to ensure that our patients are given medications that have been through a set of quality control and limit the illegal sale of manufacturing medications, this has caused collateral damage to our industry and other typically smaller healthcare industries. Although this was enacted at the federal level, it must be state law rules and regulations that help us navigate the provisions and to modify those laws, rules, and regulations to help us fulfill and be compliant with the law, but be efficient within our own systems. Today, I ask for your help to find an option for us to be able to purchase these lifesaving medications that we need in order to perform our duties, while being fiscally responsible and reduce our waste of these products. This could be the difference between a service being able to provide at the advanced life support level or with a higher cost of personal medications, having to reduce their care to a lower level. And although I do not know if this bill provides us with the perfect solution with these, I believe this is a great step in the right direction to open more doors of opportunity here. Thank you.

HOWARD: Thank you. Are there questions? Seeing none, thank you for visiting with us today.

ANDREW SNODGRASS: Thank you.

HOWARD: Our next proponent testifier.

DAVE HUEY: Good afternoon, again, senators. My name is Dave Huey, D-a-v-e H-u-e-y. I am testifying in support of LB1002 on behalf of NEMSA, the Nebraska Emergency Medical Service Association. As I stated before, we're an association represented by volunteer and career EMS providers across the state. We're very concerned with this, this bill and really appreciate Senator Bostelman addressing it because we've identified two potential problems that could occur in our state. One is it's been reported to us that we've had several departments or communities whose services have considered downgrading; going from advanced service provided, you know, having paramedics or advanced EMTs in their community, to basic level because they can't afford the medications. That's not in their budget. As you know, EMS is very

limited in their budget in a lot of communities. And so they're considering, you know, not providing that level of care to the citizens because of the financial issue. The second is the potential for departments to buy in bulk and then trade or share or I'll buy a case, you buy a case; I'll give you half, you give me half. Again, not exactly legal as far as medication distribution or purchasing for medication, especially when it comes to narcotics or controlled substances. So, you know, that potential is there. When the expense gets out there, EMS becomes very creative in how we deal with things and we would like to see that not occur as well. These services need to be able to restock in quantities that they need. A lot of the small departments, as you have heard, you know, only use a limited amount of medications. They don't use large quantities on a regular basis depending on their call volumes. So in order to eliminate waste, they have to be creative and come up with other solutions, OK? So the Nebraska Emergency Medical Services Association appreciates the committee's consideration and urges you to advance LB1002. Thank you for your time. And again, I'd be happy to answer any questions.

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

LYNN REX: Senator Howard and members of the committee, my name is Lynn Rex, L-y-n-n R-e-x, representing the League of Nebraska Municipalities. We're here today in strong support of this measure. I'm not going to duplicate what's already been stated today, but I do want to underscore the importance of this financially. Obviously, the healthcare and the level of healthcare that can be provided is critically important. I think what the gentleman said before me about the fact that some departments are thinking of downgrading from advanced to basic-- we've heard that too at the league office. I think that is problematic. We really appreciate Senator Bostelman introducing this bill. We hope that you can figure out a way to get this prioritized and advanced out of the committee. Those of you that are familiar with municipalities-- several of you are, I know, former members of the Blair City Council and elsewhere-- you're looking at 529 cities and villages in the state of Nebraska; 380 of those are villages, 117 are cities in second class, between 800 and 5,000, and we have 30 cities in the first class, 5,000 and up, and of course, Omaha and Lincoln. This is critically important in terms of the financial obligations for municipalities across the state of Nebraska to make sure that our folks that are dedicated for EMS, most of, most of whom are volunteers, are able to provide this critical service and

have access to this without having to purchase things that they're never going to use and do this in a cost-effective way and in a way that just makes sense. It's just a commonsense bill and we hope you can figure out a way to prioritize this and get it advanced. Again, we thank Senator Bostelman and this committee. I'm happy to respond to any questions that you might have.

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

LYNN REX: Thanks very much.

HOWARD: Our next proponent testifier for LB1002.

JONI COVER: Good afternoon, Senator Howard and members of the Health and Human Services Committee. For the record, my name is Joni Cover, J-o-n-i C-o-v-e-r. I'm the CEO of the Nebraska Pharmacists Association and I'm here today in support of LB1002. And I want to thank Senator Bostelman for his work on this very important bill. Much of what has already been said, we support. We agree that there are issues with the hospitals in Nebraska being able to supply medications to the EMS squads. We think, though, that there needs to be one step further and that is how we can get our community pharmacies to also supply. They have been supplying to the squads until recently, when something must have changed. And we were told that we could not do that any longer. So after lots of conversations, we've-- I think we've found a solution, which is why I passed out this copy of the CFR, which is not something I usually bring as an exhibit to the Health Committee, but for, for your viewing pleasure. The section that I found in the CFR would allow for community pharmacies to provide those small quantities to the squads for emergency medical reasons. Typically, you know, we have small, small squads that need a dose or two of something. The community pharmacy can sell that to them via an invoice, not a prescription. We don't want to make it a prescription. That's problematic, with prescriptions, because if you need a controlled substance, the DEA and the federal law require that you have a patient name on a prescription. So just for the squad or for the medical director, that won't work. So we think that this is a good solution. I've shared this with Senator Bostelman and his staff and he said please bring this to the committee and let you see it. And we can certainly work with the committee and with Senator Bostelman's office to continue to, to make that amended language so that we can, we can sell both in community pharmacy and the hospitals.

HOWARD: OK, thank you.

JONI COVER: I'm happy to answer any questions.

HOWARD: Are there questions? Senator Williams.

WILLIAMS: Thank you, Chairwoman Howard. And thank you, Ms. Cover, for being here. And you mentioned in your testimony selling this to the--

JONI COVER: Um-hum.

WILLIAMS: --EMS. Do you know-- and I should have asked this of one of the others. Are the EMS operators able to charge their patients that they have transported for these drugs?

JONI COVER: I'm assuming that is a transport--

RHONDA MEYER: There is a set fee so--

WILLIAMS: I see, I know you're not allowed to speak, I'm sorry.

JONI COVER: So, so I would say yes.

WILLIAMS: I see heads shaking so--

JONI COVER: Yes, the answer is yes to your question.

WILLIAMS: That's what I wanted to know. Thank you.

JONI COVER: But I'll bet there are some smart people after the hearing that could probably explain to you more about that. But yeah, we, we can sell on invoice under a certain amount. It'd be just like if the physician office, the local physician office, needed a supply of something because they ran out and they had a patient coming in. We, we sell every day to physician offices. This would be the same sort of thing. And under this federal law, we could put that section, that language in the same section and do the same thing so--

WILLIAMS: Thank you.

JONI COVER: It's, it's a fairly easy process, but it would help alleviate those shortages; just one more way in addition to the hospitals.

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

JONI COVER: You're welcome. Thank you.

HOWARD: Our next proponent testifier for LB1002. Seeing none, is there anyone wishing to testify in opposition? Seeing none, is there anyone wishing to testify in a neutral capacity?

GARY ANTHONE: Good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. My name is Gary Anthone, G-a-r-y A-n-t-h-o-n-e, and I am Chief Medical Officer for the Division of Public Health within the Department of Health and Human Services. I'm here to testify in a neutral capacity on LB1002. LB1002, as introduced, would add emergency medical services to Section 71-7436 of the Nebraska Revised Statutes in a temporary shortage situation. The department has recommended an amendment to Section 71-7436 to subsection (2) to include emergency medical services, as defined in Section 38-1207, to emphasize that a temporary shortage does not include regular and systematic sales. The department worked with Senator Bostelman on AM2336 to address this issue and added a new subsection (i) to Section 71-7444(2) to allow for the restocking of drugs to an emergency medical service by a hospital for drugs used in the treatment and transport of a patient to the hospital. The amendment also adds a new Section (3) to govern the general stocking of prescription drugs for emergency medical services. We are grateful for the Senator's work with us and we would move our position from neutral to positive if his proposed amendment is adopted. DHHS would like to thank Senator Bostelman again for sponsoring this legislation and for his support of emergency medical services in Nebraska. Thank you for the opportunity to testify today and I'd be happy to answer any questions

HOWARD: Thank you. Are there questions? Seeing none, thank you for your testimony today. Is there anyone else wishing to testify in a neutral capacity for LB1002? Seeing none, Senator Bostelman, you're welcome to close. There are no letters for the record.

BOSTELMAN: Thank you. I'll be very brief. I would like to thank everyone who traveled great distances, distances, again, for this LB1002. I appreciate their coming and testifying. This is a very important bill. This is a need in our state and I would appreciate

your passing this on out into the General File. Thank you very much. I'd answer any questions.

HOWARD: Are there any final questions for Senator Bostelman? Seeing none, thank you for visiting with us today. This will close the hearing for LB1002 and the committee will take a brief break. We'll reconvene in about five minutes.

[BREAK]

ARCH: Your attention, please. We're going to continue now with our hearing and we will have LB1124, as introduced by Senator Howard. Senator Howard, you may begin.

HOWARD: Thank you. Good afternoon, 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 in midtown Omaha. Today I bring before you LB1124, a bill that creates the Opioid Prevention and Treatment Act. This bill creates a cash fund that will serve as a destination for funds the state of Nebraska is to receive as part of a Department of Justice settlement related to the advertising of opioids. This is also my last opioid bill that I'll be doing in my career, which is really exciting. So I'll tell you about my sister Carrie, although all of you know it, hopefully. So 11 years ago, my sister, Carrie, passed away from a prescription drug overdose. She was awesome. Like, she was a really vibrant, lovely person who was also a terrible driver. And so she'd gotten into a series of car accidents, just a lot of, like, minor fender bender things. And then she had back pain that resulted from that. And then it was recommended that she have a spinal fusion. And when she had that spinal fusion the year I graduated from college, she was sent home with an enormous bottle of OxyContin and she was never the same after that. And so my mom started the first prescription drug monitoring program, perhaps the first one in the country, here in Nebraska. And then I continued her work working on improving access for providers on what sort of medications are going out the door, making sure that consumers understand what they're getting when they are receiving an opioid medication. And I've had a lot of great partners in that. Senator Lindstrom has helped quite a bit. Senator Kuehn helped quite a bit. And so it's been sort of-- when people ask me what my legacy legislation is, it will most likely be the work that I've done around opioids here in this state. And the really exciting thing is that our opioid overdose death rates are the lowest in the country. And I have to believe it's because of Carrie. So about two years ago, the state of Nebraska took part in a

multi-state investigation by the Department of Justice to see whether opioid producers had violated both the Consumer Protection Act and the Uniform Deceptive Trade Practices Act. Over the last year or so, this state was also involved in negotiations on a settlement amount that states would receive as a result of this investigation. The purpose of LB1124 is to create a fund for those dollars when we receive them. We haven't gotten them yet, get excited. At this time, we do not know when that is, but we do know that there will likely be more than one payment over time. When the Health Care Cash Fund was established in 2001, we didn't yet have the master settlement funds. So it's not unusual for us to create funds for dollars that we know are coming in, especially if we anticipate that they might come in over the interim when we're not able to create the fund. I've also included legislative findings that pertain to opioid use in the state of Nebraska. The purpose of this language is to give background, as the funds that we will receive are restricted and must be used specifically to combat opioid use. Some examples of the possible uses for these funds include opioid use disorders and treatment, mental health and substance use disorders when they are co-occurring with opioid abuse-- this includes medication assisted therapy or MAT--recovery services, assisting incarcerated individuals with opioid addiction-- which is really helpful and interesting-- enhancement of the Prescription Drug Monitoring Program, training for medical professionals including instruction on dosing and tapering, law enforcement training, naloxone distribution-- that's the drug that you can use that can stop an overdose-- opioid abatement and research. Receiving this money will go a long way toward combating the opioid epidemic in our state. I appreciate your support. I'm happy to try to answer any questions. My intention is to ask for a Speaker priority for this bill because I think it's important enough that we should consider it this year. But I also want to make sure that I have my priority and the committee's priority for a lot of other committee bills. And so my intention is that-- to ask the Speaker for priority for this. So I'm happy to try to answer any questions you may have.

ARCH: Thank you. Are there any questions for Senator Howard? I have one.

HOWARD: Yes.

ARCH: OK, just so I understand, we're creating a fund. How the funds will be spent will be done by the Appropriations Committee with, with, within the guidance from the settlement--

HOWARD: Exactly.

ARCH: --whatever, whatever, whatever is specified in that litigation?

HOWARD: Exactly and I think what I-- what we're doing is learning lessons from our Health Care Cash Fund, right? We created a fund and we called it a healthcare fund, but we didn't really put strict parameters around its utilization. For this fund, the parameters would really be around substance-use disorder and opioid use.

ARCH: OK, thank you.

HOWARD: Thank you.

ARCH: Thank you.

HOWARD: OK.

ARCH: At this time, are there any proponents that would like to speak in favor of the bill? Welcome.

JOSHUA SHASSERRE: Thank you. Good afternoon, Vice Chairman Arch and members of the Health and Human Services Committee. My name is Joshua Shasserre, J-o-s-h-u-a S-h-a-s-s-e-r-r-e. I'm here representing the Nebraska Attorney General's Office in support of Senator Howard's LB1124. We'd like to take this opportunity-- over the past five years, we've had some opportunity to work with Senator Howard on all of the legislation that she has put forward. And we want to thank her for her efforts in ensuring that we've done what we can on prevention and treatment of opioid misuse in Nebraska. What I've circulated to the committee is a report on the initiatives that have taken place since October 2016, in which the Attorney General convened a summit on opioids at the University of Nebraska Medical Center. That report will be publicized today. I wanted to give you a copy of it just to get a sense of what our office, in conjunction with the Department of Health and Human Services, U.S. Attorney's Office, University of Nebraska Medical Center, and many other stakeholders have done to augment the work that the Legislature has done in fighting against opioid misuse. We believe, as Senator Howard mentioned, that these efforts done at a time when the opioid crisis was coming to a pitch in other parts of the country, but not necessarily here in Nebraska, that our proactive efforts have helped to mitigate against any real substantial rise in opioid misuse or overdose deaths. And that's, that's something to, to take note of and be proud of. As Senator Howard mentioned, the purpose

of LB1124 is simply to, kind of, create this repository fund for any monies that may be received yet this year resulting from any settlements that the state of Nebraska may enter into with either opioid manufacturers or distributors. Senator Howard did a very good job in terms of outlining what those strictures may be in terms of expenditures pursuant to what we anticipate out of any settlement. I can't really go much further, publicly, about our ongoing settlement negotiations with either manufacturers or distributors. However, we think that LB1124 would be quite beneficial should any settlement reach completion prior to the next legislative session. And so, therefore, we would appreciate the committee's advancement of LB1124 to General File and I would try to answer any questions you may have.

ARCH: Thank you. Are there any questions from the committee? Senator Hansen.

B. HANSEN: Thank you. I've just got a question about this-- that you handed out. Are you pretty familiar with it?

JOSHUA SHASSERRE: Most of it, yeah.

B. HANSEN: OK, I'm trying to understand, maybe, the point of it. It says the coalition to prevent opioid abuse--

JOSHUA SHASSERRE: Yes.

B. HANSEN: --but nothing in here really talks about prevention. It talks about what can we do-- what kind of medication can we prescribe in spite of opioids or what happens if there's an opioid overdose? And so any opinion at all on maybe healthier alternatives besides opioids that are medical?

JOSHUA SHASSERRE: Oh, well, I would respond to that, Senator, with saying that the report contains many examples of, particularly, what the Department of Health and Human Services has done with regard to prevention efforts in terms of awareness for opioid misuse. And I'd probably have to defer to others with regard to alternative treatments, but I-- that's also contained in that report, to some degree, with regard to what's been going on with Department of Health and Human Services, Project ECHO, and some of the curriculum that's been installed at the University of Nebraska Medical Center, Creighton Medical Center. So I'm sorry, Senator, I know that's not a great answer.

B. HANSEN: That's fine. I bring that up a little bit because people probably know that I'm a chiropractor. And so chiropractic has been shown-- and not to toot my-- this, this pertains to the question, but chiropractic has been shown to be the number one alternative to opioid-- I'm talking about research based-- along with physical therapy, along with massage, along with acupuncture, but with the most pain management that's closest to, to using an opioid. Chiropractic has been shown to be the best alternative. And so when we're thinking about trying to prevent something, what can a doctor do besides saying, look, I don't want to put you on a medication, what should I do? And so I would think the most healthy alternative would be go visit your chiropractor, go visit your physical therapist, share some more noninvasive, alternative ways that you can do to keep people off of opioids. And so when we talk about all these kind of steps about prevention of opioids, chiropractic alternative therapies are never mentioned, hardly at all. I don't know if that's a stigma, maybe, with the profession or the other noninvasive medical-- you know, non-medical alternatives. And so I was hoping that maybe we can bring some of that to light when we talk about opioid prevention, when we talk about, you know, creating a fund to help keep people off opioids.

JOSHUA SHASSERRE: Um-hum.

B. HANSEN: I mean there can be some involvement with, you know, nonmedical procedures so-- I'll get off my soapbox now so that's all I have to say. Thank you.

ARCH: Thank you, Senator Hansen. Any other questions? Seeing none, thank you very much.

JOSHUA SHASSERRE: Thank you.

ARCH: Other proponents? Welcome.

LYNN REX: Thank you, Senator Arch, members of the committee. My name is Lynn Rex, L-y-n-n R-e-x, representing the League of Nebraska Municipalities. We're here today in strong support of LB1124. We thank Senator Howard for introducing it. We also want to thank the Attorney General's Office for their longstanding work on this issue. The League of Nebraska Municipalities has been following this issue with the [INAUDIBLE] also updated by the Attorney General's Office and others on the importance of this issue and what's going on with the settlements and the litigation across the United States. So we really appreciate these efforts. We think it's a matter of when and not if

Nebraska will be getting some funds. And we, we appreciate the way in which this is drafted because if you noticed on page 3 of the bill, line 24, it mentions that this trust-- it says the fund shall exclude from the funds held in a trust capacity where specific benefits accrue to specific individuals, organizations, political subdivisions, or governments. And what we anticipate is going to be happening here is a broad-based effort to help with prevention across the state of Nebraska. And Senator Hansen, that may very well be one of the critical issues that come into play here; just to educate people on what can be done and what alternatives are out there. So we think this is critically important. We think Nebraska needs to be positioned so that when these funds come in, there's a place to put them and that our funds are restricted to that effort. With that, I'm happy to respond to any questions you might have.

ARCH: Thank you. Are there any questions? I see none so thank you very much for your testimony.

LYNN REX: Thank you and thanks to Senator Howard. Thank you.

ARCH: Other proponents for this bill? OK, are there any opponents of the bill? Anyone wishing to testify in a neutral capacity?

ELAINE MENZEL: Vice Chairman Arch and members of the Health and Human Services Committee, for the record, my name is Elaine Menzel. That's E-l-a-i-n-e M-e-n-z-e-l. I'm here today on behalf of the Nebraska Association of County Officials and I'm in a positive-neutral position. As was testified by Ms. Rex, we have also been working with the Attorney General's Office on ways in which we can assist with the opioid-related issues. And we stand ready, after the settlement is determined, for prevention, mental health, substance abuse, law enforcement, prevention in the other areas of matters that deal with the opioid-related issues. I'd be glad to answer any questions if you have any.

ARCH: OK, thank you. Are there any questions? I don't see any so thank you for your testimony.

ELAINE MENZEL: Thank you.

ARCH: Anyone else wishing to testify in a neutral capacity? I see none, Senator Howard, you are welcome to close.

HOWARD: You know, I won't really--

ARCH: Can I-- before I--

HOWARD: Oh, letters.

ARCH: I'm reminded-- I'm sorry.

HOWARD: Teamwork.

ARCH: There are some letters to enter, to enter into the record: Marjorie Shreve-- these are all proponents: Marjorie Shreve, self; Andy Hale/David Slattery, Nebraska Hospital Association; Dr. Todd Hlavaty, Nebraska Medical Association; Ken Zoucha, self, Dr. Zoucha; Roger Wiese, North Central District Health Department; Grace Knott, American Physical Therapy Association-Nebraska Chapter.

HOWARD: Thank you. Honestly, I don't have much to say in closing, but I will tell you that my wish for all of you on this committee is that you have the opportunity to have a type of legacy legislation like this where I know that I've made a difference and I know that my eight years has had value for the state of Nebraska. And that's very satisfying. So I wish that for all of you. And that's my closing.

ARCH: Thank you. Any other questions? Yes, Senator Cavanaugh.

CAVANAUGH: Thank you. Thank you, Chairwoman Howard. I know I have said this in previous bills that you've had around this issue, but first of all, I think that Carrie would be extraordinarily proud. And because of the work that you've done on this issue with Carrie, it has actually impacted my own use of opioids, which I very much appreciate. I've been prescribed opioids for various reasons, whether it's having-- giving birth or a couple of years ago, I had viral meningitis, which was horrible. I also have thrown my back out and I went to see a chiropractor in lieu of taking the opioids that were prescribed to me because I-- my awareness of this issue has been raised so much by you and your mother and the legacy of your sister. So I just wanted that stated for the record and thank you.

ARCH: Any other questions? I just would like to echo Senator Cavanaugh. You've done a remarkable job.

HOWARD: Thank you.

ARCH: Thank you. All right, well, this will close the hearing for LB1124. And we will now open the hearing for LB1058.

HOWARD: --some amendments for you. All right--

ARCH: Senator Howard, you may proceed.

HOWARD: Thank you. Good afternoon, Vice Chair 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 midtown Omaha. Today, I bring before you LB1058, a bill that creates the Population Health Information Act. This bill creates a statutory framework for operating a state health information exchange. In 2009, then-Governor Dave Heineman designated the Nebraska Health Information Initiative, or NeHII, as the state Health Information Exchange. He did this informally. So this was-- this designation was done by a letter/an executive order. And currently, Nebraska has no statutory framework for a state health information exchange other than what's in our prescription drug monitoring statutes. Founded in 2008, NeHII works by supporting-- you guys know what a health information exchange is, right?

[LAUGHTER]

HOWARD: Just checking. It's, it's, it's an electronic highway for medical records. It's actually really neat. If all of my medical records are in Omaha on an electronic health record, but I'm hanging out in Kearney and I get hurt-- Kearney is not a good example-- North Platte and I get hurt, the emergency room physician in North Platte can access my medical records in Omaha. So NeHII is like a highway between electronic health records, but it's not the repository for them. Does that make sense? OK, all right. So founded in 2008, NeHII works by supporting the transfer of information through the healthcare environment by securely sharing health information amongst healthcare providers, pharmacists, emergency rooms, urgent cares, or wherever a patient receives healthcare. This way, providers have comprehensive health history, medication history, including possible drug interactions, lab tests, allergies, immunizations, reports, and other elements of healthcare information that will enable a patient to receive comprehensive care. NeHII ensures that all data is securely managed and accessed to a number of policies and procedures governed by HIPAA and is also overseen by a data governance committee composed of experts in health information, privacy, and security. Additionally, encryption practices, auditing, and tracking of all access to health records is closely monitored. Not only does NeHII comply with all HIPAA regulations, it requires any participant of the program to comply with it also. Patient health information to participants is only available with a provider-patient relationship and each provider

is trained in how to appropriately use the Health Information Exchange. So I first began working with NeHII in 2015 when I introduced LB471, a bill that closed several loopholes in our Prescription Drug Monitoring Program, which is sort of our main-- it's our, it's our main method of fighting opioid abuse and it enabled better reporting. When Nebraska adopted this bill in 2016, it became the first state in the nation to collect all dispensed prescriptions in our Prescription Drug Monitoring Program and also one of the first states to operate their prescription drug monitoring program inside of a health information exchange. So we were sort of ahead of our time when we were doing a lot of our work on the Prescription Drug Monitoring Program. Along with being the main interstate for electronic health data, NeHII already collects immunization data for immunization reporting, electronic lab reporting, and syndromic surveillance data. And when I say already, that's what's in the bill; they're already doing it. They've been doing it for about four or five years without any statutory-- anything in statute that says that they could or should be doing it. Throughout LB1058, we address two issues. First, we enable NeHII to continue to reduce the administrative burden for hospitals and other healthcare providers through the reporting of public health data. So first, we're saying that it's OK for them to do what they've been doing for several years. Second, by designating a health information exchange, NeHII will be able to work more directly with the Center for Medicaid and Medicare Services, or CMS, to write and submit applications for federal dollars. The real purpose behind this is so that NeHII can partner with the Department of Health and Human Services and access those HITECH 90/10 funds. You may have heard about them before. We were granted HITECH 90/10 funds a couple of years ago. We didn't use them appropriately and we had to return them. HITECH 90/10 funds are specifically around things like in MMIS, which I know we've all heard about that. But it can be used around our Medicaid services. It's essentially creating an IT framework for our, for our Medicaid services. And for every dollar that-- that's a better way of putting it-- we get 90 cents from the federal government for every dime that we spend on it. So 90/10 funds are really wonderful for a state to use if we want to, sort of, move ourselves forward in how we manage Medicaid data. Eighteen states already have designated state health information exchanges. And these include some of our neighbors like Iowa, Kansas, Oklahoma, but some bigger states like Texas and Utah, New York, New Hampshire. So across the country, states are designating, in statute, what their health information exchanges are. We're very lucky in this state in that we only have one; South Carolina has three. They're all competing. They maybe don't talk to

each other. We have one, which I think is, is really effective and wonderful. So I'm bringing an amendment to you that-- to you today that replaces the bill. My gal pal Angenita passed it out. After bill introduction, we were contacted by the Nebraska Hospital Association who had concerns that the bill language, as written, would interfere with some of the work they're doing with the HEN, or the Hospital Engagement Network, where they report hospital quality initiatives and we wouldn't want to interfere with that. This amendment removes any question of exclusivity in reporting and adds language that clearly states that LB1058 does not prohibit the Department of Health and Human Services from working with anyone else for the purposes of collecting and analyzing data. I've been assured that AM2329 removes any objection from the Nebraska Hospital Association. I know a few who may have been getting some emails about vaccinations. This doesn't change anything about vaccinations. It just clarifies that what NeHII is already doing in terms of receiving information about vaccinations is codified. So really, this bill does two things. It codifies what they're already doing around syndromic surveillance, labs, vaccines, that sort of thing. And it allows NeHII to work with the CMS and the department to access those 90/10 HITECH funds. I would like to refer you to the fiscal note. It's the longest fiscal note I've ever received in my career. Not the biggest, but the longest. It's four pages long and it outlines what the Department of Health and Human Services believes would be lost by designating a health information exchange. I firmly believe this fiscal note to be inaccurate in its assumptions and I will refer you to the legislative fiscal note where it says "there is no indication or intent that the provisions of this bill transfer ownership and control of public health data to the designated Health Information Exchange as assumed in the Department of Health and Human Services fiscal note." The bill would codify, in statute, existing practices and protocols governing health data and the pursuit of federal funds shouldn't require additional staff, as the department already has many staff who assist in applications for current and new federal funding opportunities. I would urge the committee to consider, highly, the fiscal note from the Legislative Fiscal Office. I've never seen a fiscal note quite like this that asked for additional staff. I've seen a lot of asking for additional staff, but also talking about what programs would be lost for what we're already doing. The concern is that if we're already doing it, then we're going to lose these programs. I think we have some bigger problems. So-- and it also-- fun fact: the fiscal note also includes the Prescription Drug Monitoring Program, which is already run by our Health Information Exchange. So I appreciate the committee's time and

attention to this matter. I'm happy to try to answer any questions you may have.

ARCH: Are there any questions for Senator Howard? Senator Cavanaugh.

CAVANAUGH: Thank you. The last sentence of the Fiscal Office fiscal note done by Ms. Hruska; it says that they already have many staff "who assist in applications for current and new federal funding opportunities." Wouldn't this allow NeHII to just seek that-- those funding opportunities? So shouldn't this actually cost them less because they wouldn't even need the staff to do that?

HOWARD: Well, we still want them to partner with the department--

CAVANAUGH: OK.

HOWARD: --who is our main agency for Hyannis.

CAVANAUGH: But NeHII can, can-- currently, can put together the applications?

HOWARD: Currently-- it currently does, often--

CAVANAUGH: Right.

HOWARD: --and can as well.

CAVANAUGH: And then this just means that they can then submit the applications?

HOWARD: Yeah.

CAVANAUGH: So no additional staff would be needed for that?

HOWARD: No, not--

CAVANAUGH: OK.

HOWARD: Not in my opinion.

CAVANAUGH: Thank you.

HOWARD: Thank you.

ARCH: Other questions for Senator Howard? Senator Hansen.

HOWARD: Should I have added chiropractors?

B. HANSEN: [LAUGHTER} No, not on this one. Maybe just some clarification about how information is entered in-- like, how is it collected?

HOWARD: Oh, my gosh. This is a great question. I'm so excited. I'm so glad you asked. So this is-- so we actually did this last year. So for the electronic health records, everything that goes into it, we allow for a direct interface with NeHII. So there's no additional work for a provider. Everything that goes into the electronic health record can go directly into NeHII and same with the Prescription Drug Monitoring Program. So once a drug is dispensed, it interfaces directly with the EHR. What we did last year in statute, which is really cool; we allowed the, the Prescription Drug Monitoring Program to speak back to an electronic health record. So it wasn't just that they were receiving the electronic health record data, but now they could put the PDMP data into the EHR so then it would be a more robust record for a provider when they were using it.

B. HANSEN: OK and on that, kind of, same topic, I know there are some people who are maybe a little bit more sensitive about information that is shared and so is-- those who may not want to share that information, the only way that it is shared-- is it because I go to a healthcare professional and share that information or is it mandatory that they share information--

HOWARD: Right.

B. HANSEN: --or can they not share it?

HOWARD: So the Prescription Drug Monitoring Program dispensing, that's mandatory for, for everyone. The Health Information Exchange has an, has an opt out. So when you go to the physician and you're filling out all those forms, there's a sheet there that says that you're opting in to NeHII, you allow your data to be shared with NeHII. You don't have to fill that out or sign it. There's a clear opt out.

B. HANSEN: OK and the information that is on NeHII or the information that is shared, who has access to that? Is it just physicians? Is it, like, other entities that collect data? Is it insurance companies?

HOWARD: Sure, that's a good question. And I will rely on NeHII to make sure that I don't steer you wrong. But it's, it's HIPAA-protected

providers, absolutely. And then I wouldn't want to venture a guess beyond that.

B. HANSEN: OK, thanks.

HOWARD: Thank you.

ARCH: Other questions for Senator Howard? I just have one, just for clarification. NeHII is already our designated HIE, correct, just not in statute?

HOWARD: Just not in statute.

ARCH: Right.

HOWARD: Although--

ARCH: It's been functioning, it's--

HOWARD: Right.

ARCH: Right.

HOWARD: Although an argument could be made that Governor Heineman is the one who put it in, in as the Health Information Exchange through a letter or an executive order. That argument could be made that they're not--

ARCH: OK.

HOWARD: --because we have a new administration.

ARCH: So it's, it's just time to put this into statute is what you're, is what you're telling us?

HOWARD: Yes.

ARCH: OK. All right, thank you.

HOWARD: Thank you.

ARCH: I don't see any other questions.

HOWARD: All right, I'll stay to close.

ARCH: Please do. All right, any other proponents or are there any proponents, not other, but-- welcome.

ANN POLICH: Thank you. Good afternoon, Senator Howard and members of the Health and Human Services Committee. My name is Dr. Ann Polich, A-n-n P-o-l-i-c-h, and I am testifying in support of LB1058, adoption of the Public Health Information Act on behalf of the Nebraska Health Information Exchange, otherwise known as NeHII, our statewide Health Information Exchange, as well as the Nebraska Medical Association. I am testifying today as the vice president of quality, patient safety, and population health at the Methodist Healthcare System. We are a founding member of NeHII and actively support their mission to bring trust and value to health information technology by creating solutions for moving health data forward. Methodist Healthcare System actively supports LB1058. As a clinician and a partner with NeHII, I am supportive of and excited about the promise of LB1058. We are grateful to Senator Howard for introducing this bill and for her tireless leadership on health issues. With the adoption of LB1058 and our partnership with NeHII, providers will have access to comprehensive medical information including social determinants of health through the public health data, resulting in better outcomes for patients with care delivered in a high-quality, cost-effective manner. I would remind you that the current state of healthcare-- there is a lot of looking for healthcare information that takes a lot of time. It's very inefficient and a lot of retesting is done. Additionally, LB1058 reduces the burden of reporting to multiple systems. Data registries consume valuable clinical and technology resources. Reducing this burden alone is a win for the health systems as we are continually being asked to report more and more data to more and more agencies. Clinicians are exhausted documenting, collecting data, which takes time away from patient care. And the data really shows that the more time spent with inputting data on the front line leads to burnout. LB1058 allows for greater access to data across the health continuum. Knowing all the locations where the patients sought care, immunizations, test results, and treatment are invaluable in optimizing patient outcomes and reducing waste. Housed in NeHII, a neutral convener is the right place for this information and improves the integrity of the data, leading to better decision making, thus improving the quality of healthcare and the outcomes for Nebraskans. Medicaid beneficiaries also benefit from the utilization of NeHII data, which provides access to demographic and comprehensive clinical information for appropriate and efficient care co-organization. In closing, I would like to thank the committee members for allowing me

to testify today on behalf of NeHII in support of LB1058. I am happy to answer any questions that you may have.

ARCH: Are there any questions from the members? Senator Hansen.

B. HANSEN: Are you the NeHII expert I can ask the question to?

ANN POLICH: No, but she's coming; Jaime Bland.

B. HANSEN: That was the only question I had then, thanks.

ARCH: I, I have one question as-- have you seen, have you seen the changes over the years with NeHII? Have you been involved enough to, to see those changes and what's, what's-- with how it has evolved? Could you, could you give us your perspective on, on the changes and how that's, how that's impacting care?

ANN POLICH: Sure. So what NeHII has really done in support of healthcare systems is to help procure datasets that otherwise, we have internally attempted to spend time and effort on. And it has improved the accuracy of which we know that data and the timeliness. So it really makes healthcare systems very efficient and reduces our dependence on vendors who are very costly and who really are not in it to bring the health of Nebraskans to a better state. So that has been very, very helpful for us, that we have been able to have relationships and a lot of communication and mentoring around data analytics.

ARCH: All right, thank you. Thank you, thank you for your testimony.

ANN POLICH: Yes, thank you.

ARCH: Other proponents? Welcome.

JOY DOLL: Thank you. Good afternoon, members of the Health and Human Services Committee. My name is Joy Doll, J-o-y D-o-l-l, and I'm testifying in support of LB1058 on behalf of Creighton University. As an academic partner of NeHII, we value our relationship with NeHII and are excited about the promise of LB1058. We're really grateful to Senator Howard-- and I'm proud to live in her district-- for her tireless leadership on health issues. LB1058 will help us facilitate interprofessional competencies for providers, something that's important to us at Creighton, as-- in my role as director of Creighton's Center for Interprofessional Practice, Education and Research. For example, we did a study on high-utilizer patients of

healthcare using an interprofessional collaborative model in primary care. Out of 276 patients in one year, reduced emergency department visits by 16.7 percent, hospitalizations by over 17 percent, and lowered hemoglobin A1C, a type 2 diabetes indicator, by 10 percent. This not only improved healthcare outcomes, but led to a cost avoidance of over $4.2 million in healthcare costs. Our work was published in the Annals of Family Medicine this past year and our work has been sustained and replicated to be published later this year. The challenge is that we could only study within our own health system at CHI Health. The state HIE would allow us to follow patients outside our system, as we know that patients see providers outside our hospital system, to truly demonstrate the outcomes of our collaborative care model. We need this work to support the movement towards value-based payments to address rising healthcare costs and improve the patient experience. With the adoption of LB1058 and our partnership with NeHII, providers will be better integrate [SIC] and address social determinants of health into the delivery of healthcare. We're able to do this through the access to public health data, resulting in better outcomes for patients with healthcare delivered in a more cost-effective manner. This is important to CHI too because across Nebraska, CHI providers and hospitals provide a disproportionate amount of care to low-income Nebraskans. In fact, nearly 70 percent of the Medicaid care provided in this state is delivered by a CHI network provider. Again, I want to thank Senator Howard for bringing forward this legislation and I'd be happy to answer any questions.

ARCH: Thank you. Are there questions? I don't see any, but thank you very much for your testimony.

JOY DOLL: Thank you.

ARCH: Other proponents? Welcome.

ERIC DUNNING: Good afternoon, Mr. Vice Chairman and members of the Health and Human Services Committee. For the record, my name is Eric, E-r-i-c, Dunning, D-u-n-n-i-n-g. I'm here today as a registered lobbyist on behalf of Blue Cross and Blue Shield of Nebraska. And I've also been authorized to testify on behalf of the Nebraska State Chamber of Commerce and Industry in support of LB1058. Blue Cross and Blue Shield of Nebraska is very proud of the work that NeHII has done over the course of the last 15 years. We were, along with colleagues from a number of health systems from around the state, founding members of NeHII. And we have noticed that over the years, it's, it's

grown and it's developed in ways that will support the long-term healthcare needs of our state. As a payer, our interest is, is twofold. One, we're going to look to getting the best goods and services for our members. But, two, we need to make sure that there's processes to support the delivery of good healthcare. So for example, one of the things that we look to NeHII to do is to give providers tools to avoid the unnecessary repetition of tests to support-- and to support preventative readmissions. And so those are simple reasons why we're in support of this legislation and of NeHII. And we have worked very successfully with Senator Howard over the course of her time to further the work of the state's IT health infrastructure. And we're really proud of all of those efforts. And with that, Mr. Vice Chairman, I would love to answer any questions.

ARCH: OK. Are there any questions for Mr. Dunning? Seeing none, thank you very much. Next proponent. Welcome.

ROB RHODES: Good day. Honorable Senator Howard and presiding Senator Arch, my name is Dr. Rob Rhodes, R-o-b, last name, R-h-o-d-e-s. I am a board-certified family physician from Lincoln. I've practiced for over 25 years here in this state. I also am the chief medical officer of WellCare of Nebraska, an Anthem company. I speak to you today in support of Senator Howard's LB1058. As you may know, WellCare is one of the managed care organizations serving Nebraska's Medicaid recipients. Under my direction, my team works daily to improve the health of some of our more vulnerable members in the state of Nebraska. Our integrated care model brings many years of expertise to the table as we strategize on our members' behalf to improve their health concerns. This includes nurses and psychiatrists, licensed mental health practitioners, pharmacists, and physicians. This requires us to have a complete view of all the care the member is receiving, not only the medical and behavioral health treatments and therapies, but also the prescription drugs that they are taking, lab results, and as mentioned before, immunizations. Our team is striving to look forward into that record, if you will, or to, to compile that record to complete that patient care and identify even things as mentioned, the social determinants of health; food insecurity, transportation, and those life necessities that are part of what makes a healthy individual. We utilize NeHII information for this on a daily basis to do our jobs. Probably, WellCare was the first MCO to elect to participate with NeHII. And today, it's an integral part of how we provide daily care. Passage of LB1058 will give us an even more efficient, comprehensive opportunity to treat patients in Nebraska. As

we discuss future efforts and platforms with NeHII, this integration is of everything-- from social determinants of health to the insight into the drug monitoring program-- is really very exciting to be a part of. When I discuss NeHII and Nebraska's unique model of a single health information exchange with other colleagues across the country, we're kind of the envy. And there's great support and admiration for what we have. For example, in New York, they have five competing health information exchanges that, you know, with our single one-stop shop, if you will, it's a great place for us to access that. The NeHII team is helping build that future. This helps to, I think, identify and codify what we're trying to accomplish. It's rare, it's necessary, and it's appreciated. And NeHII puts efficiency in our healthcare delivery process. I thought I'd give you a couple real life examples. About six months ago, I was still a practicing physician here in Lincoln. And I know that my nurse would come to me and say, hey, Dr. Rhodes, we just had this patient that just was in the ER. They don't know what meds they were on. And she would go on and find what they were on in the NeHII portal or the classic-- I would-- as an example is hey, Doc, I got that shot at Walgreens and I don't know what it is. And we'd be able to tell them, well, it was your shingle shot. It's the first one you had. So just being able close that loop was priceless. As [SIC] my new role as chief medical officer, again, as I mentioned, this is a daily occurrence for our staff to tap into. And one example would be our restricted services committee where we try to identify patients that might be on scheduled medications. And should we identify and maybe help them to lock into one pharmacy and one physician? And our team can look at that in real time. So I'd ask you to support LB1058 and I'm happy to try to answer any questions.

ARCH: Are there any questions? Senator Murman.

MURMAN: Yeah, thanks a lot. With all the doctors and providers in the room here, I'm probably the only one who doesn't know this, but how well does NeHII interface with other states' exchanges?

ROB RHODES: To my knowledge, it's just the Nebraska base. We do have access or maybe a sister relationship with adjacent states like Colorado and Iowa, but I'm not an expert in that. But I do know that sometimes, we can have access to adjacent states as well.

MURMAN: Thank you.

ARCH: Other questions? I have one.

ROB RHODES: Yes.

ARCH: So you mentioned social determinants and as you see the future of, of population health and improving care, what, what, what is that going to add to our ability to improve care in Nebraska?

ROB RHODES: As a Medicaid provider, it might be using food as medicine. When we find out that someone doesn't have access to healthy food or transportation, that will be something that we'd be able to integrate as part of our either value added benefits or as our, our care for these members. Some of it's just knowing do they have a safe place to sleep and live? And that's, that's again, a part of how we, as a company, want to make sure that we're there for our members. So the social determinants of health, which is very, kind of, hot button, if you will, we still are trying to define that, research it. Where do we get the data? But NeHII is going to help us to move that forward.

ARCH: Thank you. Any other questions?

ROB RHODES: Thank you.

ARCH: I don't see any, thank you very much.

ROB RHODES: Thank you.

ARCH: Any other proponents? Welcome.

MARGARET WOEPPEL: Thank you. Good afternoon, Vice Chair Arch and members of the Health and Human Services Committee. My name is Margaret Woeppel, W-o-e-p-p-e-l, and I am the vice president of quality and data with the Nebraska Hospital Association. I am here to testify in support of AM2329 to LB1058. The NHA thanks Senator Howard and NeHII for working with the NHA to address our concerns over this legislation as it was originally introduced. The amendment that was submitted for committee consideration today strikes the right balance between providing NeHII the concrete language they need for federal funding and grants, while also recognizing that data collection and analysis work is and should be done in multiple ways in our state. For 25 years, the hospitals of Nebraska have been submitting their claims data to the Nebraska Hospital Association for the purpose of analytics. The Nebraska Hospital Association then uses that information to improve service delivery, improve patient outcomes, and submits aggregated data to a number of required regulatory and reporting entities, including the Nebraska Department of Health and

Human Services, Nebraska public health departments, the Center for Disease Control and Prevention, and the Centers for Medicare and Medicaid Services. The NHA is able to do this work through partnerships with the Nebraska Department of Health and Human Services and federal government's Center for Disease Control and Prevention and even Centers for Medicare and Medicaid Services. The language in AM2329 makes clear to granting agencies that such funding for the NHA-specific work is still appropriate. The NHA supports the amended bill for the state and for the Health Information Exchange, NeHII, as it allows the Nebraska Hospital Association to continue its work and its mission. Thank you for the opportunity to provide input and I'm happy to answer any questions.

ARCH: Thank you.

MARGARET WOEPPEL: Thank you.

ARCH: Are there questions? Senator Hansen.

B. HANSEN: Can I ask the same question I asked-- are you the person I'm supposed to talk to?

MARGARET WOEPPEL: Sorry, she's coming.

B. HANSEN: Just one question, that's all. I just want to make sure.

ARCH: So you'll hold that question?

B. HANSEN: Yes, I'm good. Thanks.

ARCH: OK, all right. Any other questions? Seeing none, thank you very much for your testimony.

MARGARET WOEPPEL: Thank you.

ARCH: Other proponents? Welcome.

MICHAEL SKOCH: Thank you. Senator Howard, Vice Chairman Arch, and members of the Health and Human Services Committee, my name is Michael Skoch, M-i-c-h-a-e-l S-k-o-c-h. I am a physician, board certified in family medicine and I've spent just over 25 years in primary care practice in Hastings, Nebraska. I come today as the chief medical director for Nebraska Total Care, a Medicaid managed care organization. I speak in support of LB1058. As a clinician and partner with NeHII through my work at Nebraska Total Care, I anticipate the

promise of LB1058. As my colleagues have indicated, the healthcare community as I know it is grateful to Senator Howard for introducing this bill as well as her leadership-- her tireless leadership on healthcare issues during her tenure in the Senate [SIC]. With the adoption of LB1058 and our partnership with NeHII, Nebraska Total Care will be better equipped to assist providers and beneficiaries in achieving higher quality and more cost-efficient healthcare. As an active physician caring for patients, the patients I serve will benefit from my ability to access a more comprehensive healthcare database that integrates important data variables including physical health records, pharmacy records, and as has previously been mentioned, social determinants of health. Better data means better clinical decisions on behalf of the patient and better management decisions by providers and payers. Population health management is improved. LB1058 promotes access to health data through NeHII, a neutral convener of clinicians, health systems, and payers. This is the right place for this critical information. The structure endorsed in LB1058 creates an important efficiency across Nebraska, enabling individual providers, hospitals and health systems, pharmacies, and payers' access to demographic information and health information important in the coordination and delivery of effective, quality healthcare. Thank you for the opportunity to testify in support of LB1058. I'll be happy to answer any questions that may arise.

ARCH: Are there any questions? Seeing none, thank you very much for your testimony. Other proponents? Welcome.

JAIME BLAND: Vice Chairman Arch and Senator Howard and members of the Health and Human Services Committee, my name is Jaime Bland, J-a-i-m-e B-l-a-n-d, and I am in support of LB1058 as the CEO of NeHII. NeHII supports the bill as a way to reduce administrative burdens placed on the providers from federal and state policies that require them to report the same data to multiple sources. There were multiple assumptions of the fiscal note that I would like to address directly and then I will take your technical questions as well. First, the bill is not seeking to control any data. We are keeping the same data rights as are currently in place. The activities outlined in the bill are simply to collect and provide data to the department. LB1058 does not change or affect the department's ability to access federal funding of current programs and the work outlined in the bill happens today and has not reduced the department's FTE, nor impacted their ability to access funds from sources like CDC, HRSA, or CMS. Because NeHII has excellent working relationships with the department and CMS

federal partners as well as multiple federal agencies, the NeHII team, along with the department, have collaborated across states and our borders. We are actually considered experts in HITECH 90/10 and often receive calls from our interstate partners to model what we have here in Nebraska. This includes the SUPPORT Act, in which we were able to bring in additional funding for the workflow integration that Senator Howard spoke of. And many of the funding opportunities across the federal agencies have also been synergized by our collaborative work with the department. We've been able to bring a spotlight to Nebraska, NeHII, and the work in data sciences and advancing interoperability. We are building economic value to the states and communities where our partners operate. Not only are we providing access to technologies that are in other situations not available to providers, we are highlighting the success of Nebraska in this space and enabling rural health equity by providing access to analytics and other technologies that are very expensive if purchased alone. HIE's reporting for public health registries that are outlined in CMS' seven conditions and standards for accessing HITECH 90/10 funds and are consistently a process in all 50 states and territories-- nowhere in the country has an HIE supplanted any of the public health responsibilities or the public health department, as outlined in the fiscal note. The bill is simply designating an HIE as a collector of data utilizing the infrastructure CMS has invested in the state of Nebraska. The bill is stating that there are efficiencies to be gained and this is what our federal and state partners want to see in the HIT space, which is why we are a spotlight. In fact, the bill complements the work of DHHS and allows NeHII to be a technology backbone for the department so the staff in the division of public health, who are epidemiologists and do the great work of the public health for the state, can return to the work of being an epidemiologist. And we are the data collectors and the technology backbone. Instead of being bogged down by the IT infrastructure and technology, they are able to study the disease processes in populations, identify risk factors, and have better data to do this. The opportunity to create efficiencies and reduce administrative burden and spend in hospitals and reporting to multiple requests for data is largely welcome in a time when health technology expenditure continues to grow in providers' budgets. The bill allows hospitals to save $60, $70, or $100,000 in meaningful use modules to report to public health entities. This is real savings in an era where, where the health IT budgets continue to grow by 8 to 10 percent. And last year, the country spent $7 billion in health IT. As a clinician with a long history of care coordination, care management, and health data expertise, this bill supports the infrastructure

necessary to support a vital piece of the puzzle for all participants in the healthcare system. Speaking of participants in the healthcare systems, I want to emphasize that this bill changes nothing to the respect of the privacy considerations and process for an individual to opt out of any HIE or the network of data sharing. Absent of comprehensive health information and access, patients often experience overmedicalization through excess testing and procedures, ultimately contributing to an increased cost of care. In an era of high-deductible healthcare plans, when 40 percent of Americans don't have an extra $400 in their budget, but have high-deductible healthcare plans of $7,000 in deductible, this is a real cost savings and is an economic question. What NeHII does is provide accessible, comprehensive data to providers and patients, meaning that they can avoid for the duplicate immunization or drawing of titers at $130 or $150 out-of-pocket or a duplicate hemoglobin A1C that was drawn in a clinic and they are now at their endocrinologist; it would be an additional $300. As a clinician, a mother, and a daughter who serves as a chronic disease manager for my parents, I am deeply appreciative for Senator Howard's tireless work in the interests of better health for my family, friends, and neighbors and this committee's work to facilitate a better path forward towards efficiencies and transparency. With that, I'll take any questions you may have.

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

B. HANSEN: Thank you. It's just one question--

JAIME BLAND: Sure.

B. HANSEN: --but I feel like I should provide a little background maybe. Some of them have already been answered. Some of my questions that pertain to where some information goes.

JAIME BLAND: Sure.

B. HANSEN: Ms. Woeppel, I think, talked about that a little bit, kind of how they share information. And I have no issues with information being shared from provider to provider. I think that's a very useful tool to have. Dr. Rhodes even kind of mentioned that a little bit about how they, you know, can even save lives, reduce costs, and makes things more efficient. But I think it's more-- I think us, as legislators, we should be good stewards of the taxpayer money, but I

feel we're supposed to be also good stewards of protecting the patient's rights.

JAIME BLAND: Um-hum.

B. HANSEN: And so anytime we have a lot of information being shared over-- electronically to different providers, to different recipients, you know, entities, that caused me a little bit of a pause to make sure that we are being safe with patient information.

JAIME BLAND: Sure.

B. HANSEN: And you'll have to excuse my, you know, semi-conspiracy theorist question, but sometimes I liken this to, you know-- I don't remember if Facebook or Google sends you those updates and you get to like them and they say, will you agree to the terms and conditions and you click on it. And then you have no idea where the heck some of this stuff is going until you realize later that it's been shared with all these other people. Just-- if you can give us some confidence-- and the fact that we can opt out of this thing is a big thing, too. There are some people who do want their patient information protected. They do not want to share with anybody else for whatever reason. And so I get that they can opt out of this. It is a good thing. But besides some of the entities that they talked about, like the public health department, Center for Disease Control, et cetera, does this information go anywhere else or can it be used for any other purpose besides, you know, statistics or provider-to-provider relations that you know of?

JAIME BLAND: Sure. So we operate the data governance committee that was talked about previously and we have robust data policies that follow all the HIPAA guidance around treatment, payment, and operations and information that would be used for research. We don't sell any data sets; I think that's what you're asking. We've adopted-- we don't do that. We are really facilitating interoperability. And to your point about true patient agency around where their data goes, in fact, NeHII is investing in information technology architecture today that will allow individual citizens to have access to their information. So you know where your data's coming from and, and in some respects, where it's going so that-- through the interoperability of rules that CMS intend to post here shortly, we will be facilitating that access to individual folks so they can have access to their

information. It's as much of a right as a provider has a right to access information to provide the appropriate care.

B. HANSEN: So insurance companies won't be able to get this information for some reason to help determine costs or anything like that?

JAIME BLAND: No.

B. HANSEN: Just making sure, OK.

JAIME BLAND: No, we actually don't participate in anything like that. Insurance companies, when you say payers like Blue Cross Blue Shield, they have care managers that access the information for treatment payment in operations, which is a covered access underneath HIPAA. And I will say this about our data governance committee: we recognize the responsibility around protecting individuals' information. And to that point, when we are working collaboratively with the department, we have robust discussions around the PDMP data. We actually brought in a legal expert that, that actually drafted HIPAA so that we could ask them some more complex questions about how we manage information technology safeguards, security safeguards, processes, procedures. And they are on retainer with us today so that we, in the data committee, can actually ask those questions to the HIPAA expert. We've actually testified in front of the-- or met with the Office of Civil Rights around access to information for entities like commercial payers, purchasers.

B. HANSEN: Thank you for answering my questions.

JAIME BLAND: And to your question about how data is shared, we-- the technology components-- so we actually follow HO7 interoperability data standards and-- in exchanging of information and we have actually-- the workflow integration components is called a FHIR API. And how we match information is important because you don't want the workflow integration to happen; to go into Senator Arch's record when it should have gone into Senator Hansen's record. So those components are very critical for us and that's the technology infrastructure that we've invested in in the last two years that really make us the premier HIE in the country.

ARCH: Other questions? Senator Williams.

WILLIAMS: Thank you, Senator Arch. And thank you for being here. I'd like to follow up just a little bit--

JAIME BLAND: Sure.

WILLIAMS: --and talk about data security, not from the standpoint of other providers, but from the outside and ask what protections do you have in place for that data security, penetration, testing, all of the things, and are you using outside people, outside of your organization, to come in and do testing?

JAIME BLAND: So we are following-- all our vendors are high trust or EHNAC certified so they-- or NIST, which are different security protocols that they follow. And this is where the data is stored. We do not, as an organization, actually store the data in any physical place in the state. It is, it is distributed information across a cloud infrastructure so that it remains secure underneath technology protocols and security protocols. So we use the software as a service infrastructure and the vendors are-- go through these-- penetration-- we do do audits. And they are-- your data is as safe as the national secrets are safe.

WILLIAMS: Thank you.

ARCH: Other questions? I have, I just have one.

JAIME BLAND: Sure.

ARCH: Could you talk to us a little bit about some of the recognition, nationally, that has occurred with some of the work that, that has been done here--

JAIME BLAND: Sure.

ARCH: --in Nebraska?

JAIME BLAND: Sure. So, so I've presented at several events about the comprehensiveness of PDMP, what we're doing in the population health space. Our team presented to other HIEs today around our work to be the first HIE that's received the National Center for Quality Assurance designation. So we can read-- aggregate and report data for NCQA. CMS has also granted us the qualified entity certification, in which we can-- we have met several security hurdles and we've been tested on those so that we can adjust Medicare and Medicaid claims data and those are not easy things to achieve and it requires

additional infrastructure. NeHII has grown from eight FTE two years ago. We, we are now at 40 FTE; really investing in the data sciences component and this is how we deliver world-class analytics. This is how we are ensuring that we're delivering that data into the right record. We have clinicians on staff. We have five or six now; PhD bioinformaticians that are on staff. This is where the future is going. And we are actually one of the first states that are going to invest in statewide-- or actually, we're just finalizing contract terms for this statewide social determinant health platform, which will couple socially-determinate clinical claims data together so that we truly have this comprehensiveness. And, and I actually presented to a, a hospital network board last night and they called it the Holy Grail. If they had this information five years ago, ten years ago, they would be in a different place today around comprehensiveness of care than they are right now. So this is the change that we're bringing. We have two presentations at HMS. I mean, we are nationally sought out now to have conversations with other entities because we're doing this work. That is the promise of HIT. This country has invested $100-plus billion in HIT and we have to see some value from it. Right now, it's disparate data systems. It's not connected and we are doing that work and, and that's why it's novel and that's why it's important.

ARCH: Thank you. Thank you, Dr. Bland. Any other questions? Seeing none, thank you very much. Any other proponents? Seeing none, any opponents? Welcome.

BOB RAUNER: Hi, I'm Dr. Bob Rauner B-o-b R-a-u-n-e-r. My day job-- I spend 70 percent of my time as a chief medical officer of an accountable care organization, 30 percent running a community health nonprofit, and the rest of my time as an elected official on the school board. I'm testifying-- kind of menagerie of hats and so I'll testify as an individual. I would say I would be a proponent of the bill provided one thing and that there was public oversight. I think it's very important that we do have a designated HIE where there is, where there is a depository of health information. I do think it's very important that this entity, because this entity would have so much power, potentially, over the state, that there be some more-- some public oversight. And so I would say I would switch to a proponent if it were combined with LB1183, which we'll be hearing about shortly. I'll be back testifying as to a use case about what [SIC] I think it's important because some of the potential benefit that was mentioned, it needs to make-- we need-- I think the oversight

would make it-- make sure that the options would be available. I do think it likely-- it could happen, but I think this is-- there's so much power here that I do think there needs to be some public oversight. So I'll be back up shortly testifying using a use case for LB1183. Thanks.

ARCH: Thank you. Just a second, are there any questions? Seeing none, thank you very much for your testimony. Other opponents? Welcome.

GARY ANTHONE: Thank you, Senator Howard, Vice Chairman Arch, members of the Health and Human Services Committee. My name is Dr. Gary Anthone, G-a-r-y A-n-t-h-o-n-e, and I'm the Chief Medical Officer for the Division of Public Health within the Department of Health and Human Services. I'm here to testify in opposition to LB1058. This bill would designate the Nebraska Health Information Initiative, NeHII, or its successor as the Health Information Exchange, HIE, and task it with aggregating clinical information, acting as the designated entity for purposes of access to and analysis of health data, and acting as the primary collector and reporter of public health data. LB1058 creates a new act, but duplicates existing infrastructure. This bill would designate the Health Information Exchange as the primary collector and reporter of public health data for registry submissions, immunization reporting, syndromic surveillance. The use of the term "primary" here contraindicates multiple state statutes and rules and regulations that require reporting to DHHS. In addition, the bill's language may require duplication of reporting through the Health Information Exchange and DHHS, adding a burden to the people we serve who choose to report data to submit through the Health Information Exchange. Our priority is protecting doctor-patient relationships and information. What information can be released for what purposes and to whom? Without clarity on this, there are insufficient safeguards to protect privacy, confidentiality, and doctor-patient relationships. In addition, LB1058 does not address whether other divisions of DHHS are affected. For example, it's unclear whether the bill would include other agency data, such as behavioral healthcare data. Finally, if LB1058 is intended to supplement the current public health data work provided by DHHS, then additional staff would be needed to assist the Health Information Exchange with access to federal funding. The number of staff needed would vary depending upon the number of grants needed to implement LB1058. We have discussed our concerns of LB1058 with NeHII and we will continue to work closely with them. It's our understanding that there may be an amendment to this bill that would address and potentially alleviate some of these concerns. I'm happy to

take a look at it and get back to Senator Howard and the committee after that is done. Absent such amendments, we respectfully, respectfully request that the committee oppose the legislation. This is one area that I'm still learning about. As you know, I was a practicing surgeon up until five months ago and I'm doing the best I can to educate myself as fast as I can on issues such as these. So I most likely will have to take your questions back to my team for follow-up with the answers after the hearing. I do want to thank you all, though, for allowing me the opportunity to testify today. And I'd be happy to do my best to answer any questions you might have.

ARCH: Thank you. Are there any questions? Senator Hansen.

B. HANSEN: This may be a question to take back to your team, but the paragraph where you said you're, you're there to protect the patient relationships and information, I get that. What information can be released for what purpose and to whom? Is there any way you can expound on that? Like, what are some of your concerns, like, the "and to whom" part?

GARY ANTHONE: I mean, just from a provider standpoint, I mean, we've all, as providers, waited for this to happen. We want it to happen, but we, we need safeguards to make sure that other people besides the people that need to see this data are able to see it. And we need clarity on that issue.

B. HANSEN: Thanks.

ARCH: Other questions? Senator Williams.

WILLIAMS: Thank you, Senator Arch. Thank you, Doctor, for being here. And I, I don't expect you to answer this, but I expect some accountability for the fiscal note that is attached to this from DHHS. That is hard for me to understand and hard for me to get my arms around the amount of that when I hear the testimony that this information is already there and that-- so if, if you could help provide this committee with, with some more background or some more help with that fiscal note?

GARY ANTHONE: I understand it's pretty substantial and I will have to get back to you with that answer, Senator.

ARCH: Any other questions? Seeing none, thank you for your testimony. Are there other opponents to this bill? Anyone wishing to testify in a neutral capacity? Seeing none, Senator Howard, you may close.

HOWARD: OK. I'll be brief. I want to thank the committee for their time and attention to this issue. Before I sort of address some of the concerns, I'd like to just take a minute and tell you my favorite NeHII story because I've, I've heard a lot of them that this is like-- last year, when we were in committees, my father-in-law was really struggling. He had Alzheimer's and dementia. We moved him into a nursing home. He was the sweetest man in the whole world, like, would do anything for Dr. Pepper, like, just the nicest guy. And-- but consistently, he always only got sick on Friday, Saturday, or Sundays. And so-- when the, like, night nurse was not there-- and so they would always call Doug and Doug and I would have to meet up. And so there was one night where I had just gotten done here and it was a Friday and Ernie had gotten a nosebleed that, like, would not stop; like, it was like the Niagara Falls of nosebleeds. And so I drove in, I met up with Doug at the emergency room. And Doug's there and he's beside himself because it really does look like Ernie's been punched in the face. But he just really-- he was on blood thinners, which we didn't know. But when they asked us what meds is he on, we didn't have his medication list because he'd been brought over from the nursing home to the emergency room. And I said, would you mind, terribly, checking the PDMP and NeHII to see what meds he's on? And the minute they knew he was on blood thinners, they could give him something to stop the nosebleed and they could look it up right away. And so it was really satisfying to know that NeHII-- it's not just sort of this bigger picture. It's also this minute picture of me in an emergency room with my father-in-law with a nosebleed that will not stop. And so it's just-- this is an incredible program and I think our state is very lucky to have it. Senator Murman, you asked about interface with other states. I can't speak to interface for NeHII in particular, but this Legislature did allow our Prescription Drug Monitoring Program to speak to other states. And so drug information is available across state lines, but I wouldn't be able to speak to NeHII. But I think your question was answered, therein. And for Dr. Rauner, who came up, I actually cosponsored Senator Arch's bill. Our intention is to combine them, but we felt as though they were two bigger issues and so we separated them out into two separate bills. In regard to Dr. Anthone's letter, the, the first paragraph talks about this "designated entity." I want to remind you, we've had a designated HIE because of Governor Heineman since 2009. So that's kind of old news.

And also, I apologize, I didn't know the department was coming in or had an interest. And so if I had known, I would have shared the amendment with them so they knew that the word "primary" had already been removed through conversations with other individuals. I disagree that they need additional staff because they already have staff who are applying for these federal grants. And also NeHII is more than ready and willing to provide staff to write grants as long as it means that these dollars are flowing into the state and they can improve their programs. You know, it is very difficult to address concerns when we don't know what they are. And so I would encourage anyone who is here who has a concern about a bill-- I think we're always welcome, particularly as a committee and as individual senators, to speak to people when they have concerns and try to fix them. But we certainly can't fix things if we don't know what they are. So I appreciate all of your time and attention to this issue. I know it was a little bit of a longer hearing than I anticipated, but it's such an important issue and it's such a neat program that I'm so glad we got a chance to talk about it today.

ARCH: So before I take any questions or before we--

HOWARD: Oh, do the letters.

ARCH: --you take the questions--

HOWARD: Do the letters.

ARCH: I would like, I would like to do the letters. There are, there are proponent letters; Kristen Hassebrook from the Nebraska Chamber of Commerce and Industry, Dr. Todd Hlavaty from the Nebraska Medical Association, Rodrigo Lopez from Children's Hospital & Medical Center, and Cliff Robertson from CHI Health. There are no opponents and no neutral. Are there questions for Senator Howard? Senator Cavanaugh.

CAVANAUGH: Thank you, Vice Chairman. This is more of a comment. And I was remiss in not making this comment on the last bill, but the comments that you made about our page, Angenita, your gal pal--

HOWARD: My gal pal.

CAVANAUGH: --reminded me that today is "Galentine's Day" and I just wanted to say Happy "Galentine's Day." And I'm pretty sure that last year, when we did your opioid bill, it was also "Galentine's Day" in here because that's what Carrie would have wanted.

HOWARD: Honestly--

CAVANAUGH: So Happy "Galentine's Day" to you and all of the ladies here today.

HOWARD: Thank you.

ARCH: Thank you. Any questions for Senator Howard? Seeing none, thank you very much.

HOWARD: Thank you, Senator Arch.

ARCH: This will close the hearing for LB1058.

HOWARD: It's so much warmer over here. All right, this will open the hearing for LB1183, Senator Arch's bill to create the Health Information Technology Board and change Prescription Drug Monitoring Program provisions. Welcome, Senator Arch.

ARCH: Thank you, Senator Howard. These-- as Senator Howard mentioned in her closing remarks, these two bills are related. And, and I think you'll, you'll find some of the questions that were asked in LB1058, hopefully, answered with LB1183. For the record, my name is John Arch, J-o-h-n A-r-c-h, and I am here today to introduce LB1183 and I will be very brief as there is a number of testifiers following me. Health information technology has become an integral part of our healthcare system. The secure exchange of health data gives providers the information needed to serve-- to best serve their patients and provides researchers the information necessary to develop protocols to improve healthcare outcomes. Nebraska's Health Information Exchange, the Nebraska Health Information Initiative, or NeHII, represents a public-private partnership that is the central point of data for participating providers and it is the entity charged with running the state's Prescription Drug Monitoring Program. As the nation deals with the opioid crisis, the PDMP continues to evolve and we must be able to be flexible to change in order to remain the role model for PDMPs across the nation. I thought we could better-- be better equipped to stay on the forefront by putting in place a governmental board that is able to respond quickly to national trends with respect to changes in PDMP protocols. LB1183 would establish the Health Information Technology Board. Under the bill, the board would have the authority to determine if additional data should be collected to assist in the fight against prescription drug abuse. As it stands now, NeHII and the Department of Health and Human Services must go through the entire

legislative process each time a minor change to the PDMP is needed. It comes to this committee as a statute change. NeHII and data collection will also be playing a significant role in case management for the upcoming Medicaid expansion. To date, NeHII has worked closely with the Department of Health and Human Services to ensure that correct data is collected, patient privacy is protected, and the information collected is secure. However, as the electronic mobilization of health information becomes more prevalent, it would be in our best interests to provide formal oversight as we head into the future. In addition to recommending changes to the PDMP, the board created under LB1183 would be responsible for establishing criteria for data collection and disbursement of that information. It would evaluate and ensure that the exchange is meeting technological standards and would provide the oversight necessary to ensure the information collected is only accessed, used, or disclosed in accordance with HIPAA and other privacy protection policies. This bill does not transfer ownership or responsibility of the data. It does not eliminate the duties of the department with respect to the PDMP. It does not create a new governing board for NeHII. NeHII would, would still maintain its own board. It simply creates an oversight board for the collection and disbursement of health information. As drafted, the board would consist of 14 members of varying professions and expertise to guarantee a broad representation. There will be an amendment coming to increase the number of members to 17 and to address additional issues that have been raised, particularly by DHHS. We continue to work with the department and NeHII to make sure we have the regulatory framework in place to guarantee the secure collection and disbursement of health data. That concludes my testimony and as I mentioned, there will be an amendment coming-- it's not ready at this point-- that I will make sure the committee members have, have once we have the details finalized. And with that, I would take any questions you might have.

HOWARD: Thank you, are there questions? Seeing none, will you be staying to close?

ARCH: I certainly will, thank you.

HOWARD: Fantastic. We'll invite our first proponent testifier up for LB1183.

ANN POLICH: Good afternoon, Senator Howard and members of the Health and Human Services Committee. My name is Dr. Ann Polich, A-n-n P-o-l-i-c-h, and I am testifying in support of LB1183 on behalf of the Nebraska Health Information Initiative, otherwise known as NeHII, as

well as the Nebraska Medical Association. I am testifying today as the vice president for quality, patient safety, and population health for the Methodist Healthcare System. We are a founding member of NeHII and actively support LB1183. LB1183 is an important bill that will provide transparency and greater understanding of the work that NeHII has accomplished in the improvement of the health of Nebraskans. We are grateful to Senator Arch for introducing this bill. NeHII has been a catalyst to position Nebraska as a national leader in health information technology and development. LB1183 ensures that these accomplishments are known and are transparent to healthcare stakeholders across the state by creating a health information technology board. We stand behind the formation of an HIT board to support and promote open dialog between providers and other stakeholders for purposes of appropriate data governance. As a neutral convener of healthcare data, NeHII will partner with this board, which includes stakeholders, both in academia as well as community partners, to improve data transparency, data governance, and advancements of health data sciences in Nebraska. The second part of the bill, which addresses the PDMP changes, are needed in order to fully address the issues around prescribing and workflow. We are committed to adhering to all opioid-related regulatory requirements and reducing unnecessary opioid prescription and usage. In order to do so, we need access to data that will support this work while maintaining our clinical efficiencies. These changes support hospitals and healthcare systems in the testing, too, and auditing for CMS programs such as promoting interoperability measures. Just of note, in 2020, the promoting interoperability by assuring PDMP query prior to prescribing is voluntary. As of 2021, it will be mandatory. So we really need the access to data so that we can prove that our providers are doing this function and if they're not, that we'll be able to give them feedback. In closing, I would like to thank the committee members for allowing me to testify today on behalf of NeHII in support of LB1183. I'm happy to take any questions that you may have.

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

CAVANAUGH: Thank you and thank you for being here. So are you currently having issues with access to data or requests for--

ANN POLICH: Sure. So this last year, we requested data from the department through NeHII to be able to understand at what percent we were querying the PDMP prior to prescribing narcotics. We were unable to get that data. It was restricted. As a clinician, I think it's--

many times we have not had data in the past. And so we had to do the best we could. Now we have the data, but we really need more support in being able to expand our access to it.

CAVANAUGH: So the data exists, it's the access that doesn't--

ANN POLICH: That's correct.

CAVANAUGH: Thank you.

ANN POLICH: Um-hum.

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

ANN POLICH: Thank you.

BOB RAUNER: My name is Dr. Bob Rauner, B-o-b R-a-u-n-e-r. I am testifying in support of LB1183. One it, as mentioned earlier, it provides the oversight that I was hoping for. What I'm most excited about is Section 9, which specifies how the use of the data would be used in Nebraska and why I put together a-- sort of an example of what I think would be the best outcome of this in the future. So many of us in the public health community have been a little concerned because Nebraska has been falling in America's health rankings for the last 20 years or so and right now is on what looks like a steady decline. We used to be in the top five, but we're not now. But if you flip over the page, there's a brief summary. There's a full report and you can go online to look at it. Our number one area is disparities in health status. And so what I've put together is some examples of disparities in Nebraska. On this page, this is mammography screening rates across Nebraska. You see a huge disparity, both urban and rural, between these. This is why-- one of the reasons we look so bad in America's health rankings. If you looked at colon cancer screenings, you'd see the same thing. There are dozens of rural Nebraskans that die each year because they don't get screened at the same rates as urban Nebraskans. This is a problem. If you go to the next page, there is another area-- look at the spending. We need the money side of healthcare as well. What that is, is a map of primary care spending across the state based on Medicare data. You'll notice that the Medicare spending and primary care in rural areas is about half what it is or even a third of what it is in urban areas. It's no accident that those disparities in cancer screening correspond pretty well with disparities in spending on primary care. If you don't have the primary

care infrastructure to, to provide the care, it doesn't get done. And again, if you flip over one more page, you have influenza vaccination rates. You see what looks like almost the same rate again. So who is it that gets these things done? It's the primary care health system. Without that spending, without that monitoring, we don't even know what these disparities are. We have these maps because this is based on Medicare data, which is publicly available. Right now, unfortunately, there's no commercial or Medicaid data to echo that fact. So for our elderly Nebraskans, we have a good way of measuring health disparities. But for the rest of Nebraskans, we don't have a very good way of measuring health disparities. The influenza is timely because there's a twofold variation; that's just getting a flu shot once a year. What if coronavirus is the real deal? What does it say about our public health system in Nebraska? If you go further, who enacts this? And one of the best things right now is the accountable care organization format that Medicare instituted and Blue Cross Blue Shield is also now participating in statewide. I describe who all these people are because on the next page-- it might not be clear who they are, but essentially this is all public record. And so you can go look at this every year and you can see how these organizations do across Nebraska on our Medicare population, everything from cancer screening to blood pressure control to diabetes control, all those very things that we're failing on America's health rankings. So it's nice that you can actually see what those numbers are; it's there. The good news is in Nebraska, they're almost all green. So on our Medicare population, we provide above average care for Medicare. I think it's pretty much the same for Blue Cross. Blue Cross has similar data, but we don't have similar data for Medicaid or the rest of the commercial population. Just think what we could do if we had that on everybody. So if we had one designated home of all health data in Nebraska, we'd know what's working. We'd know where to target our resources. We'd make sure those resources are targeted appropriately. There is actually an evolving entity that's trying to work on this. So far, it's called the "Align Group" for lack of a better term. We may change the name. A bunch of us have been meeting at the college of public health for over a year now. Ali Kahn has been convening us, the chief medical officers of those accountable care organizations, of which I'm one, BlueCross BlueShield, a couple other entities have been coming. But we've basically put together a list of the top 11 measures we could really work on. If we could do a good job on all of these across Nebraska, not just for Medicare, not just for Blue Cross, but for commercial Medicaid too, we could quickly reverse our slide in America's health rankings. But to do this, we need a common way to

measure it. We need a way to make sure that all people are showing up and doing their part. One of the problems we have in Nebraska is we've got about half of our insurers participating in the accountable care approach and half not. So a lot of us that are doing this are sitting there with one foot in the canoe and one foot on the dock trying to make it work. We've got great evidence showing that it works when we can get everybody aligned. And so we're calling it "Align" now because that's what we want; is some alignment around quality measures and efforts. And so with that, I think that's one of the biggest cases for LB1183; the public oversight to make sure this is done, to hold people accountable, and to create this common entity so we'd have this data to reverse Nebraska's slide. So with that, I'll conclude.

HOWARD: Thank you, Dr. Rauner. Are there questions? Seeing none, thank you for visiting with us today. Our next proponent.

KEVIN BORCHER: Good afternoon, Chairwoman Howard, Vice Chair Arch, and members of the Health and Human Services Committee. My name is Kevin Borcher, K-e-v-i-n B-o-r-c-h-e-r, and I'm testifying in support of LB1183, as introduced by Senator Arch. I'm testifying here today as a senior director for pharmacy services and the Prescription Drug Monitoring Program director at the Nebraska Health Information Initiative or NeHII. Thanks to the hard work of Senator Howard and the Health and Human Services Committee, the PDMP was greatly enhanced in January 2017 with passage of LB471 in 2016. As the Nebraska PDMP continues to be a leader in the nation and evolves and progresses to provide a greater quantity and quality of data, changes are needed to keep up with this ever-evolving landscape to address the opioid crisis and improve quality of care for patients. In order to provide changes to the PDMP requirements to collect the best data possible as well as utilizing the data, we need to be responsive as well as responsible with the data. To adapt a phrase that you may have heard in Spider-Man-- the original, not the newer ones-- with great data, comes great responsibility. And that's one of the purposes of the Health Information Technology Board, as created in LB1183. The entity is composed of a representation of healthcare professionals as well as DHHS representation who will be responsible for decisions, recommendations, and oversight over the collection and use of the data for PDMP as well as the Health Information Exchange. As an example, if there is information that pharmacies collect prescriptions-- as the medication directions or possibly the ICD-10 code or, or the reason for use of these prescriptions-- the HIT board would have the responsibility to determine if this information would be of benefit to

healthcare providers and ultimately, to patients. Changes related specifically to LB1183 include updating language from the word "designee" to "delegate," which is the consistent terminology used throughout the country. We are also allowing pharmacies and other dispensers to report their data, at least daily, as states, organizations, and federal government are supporting more real-time PDMP reporting. Wouldn't it be nice if, as you're seeing an increase in influenza, to have pharmacies report their prescriptions that have been dispensed of Tamiflu within minutes or hours of that dispense and provide greater information to public health departments to look for trends as you see an uptick in that or other diseases that come about? In order to facilitate the collection of better data, reporting to the date the prescription was picked up or sold to the patient provides the most accurate and valuable information so clinicians not only know did the pharmacy fill the medication? Did the patient actually pick it up? Did they receive it or was there a barrier, such as maybe transportation or cost issues, preventing medication compliance? Then healthcare providers can then follow up with a patient, thus preventing potential hospitalization or an adverse event. We heard about that earlier and this may be able to help with that. We've also heard about interstate data sharing. Nebraska now, through legislation changed last year, is going to be able to share data back and forth with other states. That's expected to occur this spring so we'll be able to have that interstate data sharing very soon. I'd like to say dates, but I always put my foot in my mouth when I do that so I'll say soon. While the majority of pharmacies can and do report the date sold to the patient, there are some pharmacies which currently don't report that. Through the SUPPORT Act project, NeHII can provide resources to pharmacies and their vendors to help report this valuable information, thus better supporting federal initiatives. LB1183 also allows the judicious and responsible use in release of the data. This will allow providers and healthcare organizations to be able to obtain the needed information relating to their providers, such as who has queried the PDMP for auditing purposes for CMS promoting interoperability requirements and to improve quality of care. I thank you for allowing me to speak today. I would like to thank Senator Arch for supporting and introducing LB1183 and the Health and Human Services Committee for continuing to support the initiatives that the PDMP is providing to be a leader in the nation. I'm honored and fortunate to be Nebraska's PDMP program director in keeping Nebraska's name and reputation noticed across the country. With your help, we can continue to build

on the strong foundation the Nebraska Legislature has created for the PDMP. With that, I'd be willing to answer any questions.

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

KEVIN BORCHER: Thank you.

HOWARD: Our next proponent testifier for LB1183. Good afternoon.

MICHAEL SKOCH: Good afternoon. Chairwoman Howard and members of the Health and Human Services Committee, my name is Michael Skoch, M-i-c-h-a-e-l S-k-o-c-h. As I indicated in my previous testimony, I'm a board-certified family physician spending much of my career in Hastings. I come today as the chief medical director for Nebraska Total Care, a Medicaid managed care organization. I speak in support of LB1183. An important function of LB1183 will be to provide transparency of the work of the state's Health Information Exchange, NeHII, while also broadening the awareness of the positive work NeHII is doing both within the state and beyond. We are grateful to Senator Arch for introducing this bill. NeHII is a catalyst for health information exchange, positioning Nebraska as a national leader in health information technology and development. NeHII has worked collaboratively with our health plan, other plans, and providers to bring greater efficiency to the Health Information Exchange, facilitating quality improvement and more timely service to our members. NeHII has done a great job spotlighting the importance of health information exchange in Nebraska. LB1183 establishes a Health Information Technology Board tasked with the responsibility of assuring appropriate application of health information technology, wide availability and access to data sources, and adherence to federal regulations involving privacy and security. NeHII, as the flagship of health information management in Nebraska, anticipates close collaboration with the newly-created board and key stakeholders in Nebraska in achieving great outcomes in population health management. Thank you for the opportunity to testify in support of LB1183. I would welcome any questions.

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

MICHAEL SKOCH: Thank you.

HOWARD: Good afternoon.

ERIC DUNNING: Good afternoon, Madam Chair, members of the Health and Human Services Committee. For the record, my name is Eric Dunning, E-r-i-c D-u-n-n-i-n-g. I appear today as a registered lobbyist on behalf of Blue Cross and Blue Shield of Nebraska and in addition, I am authorized by the Nebraska State Chamber of Commerce and Industry to enter testimony on their behalf. Very briefly, we believe the Health Information Exchange is a good thing. Nebraska has done a very solid job in building that infrastructure, but we also believe that oversight is good. It's time for the program to take its next steps in evolution and we welcome LB1183 as a wonderful step in that direction. So with that, Madam Chair, I'd answer any questions.

HOWARD: Thank you. Are the questions? Seeing none, thank you for your testimony today. Our next proponent testifier for LB1183.

JOY DOLL: Good afternoon, members of the Health and Human Services Committee. My name is Joy Doll, J-o-y D-o-l-l, and I'm testifying in support of LB1183 on behalf of Creighton University. This is an important bill to promote transparency and greater understanding of the positive work NeHII is doing and Nebraska is truly a national leader in health information technology and development. LB1183 ensures that these accomplishments are known and transparent to healthcare stakeholders across the state. And in the research I do, we constantly have questions from clinicians, learners, researchers about data use and data governance. And while NeHII has a robust data governance committee, this HIT board will allow stakeholders, the Legislature, and the public an opportunity to see the considerations undertaken, which is a good thing. Without connecting systems as contemplated under LB1183, we risk conducting research without proper data use. And with that, we need partnerships like the HIT board to ensure studies are designed that consider patient consent when-- and it's appropriate to share de-identified patient information and abide by policies of governing bodies like institutional review boards that are in place to protect patients and research. Thank you again and I'd be happy to answer any questions.

HOWARD: Thank you. Are there questions? And, Joy, just out of curiosity, what would you say is the best legislative district?

JOY DOLL: I would say your district, yeah, ours.

HOWARD: Good. Yeah, cool.

JOY DOLL: You got us our schools.

HOWARD: She said District 9, that's weird. Yeah.

[LAUGHTER]

JOY DOLL: I live in District 9, sorry. But as an occupational therapist, I resonated with your referral to nonpharmacological interventions so I got your back on that one.

HOWARD: Nice of you to help him out. Thank you for visiting.

B. HANSEN: You should be a politician. That's smooth.

JAIME BLAND: Chairman Howard, members of the Health and Human Services Committee, my name is Jaime Bland, J-a-i-m-e B-l-a-n-d, and I am testifying as the CEO of NeHII and in support of LB1183 and I will be brief. I really just want to address the fiscal note that was attached to LB1183 in this way. As you have spoken in session today, NeHII has very talented grant writers and in the past two years, we have brought in more money to support the PDMP than cumulatively in the past five years. There is no risk for the department, in my opinion, losing money based upon what is currently in LB1183. And in fact, we've identified a clear path for sustainable funding for the PDMP through, through the Medicaid information technology architecture, where they would not have to rely on competitive grants. We-- why would we welcome oversight? Because we believe in what we are doing and that we have the appropriate technology and security safeguards. And we want to ensure that that is transparent to, to individuals, to legislators, to policymakers, to providers, and beyond-- across the healthcare system. So we very much welcome and support the HIT board and understanding what we do, how we do it, and the appropriateness of oversight. With that, I will take any questions.

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

WILLIAMS: Thank you, Chairwoman Howard, and thank you, again, for being here. The fiscal note seems to, again, be difficult to understand and it acts like it contemplates the transfer of data.

JAIME BLAND: Yep.

WILLIAMS: Would you address that situation?

JAIME BLAND: Yeah, we-- through the data governance committee, we, we don't talk about data ownership in the PDMP because we actually, as an organization, align to that-- the data belongs to the individual, to the patient, and that the true agency for the data belongs to, to the individual. So what, what we see as ownership is actually right. So a provider has rights to the data when you enter into a care relationship. The individual has rights to the, to the data. There is no transfer of ownership to the HIT Board. It is simply providing, in our opinion, oversight to how the data is used; how the data is used by the department, how it's used by NeHII, how it's used by providers, and providing transparency in that respect.

WILLIAMS: And there's certainly no intent to transfer ownership?

JAIME BLAND: There is no intent for ownership.

WILLIAMS: Thank you.

JAIME BLAND: Um-hum.

HOWARD: Senator Cavanaugh.

CAVANAUGH: I-- just along with Senator Williams' question, it seems like the, the fiscal note from the department is very contrary to everything else I am reading about the bill itself. And including the fiscal note from our Fiscal Office, it seems like there, there is a misunderstanding as to the intent.

JAIME BLAND: Yeah, I think there's-- a couple of points for, for your consideration is that in the third, the third paragraph here, where it starts with $375,00 per year for two years for the Department of Justice, you'll see that DHHS has been awarded, but not yet accepted, a grant in the amount of $375,000 per year. So that's included. It's at $750,000, but the department has not accepted that award. And we don't accept that award for a couple of reasons, but it's actually included in the total that, that is provided here, so--

CAVANAUGH: Are you able to share those reasons?

JAIME BLAND: I-- well, I didn't write the fiscal note, but I think--

CAVANAUGH: No, I mean the reasons why we haven't accepted that?

JAIME BLAND: Sure, so there's a, there's a caveat in one of the CDC grants or Department of Justice grants that, that says data ownership-- that if we accept the funding, then the ownership of the data belongs to the Department of Justice or the organization and we reject that as a premise. Again, just reinforcing that we believe that there's data rights versus data ownership.

CAVANAUGH: I appreciate your due diligence on that, thank you.

HOWARD: Senator Hansen.

B. HANSEN: Thank you. I hope I can ask you a couple questions about the board itself; I guess, the makeup. Why is there a veterinarian on there?

JAIME BLAND: Why is there-- because veterinarians submit data to the PDMP.

B. HANSEN: OK, that's-- OK, I didn't know for sure. I just wanted to make sure.

JAIME BLAND: Um-hum.

B. HANSEN: I noticed that they will-- they have-- they're in charge of funding such activities. Do you know, like--

JAIME BLAND: Oh, the department?

B. HANSEN: "The board shall adopt policies"-- yadda, yada, yada-- "administrative tasks and funding of such activities." Do you know, like, who has oversight over that? Would that be DHHS, I'm assuming?

JAIME BLAND: I believe so. I would defer to Senator Arch, but from what I know from conversation is that there's some constitutionality concern around tasking private organizations like NeHII to support the funding of the board, so--

B. HANSEN: I was kind of wondering, in fact, how that's all going to work with this.

JAIME BLAND: Yep.

B. HANSEN: And if, if I'm reading this right, the board sets-- the oversight board sets its own policies on what to do with the information?

JAIME BLAND: It would, I believe, recommend-- I would defer to Senator Arch on the regulatory or writing authority of rules.

B. HANSEN: OK.

JAIME BLAND: But in, in conversations, I believe that the HIT Board-- I will provide you an example. What I think is that we would provide examples of our policies to provide data sets-- deanonymize data sets to the college of public health or at the University of Nebraska or Creighton University's College of Public Health for the various use cases that Dr. Rauner presented around a colorectal cancer screening because there is a difference between claims data and clinical data. So-- or Medicare and commercial and, and various issues with the comprehensiveness data in this country. But I would say that we would present how we address that kind of request. The HIT Board would then agree or disagree with those types of decisions and then provide recommendations back to the NeHII board, which would-- we would then take in consideration for our data governance.

B. HANSEN: OK. I'm just assuming this all still goes in the purview of the Department of HHS--

JAIME BLAND: Um-hum.

B. HANSEN: --who still kind of directs this in some way, maybe?

JAIME BLAND: So for the PDMP, there's definitely collaborative decision making for, for that piece. The HIE and policies adopted aren't, aren't really governed by, by the department necessarily. It's really governed by HIPAA and interoperability rules that are promulgated under the Centers for Medicare and Medicaid Services because of the seven conditions and standards that are funded through MMIS and the Medicaid information technology architecture, who really funded all of electronic health record adoption. So we worked with that federal agency to, to really define what are the data standards; what we collect and how we collect it. And, and then to your question, Senator Murman, we participate in national networks, so we exchange data with the DOD, the VA, and across the nation on a number of national networks so that if there's a query in Cincinnati and we have that patient record, we would send that data to Cincinnati, as an example.

B. HANSEN: Thank you.

JAIME BLAND: Yep.

HOWARD: All right, I just have a question about the fiscal note because it says that LB1183 removes the required collaboration between the department and the HIE. Do you think LB1183 does that?

JAIME BLAND: There were-- I don't, I don't know that we have to codify, in statute, collaborative relationships. But it was in statute and then I think the conversation that-- and I'll defer to Senator Arch-- was that we don't want collaboration and statute to override the intention of the HIT Board. It's our job, as entities working together, to maintain the collaborative relationship and the HIT Board to recommend changes or rules or however the authority is granted.

HOWARD: Thank you.

JAIME BLAND: Um-hum.

HOWARD: Any final questions? Seeing none, thank you for your testimony today. Our next proponent testifier for LB1183. Seeing none, is there anyone wishing to testify in opposition?

GARY ANTHONE: Chairman Howard, Senator Arch, members of the Health and Human Services Committee, my name is Dr. Gary Anthone, G-a-r-y A-n-t-h-o-n-e. I am Chief Medical Officer for the Division of Public Health within the Department of Health and Human Services. I'm here to testify in opposition to LB1183, which would establish a health information technology board and make changes to the Prescription Drug Monitoring Program. Department personnel have met with Senator Arch and it's our understanding that he is preparing an amendment to alleviate many of the department's concerns. We appreciate Senator Arch's efforts to work with us on these matters. This bill would create a health information technology board without establishing any processes for public comment on changes to the required reporting elements for pharmacy or facilities, such as occurs with rule and regulation promulgation. This process is essential to the understanding and avoiding potential unintended consequences of decisions. NeHII has a board and several committees with subject matter experts that are able to address concerns of the Health Information Exchange, including data governance, HIPAA, privacy and security, professional healthcare providers, and patients. Both the Nebraska Health Information Initiative and DHHS have held and participated on committee and advisory boards with the individual groups named in the bill and other interested parties to inform

decisions and provide guidance on the direction of systems for several years without being required by statute to do so. Finally, the removal of the collaboration between DHHS and the Health Information Exchange and the lack of clarity on the data rights and ownership of PDMP and other data would result in insufficient safeguards to protect data release, privacy, and confidentiality. DHHS and NeHII have been successfully collaborating on all subjects concerning the PDMP, including technology requirements, system enhancements, and data release for over four years. We value our partnership with NeHII and our successes throughout the years with our collaborative efforts. In summary, LB1183 would establish a board that does not have clear processes, procedures, or a public comment period, which is not in the best interests of patients, prescribers, or dispensers when there are already boards and committees in place. Again, department personnel have met with Senator Arch and it's our understanding that he is preparing an amendment to alleviate many of our concerns. We appreciate Senator Arch's effort to work with us on these matters. Again, this is an area I'm still educating myself on and I might have to take most of your questions back to my team for follow-up answers after the hearing. But I want to thank you for the opportunity for allowing me to testify today. Thank you.

HOWARD: Thank you. Before we get started, would you mind walking us through the department's fiscal note on this bill?

GARY ANTHONE: I will have to get back to you on that, Senator.

HOWARD: OK. Are there questions? Senator Williams.

WILLIAMS: Thank you, Senator Howard. Is there someone here that could walk us through the fiscal note?

GARY ANTHONE: I don't think so at this time.

WILLIAMS: That's disappointing. Twice in your testimony, Doctor, you used the term that the amendment that you are working on, or that Senator Arch is working on, would alleviate many of your concerns. And you said that twice, but I'm assuming from that comment that even if he brings that amendment, you will still be opposed to this bill?

GARY ANTHONE: We will take it into consideration. I think one of the concerns is with the formation of a new board and that is something we'll have to, to discuss.

WILLIAMS: OK, thank you.

HOWARD: Other questions? Seeing none, I'm very glad you're able to take the time to meet with Senator Arch about this bill in advance of this hearing. Thank you for visiting with us today.

GARY ANTHONE: Thank you.

HOWARD: Thank you. Is there anyone else wishing to testify in opposition to LB1183? Seeing none, is there anyone wishing to testify in a neutral capacity? Seeing none, while Senator Arch is coming up to close, we do have some letters in support: Dr. Steven Williams, Josue Gutierrez, Brett Wergin, Nebraska Academy of Family Physicians; Andy Hale, David Slattery, Nebraska Hospital Association; Susan Fritz, University of Nebraska; Kristin Hassebrook, Nebraska Chamber of Commerce and Industry; Dr. Todd Hlavaty, Nebraska Medical Association; Terry Shannon Thomas, Nebraska Nurse Practitioners. No letters in opposition, no neutral letters. Welcome back, Senator Arch.

ARCH: Thank you. This-- I hope this has been informative to the committee and-- both of, both of these bills-- as it relates to NeHII and, and, and the HIE. I think, I think what's very obvious is that health information is a, is a very powerful tool, but with that comes great responsibility. And Senator Hansen, earlier in your, in your questions to the previous bill, you were asking questions of oversight and how do we ensure-- how do we make sure that our citizens' information is protected, that it is released according to rules, that it is, that it is-- all of it is appropriate. And it's, and it's a very powerful tool for a couple of things. One, I think you've heard, in both of these bills, the power in clinical care so that the ability to share information amongst providers, where a patient may be seeing one doctor in one system and another doctor in another system or being in different hospitals moving across the state, that information is available to provide better clinical care. And that just hasn't been the case. We're very, we're very proprietary in our healthcare systems and the particular electronic health record that we're using in those systems don't easily talk to one another. And so this, this could be a very powerful tool. The second, however, of course, is, is the whole concept of population health. How, how do we know that our population is getting healthy? How do we know that we're taking good care? What are those quality indicators? And, and without having some, some ability to share that information, those questions can't be answered. And we've struggled with that in healthcare. We, we, we may go to a-- Blue Cross or another, another insurance company and we'd say could,

could you please provide us with data? Well, the data there is also limited due to the purpose of their, of their collecting of that data. And oftentimes for anybody, these data sets just aren't easy to query and they're not easy to get information from. So as it relates to research, as it relates to those questions-- of the larger questions of population health, it's very difficult. But it's not just, it's not just government, it's not just government that we're talking about. We're talking about commercial patients as well and the general population. And are we, are we, are we really improving any healthcare in our state? And those questions need to be asked. And-- but it's, it's-- it hasn't been easy for healthcare providers to answer those questions. So with, with the recognition that information is a very powerful tool, I felt, I felt the need, at this point, now to set up some form of public oversight. And as you can see from the, from the green copy that you have of the bill, it, it is a very technical board. The membership is, is-- are, are-- brings technical expertise. This, this is not-- this is-- there's going to be very, very technical questions asked with regards to compliance with regulations and, and, and making sure that the technology, as well as the release of information, all follows the law and is-- and it is a very technical response to that. So this-- it is a, it is a very technical board. You can see the Department of Health and Human Services has a place on that board. We've, we've talked with the department about this issue of collaboration. This, this is evolving. The NeHII HIE is evolving and, and it has been a lot of communication back and forth to Department of Health and Human Services and NeHII in developing the protocols and developing and making sure that we're following those regulations. But I felt as though we are moving to a new level. I was, I was very much aware and involved in that early stages of NeHII when it was born. And it was, it was primitive, very primitive. A lot of the emergence-- it was, it was-- at that time, a lot of the use of NeHII was in emergency rooms. So if you had somebody that was seeking narcotics or opioids or whatever it may be, you, you could see that there may be some individuals that were traveling from emergency room to emergency room complaining of pain that would be receiving multiple prescriptions. And, and so it started at that level and I say that level is, is very primitive. While very important, it was, it was very basic information. But the use in the doctor's office, it was, was very formative at that time and wasn't used, used widely. But now it's, it's very different. The vision, vision that our HIE, NeHII, is bringing now to the table is, is, is much broader. You've heard even discussions today of social determinants of healthcare, which now, now the question is going to be asked; if we're, if we're going to begin

collecting social determinants of healthcare, now we're going to also be asking the question of, well, which of those social determinants really improves-- if we were to put dollars into that particular social determinant of healthcare, would we see significant improvement in, in, in quality of health in the state of Nebraska? So we're moving to a different level. We're moving, we're, we're moving much farther beyond, perhaps even what the original vision was for NeHII when it was created. I want to address a couple of things specific to the, to the bill and a couple of the questions that were asked. One had to do with funding. We struggled with some of the language in, in exactly how this technology board would be funded. Because from my understanding, you as a government, as the Legislature, can't direct somebody, well, you have to pay for this and so NeHII, you have to pay for this. However, through, through contracting through the Department of Health and Human Services, I think we found a vehicle that, that NeHII can support this HIT Board and, and provide that funding. So I think you're going to see some of that in an amendment that, that is, that is going to come. This amendment of collaboration, some of the language was struck in that-- in the original, in the original bill, regarding collaboration with the department. There is no intention to stop collaboration with the department and, and prevent that from occurring. That's going to occur. That, that has to occur. But it's not just Medicaid. Now as we look to Medicaid expansion and as we've heard from some of the MCOs in testimony today, I think that we're all seeing this as an opportunity to also begin to view some of the, some of the-- this, this very basic question of, are, are we improving the healthcare in the state of Nebraska? And in particular, as we get into Medicaid expansion, where we don't have a lot of information on those who will benefit from, from receiving Medicaid as adults-- we don't have a lot of information at this point as to, as to how, how we can really improve their healthcare. So it's an opportunity. It's an opportunity, but with that comes a lot of responsibility. And this data is extremely powerful. And I felt as though having this governmental oversight would, would provide another layer of protection and, and help with our HIE to make sure that we receive the benefit, but that we protect this information that we're collecting on all of our citizens. So with that, I would, I would take any questions you may have.

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

CAVANAUGH: Thank you. Thank you, Senator Arch. On page 3 of your bill--

ARCH: Um-hum.

CAVANAUGH: --you do-- and you mentioned this in your closing just now-- lines 9 through 12-ish, that there has to be a representative from the Health Information Exchange and from the Department of Health and Human Services and I actually see Appropriations and HHS Committee Chairs as well. So that, to me, is-- I mean, it's not stated, but that is collaboration, is it not?

ARCH: Right, right. That's, that's collaboration at that HIT Board level where, where everybody's involved in that.

CAVANAUGH: Um-hum.

ARCH: But the HIT Board isn't going to be involved in the day-to-day operations. And there's always those issues that are going to occur between NeHII and the department with regards to the PDMP and some of the-- some of the nitty-gritty issues. That will continue. As it is today, that-- I would-- I-- that's how I see it.

CAVANAUGH: I guess what I was getting at-- it seems like you're adding additional collaboration, just not using the words, so--

ARCH: I would agree with you.

CAVANAUGH: --of collaboration.

ARCH: Yes.

CAVANAUGH: And I apologize because I'm kind of putting you on the spot with this question because I don't know the answer myself, but it was, it was an issue in, in the department's testimony about the same level of transparency for public comment, et cetera. And on page 2, at the top, lines 1 through 9, it kind of talks about the formation of the board and the board members. And we just went through this, at the start of today, with the gubernatorial appointments. Do these not--maybe they don't apply to the public, the public meeting-- when meeting?

ARCH: And we had some of that, we had some of that discussion. This, this, this, of course, are going-- they are going to be Governor

appointed with, with approval by the Legislature as far as the members, as far as the--

CAVANAUGH: Right.

ARCH: --members of this committee is concerned, and--

CAVANAUGH: So that's pretty transparent right there.

ARCH: --and in the-- right and in the, and in the-- because I would argue that at the present time, that isn't the case. That, that oversight-- yes, yes, the Department of Health and Human Services and NeHII are working very collaboratively and all of that is occurring, but I think that this would add a level of oversight and a level of accountability. I think when you see the amendment, some of those questions are going to be answered as well because we, we did have some discussions regarding, regarding public, public input and the open meetings.

CAVANAUGH: Thank you.

ARCH: Yeah.

HOWARD: All right, any final questions? Seeing none, thank you, Senator Arch.

ARCH: Thank you.

HOWARD: This closes our hearing for LB1183 and we are done for the week.