HOWARD: --and who will be taking notes and moderating the Zoom. I'd like to thank the Legislature's Technology Office and the Clerk's Office for their assistance in putting together these Zoom meetings. And today is our first day of livestreaming on NET, which is very exciting. And so we want to thank the folks at NET for helping us out. For that, a few notes about our policies and procedures. These hearings are being recorded. A livestream of the proceedings is available on NET's Web site, net.nebraska.org, which can be found through a link on the HHS Committee's page on the Legislature's Web site, which is nebraskalegislature.gov. Please keep yourself muted unless you are testifying. There's an icon at the bottom of your Zoom window that looks like a microphone, which you can click to mute or unmute yourself. This morning we'll be hearing one interim study, and we'll be taking, taking it in the order listed on the agenda on the legislative calendar. If you're planning to testify today, please ensure the introducer of the interim study has your updated contact information, including name, email and phone number. This will help us keep an accurate record of the hearing. If you also 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. on the day prior to the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. Please provide a copy of your handout to the introducer of the interim study and a copy to our committee clerk, Sherry Shaffer. Her email address will be posted in the chat. If you have an electronic copy of your handout on the, on the screen, you are able to share your screen if you'd like to do so during your testimony. Each testifier will have five minutes to testify. When you begin, the timer will start. We'll ask you to wrap up your testimony after five minutes has, has passed. We're a little bit analog here. So can everybody, can-- T.J., can you wave so that people can see you? OK, so when you have one minute left, T.J. is going to hold up a yellow card and then, when you are done, he's going to hold up a red card. And that will be a clue to me to sort of advise you to wrap up your testimony. OK? All right. When you testify, please begin your testimony by stating your name clearly into the microphone, and then please spell both your first and last name. The hearing on each interim study will begin with the introducer's opening statement. After the opening statement, we'll hear other testimony. The introducer of the bill will then be given the opportunity to make closing statements if they wish to do so. We do have a very strict no-prop policy here in the HHS Committee. And with that, we'll begin today's hearing with LR445, Senator Stinner's interim study to update data and review the potential impact on the state behavioral health

system by expanding access to prescribing psychologists. Welcome, Senator Stinner.

STINNER: Thank you, Chairperson Howard and members of the Health and Human Services Committee. For the record, my name is John, J-o-h-n, Stinner, S-t-i-n-n-e-r. I represent the 48th District, which is all of Scotts Bluff County. LR445 was introduced as a follow-up from my bill the last session, LB817. I'd like to provide the committee with additional information on why Nebraska needs psychologists with prescribing privileges in the delivery of mental and substance abuse treatment. This is especially pronounced that we are in the midst of a pandemic. As you all undoubtedly aware, it has magnified the number of public health crisis [SIC], mental health being one. Since the hearing on LB817, we have worked to craft language that attempts to address physicians' concern, moving this debate from a dispute over who can provide these services in the healthcare professionals into a policy discussion. Dr. Ullman will provide me to-- will provide details of the changes that we proposed. I have distributed to the committee a chart showing the years of training and education for a potential prescribing psychologist compared to MDs in psychi-- psychiatry, psychiatric nurse practitioners, and physician assistants. In addition to extensive education, my legislation would continue to require additional education and training for prescribing psychologists, as well as two years of physician supervision. Safety is my first goal in this legislation. As I started in the-- as I stated in the hearing on LB817, the military has allowed psychologists to prescribe for more than 20 years. We had a presenter, Dr. Mike [SIC] Merritt, who testified on how this experience in the military, as a prescribing psychologist, worked well in expanding the treatment of-- of treatment to our service members and veterans. This is not a pioneering project for our state, as several states have also adopted in this legislation. We also know that there are psychologists being recruited in various states, Iowa being one of them. They passed enabling legislation and they are actively pursuing our psychologists. There is a critical need in our state to expand behavioral health services. My legislation won't solve all access problems, but it will certainly take a big step in the right direction. I'm dedicated to getting something done on this issue. Thank you, Chairperson Howard. Merry Christmas to everybody, and I will now open for questions.

HOWARD: Thank you, Senator Stinner. Are there questions for Senator Stinner? All right, seeing none, we will invite our first testifier up, Dr. Daniel Ullman. Welcome, Dr. Ullman.

DANIEL ULLMAN: Thank you. Chairperson Howard and members of the Health and Human Services Committee, my name is Daniel Ullman, D-a-n-i-e-l U-I-l-m-a-n. I'm here to represent the Nebraska Psychological-- Psychological Association regarding LR445. I was before the committee in January regarding LB817, the Prescribing Psychologist Practice Act. There are other testifiers here this morning you have not heard from, so I will be concise. Following me is a psychologist practicing, practicing in Norfolk, a training director from New Mexico who prepares psychologists for prescriptive authority, an advocate for Nebraskans seeking comprehensive behavioral health services, and a psychiatrist from New Mexico. All are prepared to speak about the potential impact on the behavioral health system by expanding access to prescribing psychologists. As indicated by Senator Stinner, we have worked to craft bill language since the public hearing in January, to address concerns expressed by physicians. I highlight three of those: 1) a collaborative practice agreement with a physician [INAUDIBLE] propose Prescribing Psychologist Practice Act. Senator Stinner filed the language on February 12. This reflects our full commitment to a collaborative practice model. The prescribing psychologist would collaborate with each patient's primary care provider, provider to seek concurrence on any psychotropic medications and, also, operate within the confines of a collaborative practice agreement with a physician that establishes clinical protocols and practice guidelines. 2) A family practice physician was added to the interdisciplinary committee that would draft rules and regulations for prescribing psychologists. The rules committee would be composed of a psychiatrist, a pediatrician, a family doc, a pharmacist, and a psychologist. Prescribing psychologists in Nebraska would operate under the rules created by an interdisciplinary process. 3) Bill language was strengthened to clarify that physicians or other health providers would not be liable for the acts of a prescribing psychologist. Senator Stinner also noted that the pandemic has magnified public health crises. My colleague, Dr. Anne Talbot, who practices in Scottsbluff, shared a story of how a consumer in her office presented with a severe and persisting mental illness, and she needed both psychotherapy and psychotropic medication. Although Dr. Talbot's group, group practice could provide the patient with the psychotherapy, it could not get the patient an appointment with a psychiatrist until March 2021. If there was a licensed prescribing psychologist in her office, the patient would not have to wait three months for the medication she needs, and she would have both psychotherapy and medication addressed together in the same appointment. This model of care would immediately benefit, benefit patients and spare them the added costs of seeing separate providers.

The Centers for Medicare and Medicaid Services and the American Medical Association recognize the work of prescribing psychologists with their billing codes. The prescribing psychologist treating the patient in Scottsbluff, for example, would bill for the 60 minutes of cognitive behavioral therapy for the major mood disorder and use the add-on pharmacologic code when prescribing a medication that could make treatment even more effective. This is a one-stop-shop approach to comprehensive behavioral healthcare. Senator Stinner mentioned the chart showing the years of training for prescribing psychologists compared to other professions currently prescribing in the state. Psychologists commonly have 10 or more years of undergraduate and graduate education prior to the additional specialized postdoctoral training to prescribe a limited range of medications. Despite the extensive training completed by prescribing psychologists, it is challenging to get beyond professional bias and turf wars. However, two studies in my written testimony sidestep this. I'm going to have to really be brief with this. They basically had 425 physicians and other prescribers and healthcare professionals rate the training of various professionals. And they took out the identifying information about which program was training which provider, so it's basically like medication trials. You are blinded to, to whether you got the vaccine or not. Controlling for professional bias, the writers indicated that prescribing psychologists had the highest ratings for being prepared to provide psychotherapy and medication compared to physician assistants, psychiatric nurse practitioners, licensed clinical professional counselors, and family nurse practitioners. In another study, prescribing psychologists, psychiatrists, and psychiatric nurse practitioners took the same knowledge exam. That's clinical psychopharmacology. And I need to stop, don't I?

HOWARD: We'll have you wrap up.

DANIEL ULLMAN: When you have five minutes--

HOWARD: It goes fast [INAUDIBLE].

DANIEL ULLMAN: OK, I just, [INAUDIBLE]. Can I just list a couple other things? Or is that--

HOWARD: You know, let's see if there are any questions from the committee, and then we can circle back to your final thoughts. How's that?

DANIEL ULLMAN: OK, sorry about that.

HOWARD: No, you're wonderful. Senator Arch.

ARCH: Thank you. I, I do have several questions just for clarification of what your testimony is here. And so collaborative practice agreement, you mentioned. You also mentioned collaboration with referring physician. Is there, is there a-- there would be a-- you're proposing there would be a formal collaborative agreement, is that correct, with one, with one physician?

DANIEL ULLMAN: Yes.

ARCH: OK. Is there an end to that collaborative agreement?

DANIEL ULLMAN: Not in the bill currently, no.

ARCH: OK, all right. Second, second question: family, family practice. Help me understand what this rules committee is. What, what, what's the role of the rules committee that you mentioned?

DANIEL ULLMAN: They would-- well, there's a number of things that they would have to address. Which programs, for example, would qualify an, an applicant to receive to, to receive the prescriptive certificate? So it would look at the training programs and some specificity there. It's very much like what Iowa did with their Board of Medicine and Surgery and the Board of Psychology. They got together and they got a hold of training programs like the one at New Mexico State University, and that helped craft the rules and regulations. So they would need to dig down into the weeds about the collaborative practice agreement with a physician. So for example, you know, as you remember in the hearing, there was concerns about a prescribing psychologist prescribing out of their scope of competence with vulnerable populations, say, for example, children or the elderly or people with complex medical conditions. That would need to be addressed in the rulemaking process, this all being overseen by the Department of Health and Human Services, which, of course, has a lot of knowledge about regulating prescribers. So they would-- it would be kind of a collaboration between those different groups.

ARCH: So this, this rules committee would be in an advisory capacity to the department as rules and regs are promulgated?

DANIEL ULLMAN: Yeah.

ARCH: Am I understanding that correctly?

DANIEL ULLMAN: Yeah, that's called an advisory committee. Yeah.

ARCH: OK.

DANIEL ULLMAN: So it'd be up to the Department of Health Human Services, how this would look in, in the end.

ARCH: OK. All right. And public hearing on rules and regs and all that. OK.

DANIEL ULLMAN: Exactly. Exactly.

ARCH: Third, the third men-- the third point you mentioned was physicians won't be liable for actions of the psychologists. Are you talking about the physician that holds the collaborative agreement with the psychologist?

DANIEL ULLMAN: They're-- yes. Well, let me say, if you're not-- yes, there's going to be some variation in terms of if, if the person is being supervised, there would be some responsibility as a supervisor for. But for much of this, if you're getting a referral from a physician, the physician is responsible for their medical treatments. The prescribing psychologist is responsible for the psychological care that they provide. So it's kind of hold harmless sort of thing. So with a collaborative practice agreement, the prescribing psychologist would be held accountable for staying within the confines of that. So if they go outside of that, they're liable for that.

ARCH: OK.

DANIEL ULLMAN: Now psychologists already have malpractice insurance. They're very used to--

ARCH: Right.

DANIEL ULLMAN: --you know, their liability. In fact, we're a little compulsive about it. And so I did check with these other states, and-- because one of the concerns was that, brought up is that, oh, the amount-- if the physicians are involved with prescribing psychologists, their malpractice insurance rates will go way up. So I called New Mexico and Louisiana, and they started checking with the physicians that they work with. And they said, no, our rates didn't go up. The reason being is that, if you look at the insurance industry, midlevel providers actually have a lower liability.

ARCH: OK, OK. Last--

DANIEL ULLMAN: Yeah. So if you-- if you actually bring that into your practice, your overall liability would lower.

ARCH: OK, last question I have is--

DANIEL ULLMAN: Yeah.

ARCH: --is you mentioned-- you mentioned limited range of meds. Are you proposing in-- that there would be a limited range of meds, not all psychotropic meds available?

DANIEL ULLMAN: This would have to be addressed in the rules and regulations, and, and the pharmacist on the 407 was very helpful, and-- with this-- but it's not really a formulary. You'd have to define the scope of drugs. So you can look at like what they do in the military, what they do in Louisiana, New Mexico, federal agencies. They could list things like antidepressants, antianxiety medications, mood stabilizers, certain adjunctive medications. You know, the one thing that New Mexico uses is that this needs to be evidence-based prescribing. So you'd have an FDA indication for a mental disorder, for example. You could also use resources that pharmacists use, that there's research to back up the use of this particular medication for this disorder, because you got to rein in, frankly, this off-label prescribing. And so there-- so--

ARCH: OK. So that would--

DANIEL ULLMAN: I wanted to [INAUDIBLE]--

ARCH: That would be addressed in the rules. That would be addressed in the rule development,--

DANIEL ULLMAN: Right.

ARCH: --the regulation development. Could it also be addressed in the collaborative agreement? Could a physician say, if you want--

DANIEL ULLMAN: Yes.

ARCH: --a collaborative agreement with me, I am--

DANIEL ULLMAN: Right.

ARCH: --going to restrict the type of--

DANIEL ULLMAN: Yes.

ARCH: --medications that you can prescribe?

DANIEL ULLMAN: Ab, absolutely. That's--

ARCH: OK.

DANIEL ULLMAN: That would be very important. Like for example, myself, if I was doing this-- which I'm not, I'm semiretired-- but. my training is more for people age 18 and older. Now, I may still see kids for testing and family therapy, but I would not be prescribing to them because I don't have the background. I don't have the specialization with children to be, to be prescribing them medications.

ARCH: OK.

DANIEL ULLMAN: That would be-- yeah.

ARCH: Thank, thank you. That, that helps, that helps me better understand. Thank you very much.

DANIEL ULLMAN: I, I, I-- those were very good questions. I appreciated those, Senator.

ARCH: Thank you.

HOWARD: All right, thank you. Are there other questions from the committee? All right, seeing none, thank you for your testimony today, Dr. Ullman.

DANIEL ULLMAN: OK, thank you.

HOWARD: All right. Our next testifier is Dr. Connie Petersen. Welcome, Dr. Petersen.

CONNIE PETERSEN: Good morning. Good morning to Senator Howard and members of the HHS Committee. My name is Dr. Connie Petersen. Connie is C-o-n-n-i-e, Petersen, P-e-t-e-r-s-e-n. I'm a licensed psychologist practicing in rural Nebraska. And I'm here today to discuss my-- why Nebraska needs psychologists with prescriptive authority for clients who need timely, comprehensive behavioral healthcare in rural Nebraska. I'm a native Nebraskan, born and raised in Kennard, which is down in Washington County, and I've worked at Behavioral Health Specialists in Norfolk since 2007, as an outpatient director and clinical director. In this capacity, I supervise behavioral health and addiction services throughout our outpatient clinics, as well as two

short-term residential treatment centers. In my time of working in rural Nebraska, I've personally witnessed the stress and turmoil that a lack of psychiatric providers puts on our clients, our communities, and our behavioral healthcare system. Having to tell a client their first telepsychiatry intake appointment is not for one to two months, and seeing the look of despair, and sometimes fear, on their face is heartbreaking every time it happens. Our team of therapists try to do what they can to help. But for the past 13 years, we have not seen any end in sight to the lack of psychiatric providers in our area. We've collaborated with primary care physicians and nurse practitioners to try to bridge the gap. And some of the rural physicians and physician assistants are just, frankly, not comfortable with prescribing certain medications for major mental illness, but they, too, know the importance of timely intervention. So we have to try and figure something out. If a client becomes ill, suddenly lacks transportation, gets called into work or otherwise is unable to make that one scheduled appointment, then the whole entire wait process starts over. In the meantime, clients turn to other sources for relief. For some, it's been drugs and alcohol. For others it's been self-mutilation. And for the unfortunate few, it's been suicide. The barrier in our behavioral healthcare system is created by not having enough providers with specialized knowledge in prescribing the needed medications. I've attempted to make an impact, as an employer in the behavioral healthcare field, to bring qualified psychiatric providers to rural Nebraska. But quite frankly, retaining them in rural Nebraska has not worked. In my time of working in my role, we've employed a handful of part-time psychiatrists who are already so overbooked in their full-time employment that they could only offer a few days a week of evening hours only. Evening hours tend to be less than ideal for clients who depend on public transportation. The needs of the psych-- the needs of the clients desiring psychiatric care are so overwhelming that those providers burn out so quickly. We employed one phenomenal full-time nurse practitioner who sought out a rural health site to receive the loan repayment options through the National Health Service Corps. But unfortunately, as soon as her obligation to the National Health Service Corps ended, she was quickly recruited to a more populated city in Nebraska that was able to offer a much higher salary than we could ever afford in rural Nebraska. It's a struggle to obtain and retain psychiatric providers who desire to work long-term with significant caseloads of severely and persistently mentally ill clients. And then on top of that, we're asking them to do such in rural Nebraska. I believe that psychologists with specialized training to prescribe needed medications can bridge this behavioral healthcare gap. I believe so much in helping the clients in rural Nebraska that I

personally began the journey to obtain that specialized training through New Mexico State University. I realize I took this leap without certainty of when Nebraska psychologists will obtain prescriptive privileges. I took this leap because I'm passionate about trying to make a difference in the lives of the clients that we need to serve. My best efforts to fix this behavioral healthcare system gap over the previous 13 years has not resulted in anything different. And I had had enough, and I knew I needed to be a part of the solution. I took the leap and began my journey through New Mexico State University in their clinical psychopharmacology program. New Mexico has proven that they have training and oversight processes figured out. After all, New Mexico psychologists have had prescriptive privileges for almost two decades. I knew this task would not be easy. I had to weigh the costs with the potential benefits. I have a family with five small children to raise. My husband and I own a small business. I oversee three outpatient clinics and two short-term residential programs, and I manage a crisis response team for the entire Region 4 area. But I genuinely believe that one day these efforts are going to be worth it. I've worked extremely hard to develop solid reputations with our clients and surrounding professionals, and they trust that the work that we do is going to be part of our mission. The people, they believe in our mission that we have at Behavioral Health Specialists. Many of my professional colleagues have expressed great hope that Nebraska, like other neighboring states, will recognize the great value of prescriptive authority for psychologists. They see this as an opportunity to move Nebraska ahead of other states in meeting the needs of our clients in a timely manner. I'm currently midway through my program, believe it's a very comprehensive and actually quite challenging program, but it's been very worth it. The coursework has required me to travel to New Mexico and Davenport, Iowa. I'm currently exploring options in the Norfolk area to eventually be able to complete my practicum under the supervision with a local physician. I believe to understand and meet needs of Nebraskans, I need to complete this practicum in rural Nebraska. All right, I just saw T.J. put up his red.

HOWARD: We're very analog, but it works. All right. Are there any questions for Dr. Petersen from the committee? Senator Walz.

WALZ: Hi, Dr. Petersen. Thanks for coming today. I'm just curious, has there been any data collected on how-- in Nebraska on how many people go untreated? And then follow up on that-- do people-- are there are a lot of people that end up going, actually going to their appointments when they're two to three months out, or do they just kind of like fade away?

CONNIE PETERSEN: Well, there are statistics on show rate. We actually moved to an open-access clinic for all of our therapy services because of this. And there's been a lot of research in Nebraska that, if you can't get an appointment within five days, that the actual show rate is incredibly small. Any time after five days, it's less than about 50 percent show up. We even try to do reminder calls for our clients just to help them, encourage them for their psych-- telepsychiatry appointments. And if I were to, to ask my staff, they would say about 50 percent of them end up showing up because they, quite frankly, forget that far out.

WALZ: Thank you.

HOWARD: Senator Arch.

ARCH: The last-- thank you for your testimony, Dr. Petersen. The last that I saw in statistics, family practice, pediatricians, primary care physicians, particularly in rural areas, are the, are the majority of the prescribing physicians, psychiatrists being less than that. Is that-- do you see that true in your area?

CONNIE PETERSEN: Well, we absolutely do. And the physicians actually call us and get a collaborative agreement already, which is you do therapy and you wrap your community support program around this client. And we may consider prescribing medications, but without that, we're not willing to touch it. And so we have had clients go to Omaha or Lincoln to receive psychiatric care or they'll make that wait, which is, again, one to two months out before they can see a psychiatrist. But they will call us, literally, and say: You guys know what you got? You guys have this figured out? You have a lot of therapists who can meet. If we can collaborate with you, we'll start the medications. If we can't collaborate, we're not willing to touch it.

ARCH: Thank you.

HOWARD: Thank you. Other questions? All right, seeing none, thank you for your testimony today, Dr. Petersen.

CONNIE PETERSEN: Thank you.

HOWARD: Our next testifier is Dr. Casey McDougall. Welcome.

CASEY McDOUGALL: Yes, hello and good morning, Senator and collective audience. Thank you for having me. What an honor and privilege. My name is Dr. Casey, C-a-s-e-y, McDougall, M-c-D-o-u-g-a-l-l. I am the

current training director for New Mexico's clinical psychopharmacology program, which is American Psychological Associate-- Association designated. I'm also a full faculty professor, teaching coursework, graduate coursework in clinical psychopharmacology. I'm a behavioral health consultant for a local rehabilitation hospital as a prescribing psychologist. Prior to that, before I was recruited at NMSU, I was a behavioral health director in Indian Health Service for nearly ten years and a combat war veteran of Operation Iraqi Freedom III. Simply put, progressive legislation across the nation in a great station-- state like Nebraska is improving the access and continuity of care for your constituents. It's also providing more health literacy and equality for your patient populations. I'd like to also start by saying these programs have tremendous oversight. We are held by the legislation by the state, the training and education criteria of the American Psychological Association Designation Committee, our own quality assurance parameters as a regionally accredited institute in the Higher Learning Commission. The program is very demanding. There are very-- there are three major degree requirements: over 450 hours of didactic coursework; 2) supervised clinical field experiences in pathophysiology, physical assessment; and a combined medicine-- 100 patient, 400 hour-- where you're practicing the components under supervision, not yet able to prescribe, of making medical recommendations and enhance patient education. To move forward postdegree, one must pass a very rigorous, nationally regulated by the ASPPB Association, psychopharmacology examination for psychologists. You know, getting that postdegree is actually making yourself more of a qualified consultant before you even apply for prescriptive authority. What they don't tell you, at least the, the public and legislation, off the bat, is getting the certificate doesn't stop there. It begets getting a controlled substance number. Now a psychologist can only prescribe benzodiazepines, not opioids. Then you have to get a DEA number, enroll in a prescription monitoring program. So there is lots of checks and balances involved on top of that collaborative practice that we spoke about earlier. And New Mexico has a very fantastic, in their application example, of a collaborative practice supervisory agreement. I want to also highlight what other members have said about the amazing collaborations with the Joint Commission in Iowa to have the Iowa Psychological Association and Board of Medicine approach NMSU, OK, about the training model and product that we provide that offers enhanced, robust experiential training with mock simulation exam rooms, all of the most advanced equipment that students can be prepared for once they become a conditional prescribing psychologist. So for them to take components of our model and include it in the rules and regulations shows pretty

progressive nature, how different parties can work together for the advancement of the constituents in their country. I'll leave with just saying a very small story. Even when I was in training, prior to becoming licensed as a prescribing psychologist, which was in 2018, I was working in my capacity as a behavioral health director and undergoing supervised training. And a young woman came to me and she was nowhere near ready to, to move forward with her partner with an unplanned pregnancy, had discovered, on her own volition, she was taking an herbal supplement known as St. John's Wort-- not very well efficacy research, but has some components of mood enhancement behind it, but also under contraceptive. If it wasn't for the education and some red flags that went off in my head to contact the pharmacist immediately and quickly discover we needed to educate that individual to quit taking and discontinuing the St. John's Wort altogether, or else you may have had an unplanned pregnancy and further escalated some of her preexisting depression. On that, I think I've hit all of the highlights. Thank you for your time. I'm open for questions.

HOWARD: Thank you. Are there questions from the committee? All right, seeing none, thank you for your testimony today. I see Dr. Fineberg has, has joined us.

DONALD FINEBERG: Yeah. Zoom-- this Zoom link worked. Thank you.

HOWARD: Oh, good. I'm so glad. OK, so you are next up. You have five minutes to testify, but we ask you to [INAUDIBLE] spell your name for the record.

DONALD FINEBERG: OK. I'm sorry, that was a confirmation call from Nebraska. So I assume that's about this, so I'm going to just delete that. That's good. OK, so I'm sorry, what was your question?

HOWARD: So we'd like you to state and spell your name for the record, and then you'll have five minutes to share your testimony with us.

DONALD FINEBERG: Thank you. My name is Dr. Donald Fineberg, F-i-n-e-b-e-r-g.

HOWARD: Thank you. And you have five minutes to tell us whatever you'd like about this issue.

DONALD FINEBERG: OK. Well, by way of background, let me say that I've been a psychiatrist here in New Mexico since 1978, and I've served on the state board for the prescriptive authority for psychologists since the inception of the law passed by Governor Johnson in 2002, and put into place 2003. And so in five minutes, I think I'd like to emphasize

a few results of the law that has now been in effect almost 18 years. I think first and foremost, the-- giving prescriptive authority to psychologists and allowing them to be licensed to prescribe psychotropic drugs, not drugs in, in general, has added a tremendous amount of access to this much needed care throughout New Mexico. Psychologists serve not just where there are many psychiatrists, like in Santa Fe and Albuquerque, but in-- throughout the state. Their-- most of New Mexico is rural and had very little access to care. Psychologists serve in rural clinics. Also, they have taken positions in the state corrections facilities. They also serve on the Indian reservations around the state where previously there was no access to quality care. So expanding the access was one of the actual results that was very important that we hoped would be achieved by this law. Secondly, I think that one of the concerns when the law was first passed was whether or not psychologists would have adequate training to perform this task. And two things about that: One is that the program set up to train the psychologists was extensive in two ways, not just about the pharmacology of the prescription, but as their work as a part of a team in the application. This is important because most psychotropic drugs were not prescribed by psychiatrists, where it was very difficult to get an appointment, but rather prescribed by people in general practice. And they were using psychologists as a reference not just to assess the patients, but also to make recommendations about the medication. And so in many, many instances, what happened when the law was passed was the de facto prescriber became the de jure prescriber by the law. And this was much to the relief of the people in general practice. Even the psychiatrists who were afraid the psychologists would compete too much found that their practices got no less busy because the need was so great. Another aspect of the question of, of the safety is the fact that there's a trade-off. Remember, people who don't have access to care not only suffer from many of these psychological conditions that could be treated, but it, it, it makes an incredible difference in their lives. That's why, for example, specialty emphasis on geriatrics and pediatric prescribing was part of the training program, where those services were very, very hard to find in New Mexico. I think that, you know, since I only have five minutes and since I have all this experience with the program, I'd be interested in knowing if the committee has any particular questions they'd like me to address, because this way, I think those questions can be answered more than a brief summary that I might be able to provide.

HOWARD: Sure, let's see if there are any questions from the committee. Are there questions from the committee? Oh, Senator Murman.

MURMAN: Yes, thank you for your testimony, Dr. Fineberg. You mentioned that before prescribing psychologists were allowed to prescribe in New Mexico, that most of the medications were prescribed by general practitioners. How does the training for psychologists differ from what the trained general practitioners would have?

DONALD FINEBERG: Well, general practitioners are-- and internists are trained in medical school for all variety of conditions, like my license is as a physician and a surgeon but, let me tell you, I haven't looked at an appendix since in medical school, you know. So their training is for general practice. Their training in psychiatry in particular is usually one rotation without a lot of specialty emphasis. The other thing I want to emphasize here is that the training of psychologists differs because their Ph.D., over many years, emphasizes the diagnosis of the conditions themselves. This is the key 90 percent of the battle because, with the proper diagnosis, you can look up in a manual the current regimen of treatment with medication. So what's really important here is not just to compare how long a doctor goes to medical school with mostly irrelevant training for psychotropic drugs versus how long this intensive program for psychologists is, but rather to look at the arc of the eight or ten years that the psychologist has taken to get their Ph.D. and and postdoc-- several of our psychologists have postdocs in things like neuropsychology-- but, but also, once that diagnosis is made, how to then apply the specialty training in giving the medication.

MURMAN: Thank you. That was the intent of my question, is how the training for or diagnosing and prescribing drugs, these types of drugs compared. So thank you very much.

DONALD FINEBERG: Yeah, you're welcome.

HOWARD: Thank you. All right, are there other questions from the committee? All right, seeing none, thank you for your testimony today.

DONALD FINEBERG: May, may I make one concluding remark?

HOWARD: Sure.

DONALD FINEBERG: OK, 30 seconds. Not only doctors have been appreciative, but everybody who's on the front line over the years in my network of providers has expressed appreciation. We're talking about podiatrists, chiropractors, people who provide primary care, the first line of defense. These are the very people who come and say, I can't get an appointment for my patient who needs psychotropic

medicine. And that access has made a tremendous difference in networking and teamwork. Thank you so much. I know this was very brief. Please feel free to contact me if you need more information.

HOWARD: Thank you, Dr. Fineberg. All right. Our final testifier today is-- oh, Megan, I'm going to mispronounce your last name for sure. Megan Misdegadis [PHONETIC].

MEGAN MISEGADIS: So close.

HOWARD: So was it so close? Welcome to the HHS Committee. Please state and spell your name for the record and then you have five minutes to tell us whatever you'd like.

MEGAN MISEGADIS: OK, it's Megan Misegadis; it's M-e-g-a-n M-i-s-e-g-a-d-i-s. And I am a parent of a 22-year-old on the spectrum, and I'm also the president of the Autism Society of Nebraska. Today I'm here mostly as a parent, but also as an advocate who's talked to many, many parents over the last 15 years across the state. I grew up in North Platte, Nebraska, and I've lived in Lincoln for the last 35 years. But I have roots in mid, mid-Nebraska and western Nebraska, as well. So that, that's definitely in my mind all the time. Also as a statewide organization, the Autism Society, we serve the whole state. So we feel like we try to make sure that nobody is left out of just the metro areas. When I was asked to come talk about this, I was really excited because I think this is a great need. I can talk a little bit about my personal experience and then also touch on things that I'm sure the psychologists all here and psychiatrists would hopefully, probably agree. My son was diagnosed at age 2 and he's now almost 22, so I've been in the education system and been around psychologists, psychiatrists for the last 20 years with his services and, then again, as an advocate for the last 15 or so years. A lot of things that have been brought up so far have been, have talked about access, knowledge and collaboration. And I can talk specifically about access and knowledge because those two have definitely impacted my family and, I know, many, many others. Access obviously is a huge, huge need across the state. You typically can get in front of a psychiatrist and, if you do, it's a very quick appointment. And so one of the things that we talk about access is not only just getting the appointment, but when you do get the appointment, you have a very short window of time to explain what a psychologist has likely told you are your primary issues, so there's that issue. But then the fact that-- I'll kind of tell a little bit of a story about my personal son. And so he had extensive psychological treatment his whole life because that's, that's an area that we completely believe in and

access that. We have also visited a psychiatrist for almost 18 years. There sometimes is a disconnect when you, when you see a psychiatrist who doesn't have maybe the background in autism. Maybe they don't have the extensive knowledge of your condition or your family's condition. And misdiagnosis happens in that case, and especially-- and I can't speak to any other thing other than autism, but there are often comorbid disorders with autism. And some things may look like other situations. For example, it might look like bipolar disorder or it might look like schizophrenia or it might look like some of these other things. Without the explicit knowledge of the diagnosis and the counseling that's happening, you can end up on drugs that are harmful. And in the absence of time with a psychiatrist, oftentimes you go down a route that is very difficult to get off and so we talk about-- and so far it's been talked about quite a bit about access. But once you gain access, it can be pretty time-consuming and difficult to get on and off meds. And when you don't have access to a psychiatrist or that appointment might be several months out, that gets very complicated. My son, in particular, was misunderstood by a psychiatrist and went on medications that were harmful for a couple of years actually. We backed that down off. It wasn't by any intention or any-- it was an honest mistake, I guess, is what I'd like to say. But it was one that was made without knowledge. And I've heard this many, many times across the state with other families. So again, I guess I would concur and come back to that it is an issue of access, knowledge, and collaboration. And I think this is a terrific step toward remedying some of those issues. So if you have any other questions, that's all I have.

HOWARD: Thank you. And thank you for sharing your personal story. I know sometimes that's hard, especially with a group like us, so we're very grateful for that. Are there any questions from the committee? All right. Seeing none, thank you for your testimony today. That was our last testifier of the day. Senator Stinner, would you like to make any closing comments?

STINNER: Yeah. Thank you, Senator Howard. I, I do want to comment on a couple of things that, that I heard. One of them was, is that we're predominantly-- the most-- the biggest providers in rural Nebraska are prescribing physicians and general physicians. I'm going to give you a little bit of history about the 30-plus years that I've lived in rural Nebraska, in the Panhandle here. When I first came here, I had four physicians at Gering clinic-- pick up the telephone, access them day, night. If I had-- if I was out of town and had a problem, needed, a prescription filled, they'd call ahead. Those four folks have gone. They have retired. Two of them actually passed away. Now, I'm in a

situation where I'm calling and leaving a message. I'm calling and they're telling me I've got a problem and I have to wait or I can go to a clinic. My wife just had a situation where she wanted to access a doctor. And actually her doctor is a P.A., not a doctor. I don't have a physician anymore. I can't call anybody if I'm in Florida and I have a healthcare crisis. I can't call anybody because they want to see you. Well, when can you see me? Two or three weeks from now. So that prescribing physician-- and I think there's a study that backs me up, is we've got a lot of doctors leaving rural Nebraska. I remember we used to have doctors in Bayard-- no longer there. Now they have to either go to Bridgeport or Scottsbluff; that's if you can find a physician. That's kind of where we're at with healthcare. Throw on that and talk to law enforcement, talk to superintendents, talk to anybody that has access, parole officers, those types of folks. We have a mental health and a behavioral health problem, and we don't have enough folks to cover it. Now, as policymakers, as problem solvers, you know, we can, we can do something about this. This is not a unique situation. It's in other states. And I believe that the people here will work. The psychologists in the state of Nebraska will work to provide the safeguards that are necessary so that they could become another part of answering that mental health and behavioral health problem. And I think this is important. I think it's something that the committee has to take on. I think the committee, from here on out, really needs to take a look at this workforce issue in the healthcare industry as it relates to rural Nebraska. I can't retain and attract people unless I have quality healthcare. And this is just an expansion of that. I think we've got to come to that realization. So that's why I brought the legislation. That's why I'm adamant about it. I think this should be one part of an answer, but there's a whole lot more that we need to look at. And I'm really relying on this committee really to take the lead because you're the policymakers. All I do is try to figure out how we get money to support it. So in any event, thank you for your time. We are willing to work with the healthcare community, the docs, anybody that wants to contribute to this. We have a template certainly in New Mexico and Iowa that we can, that we can utilize. You know, I'd appreciate it when we start the session again-- if we start the session, I hope we start the session on time-- that we'll take a hard look at this as a, as a way forward. So thank you.

HOWARD: Thank you, Senator Stinner. I would also say that you are also a policymaker with us, right?

STINNER: Yeah.

HOWARD: OK, yes. All right. Let's see if there are any questions from the committee. Any final questions for Senator Stinner? All right. Seeing none, thank you, Senator Stinner. This will close the hearing for LR445. And colleagues, we'll start at 1:30 this afternoon, but you are welcome to join the Zoom a little bit earlier, just so we can make sure that we have everybody, everybody there. So I'll see you this afternoon a little before 1:30. All right? Have a great day.

STINNER: Thank you.

HOWARD: Bye, everybody.

[BREAK]

HOWARD: OK, I think everybody's here, so we're going to get started. All right, good afternoon and welcome to the Health and Human Services Committee via Zoom. My name is Senator Sara Howard. I represent the 9th Legislative District in midtown Omaha. And I serve as Chair of this committee. I'd like to invite the members of the committee to introduce themselves, starting alphabetically, starting with Senator Arch.

ARCH: This is John Arch, I represent District 14: Papillion, La Vista, and Sarpy County.

HOWARD: Senator Cavanaugh.

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

HOWARD: And Senator Hansen is not with us yet, but I believe he'll be popping in and out this afternoon. Senator Murman has stepped away from, from his computer. Senator Walz.

WALZ: Hi, I'm Senator Lynne Walz and I represent District 15, all of Dodge County.

HOWARD: And Senator Williams.

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

HOWARD: Also assisting our committee are our legal counsels, T.J. O'Neill and Paul Henderson, who will be taking notes and moderating the Zoom meeting. I would also like to thank the Legislature's Technology Office and the Clerk's Office for their assistance in

putting together these Zoom meetings and today is the first day that they are streaming live on NET, which is really exciting. A few notes about our policies and procedures. These, these briefings and hearings are being recorded. A live stream of the proceedings is available on NET's website at netnebraska.org, which can be found through a link on the Health and Human Services Committee's page through the Legislature's website, nebraskalegislature.gov. Please keep yourself muted unless you are testifying. There's an icon at the bottom of your Zoom window that looks like a microphone, which you can click to mute or unmute yourself. This afternoon we're going to hear a briefing and then we'll do an interim study and we'll be taking them in the order listed on the agenda on the legislative calendar. If you're planning to testify today, please ensure the introducer of the interim study and the briefing has your updated contact information, including name, email, and phone number. This will help us keep an accurate record of the hearing. If you also 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 handout submitted by testifiers will also be included as part of the record as exhibits. Please provide a copy of your hand out to the introducer of the briefing or the interim study, and a copy to our committee clerk, Sherry Shaffer. Her email address will be put into the chat right now. If you do have an electronic handout of your-- that you'd like to share, we are allowing screen sharing today. Each testifier will have five minutes to testify. When you begin, the timer will start. We'll ask you to wrap up your testimony after five minutes has passed. We're a little bit analog. We're still figuring out how to do this on Zoom, so T.J. will hold up a yellow sheet, a yellow sheet of paper when you have a minute left and a red sheet of paper when you need to wrap up your final thoughts. There it is. All right. When you testify, please begin your testimony by stating your name clearly into the microphone, then please spell both your first and last name. The hearing on each interim study and briefing will begin with the introducer's opening statement. After the opening statement, we'll hear other testimony. The introducer of the bill will then be given the opportunity to make closing statements if they wish to do so. We do have a very strict no prop policy in the Health and Human Services Committee. And before we begin today, I just want to give the committee a little bit of background on LR390 that Senator Stinner is going to talk to us about. LR390 was an interim study that Senator Stinner introduced to assess the fiscal and economic impact of the COVID-19 pandemic on Nebraska's early childhood workforce and the early childhood care and education system. It was referenced to the Appropriations Committee and they did have an in-person hearing for

this LR in September. And just so we're all up to speed, a transcript of [INAUDIBLE] was provided to the committee. Appropriations' LR390 deals heavily with COVID. Senator Stinner realized there would be an overlap of issues and any legislation between our two committees and asked to brief the committee on LR390. He's brought two individuals with him who will be sharing some information for us as well. And with that, we'll begin today's briefing with LR390. Welcome, Senator Stinner.

STINNER: Thank you, Chairperson Howard and members of the Health and Human Services Committee. That was a great introduction. Thank you very much. Took the words right out of my mouth. Anyhow, my name is John, J-o-h-n, Stinner, S-t-i-n-n-e-r, and I represent District 48, all of Scotts Bluff County. And I thank you all for being here and allowing me to, to be with you today to try to brief you on some of the activities that the Appropriations Committee has. Before I start, LR390, I actually started with the idea that we were going to have hearings throughout the state of Nebraska and, and really what the LR was originally put together is the next step, the next step, really to look at the challenges and weaknesses cited in the report that was issued by the Early Childhood Workforce Commission back in January of 2020. The name of the report is elevating Nebraska's early childhood workforce. Obviously, then COVID came in and what happened after that was I did adjust this LR. The LR was adjusted to include a clause for take a look at COVID. We scheduled a meeting in September. We had a considerable amount of folks that showed up. The University of Nebraska showed up and DHHS showed up. There was a considerable amount of folks that wrote letters from across the state concerning the impact of COVID. We actually had-- First Five also was there, local manufacturing business, and home-- a home healthcare provider, talking about specifically about the impact of COVID and the importance that childcare has. Actually, during that and in preparation of that hearing, we actually received two reports from the Buffett Institute that had conducted a survey early on, very early on, on COVID and how it was impacting the childcare industry. Then through the summer, they also conducted a survey and hopefully you have that material. Hopefully you have a packet of information that we sent to committee members. Testimony certainly is another piece of that, the LR designating what, what we were trying to accomplish. The other part [INAUDIBLE] was obviously another study that was conducted by The Bottom Line study is what it's called, and you'll-- you will hear testimony relative to that I don't need to go into. But that was a pre-COVID study that we also looked at. And it was overall impact of, of the childcare industry as it relates to the shortage of adequate

childcare in, in our counties. And we, we actually did a survey. Ninety-one percent of the counties in the state of Nebraska are, are deemed to be insufficient to meet the childcare needs. So I'm sure that that will be something that will be shared and enlightening. I also asked, asked the public actually to respond to a survey, and that survey really wanted to focus in on how COVID is impacting you as parents. And certainly then to take a look at the business side of things and how is businesses impacted and had adjusted to what had happened. And so that survey was sent out in September, October, November. University of Nebraska was great in compiling the information for me. I'm still trying to digest all of the information, but here's some of the highlights of that report. And again, we asked the aspect that the businesses affected COVID related to employees short-- shortages. We heard from parents in every legislative district except one which was District 45. We heard from businesses, mostly small businesses, from every district except five districts. So pretty big, overwhelming support by folks, really kind of giving us a, a real good series of data that's what's really happening out there. Some of the highlights since March 15, 2020 [INAUDIBLE] parents who responded to the survey had missed work because of the childcare issues; 43.7 percent of responding parents had to reduce their work hours because of childcare issues. Almost three-fourths of the parents responded to this survey had to adjust their childcare arrangements due to COVID-19. Over a third of the parents responding to this survey did not have sufficient childcare for their needs, including evenings and workdays and weekends. Of those parents who had school-aged children that were involved in remote learning, two-thirds did not have childcare arrangements that can meet those needs. Over three-fourths of the responding business owners have made changes to their employee shifts and schedules because of childcare arrangements from COVID-19; 70.6 percent have employees who have been late, missed, or left work because of childcare problems due to COVID-19. Again, it's a compilation. I'm still trying to digest all the information, but it's, it's information that I think we need to have to be informed about what the impact of COVID is and how we can best react to it. I think one of our main missions is to make sure we understand the barriers and of people getting them back to work, will certainly work on a full-time basis if that's what they, they intend to have. And from the employer's side, we need to salvage as many businesses and make them survive the COVID-19 as well. And we already knew pre-COVID that we had a work-- workforce shortage. So COVID has complicated a lot of that, some of that we can respond to. Some, maybe the stimulus package that's being contemplated in Congress will have some help. We don't know that. The third thing, and I think the thing that I want you all

to take away from the HHS Committee, we do intersect in a lot of different ways, early childhood, certainly we're the funding mechanism. I think if you saw the report and took a look at the commission report, I sat on that, on that commission 3 years, 40 people, different across the state of Nebraska, both public and private, weighed in on this. I think we got a pretty good idea. It's a comprehensive plan about just what we do with childcare in our state and how we can enhance the educational aspect of this thing on a quality basis. But, you know, this, this report really opened up your eyes as to what the funding gap is to provide an adequate workforce in order to, to close that gap. And that's kind of what we'll work on from the Appropriations. The other thing is to try to build that system. And, of course, childcare is delivered in different, different places in different ways. Some of it's home, some of it's center-based. And it may be some other, other ways, but it's trying to, to really kind of focus on building an early childcare, childcare and educational system. And that's kind of what I'm looking to HHS to kind of be a leader in that part of it. So that's, that's really what I'm hoping the briefing gets covered and we cover some of those issues of COVID, but we also carry away the long-term perspective of, hey, we need to continue to work on this. I have asked two, two people to provide some testimony and a deeper explanation of what we found in the interim study. Elizabeth Edwards [SIC] is from First Five, is going to tell you about The Bottom Line study, which I talked a little bit about, and the economic fallout from limited access to childcare. Finally, Dr. Gallagher, Gallagher, excuse me, Gallagher with the Buffett Institute will tell you what, what we know from the Nebraska childcare providers, how they're facing the results of the COVID-19 and implications we need to be aware of. Please consider this committee as a role in building an early childhood education system based on the size of the economy, and I think that's an important aspect, the size of the economy. I'm here to tell you that I am committed to finding a way to build that, to, to really kind of close that funding gap. But we need to get started on it. Our goal is by 2030 to close that gap in some way, shape, or fashion. Some of that being state money, some of that being community money. And I think it's a good business proposition. Certainly it resonates with me as a business person that whatever, whatever community gets this right, the early childhood education, quality care gets it right, are going to be winners long term, both economically and be able to attract and retain the quality workforce that really sustains the community and helps the community grow. With that, I'll open it up for questions.

HOWARD: Thank you, Senator Stinner. Are there questions from the committee? All right, seeing none and just, just for me, who would you like to go first, Dr. Gallagher or Miss Everett?

STINNER: Miss Everett was introduced first, so if she could go first and then Dr. Gallagher.

HOWARD: Great. Thank you.

STINNER: Thank you.

HOWARD: All right, welcome.

ELIZABETH EVERETT: Hi, can you hear me?

HOWARD: Yes.

ELIZABETH EVERETT: OK, perfect. Hi, my name is Elizabeth Everett. Thank you for having me here today to testify, spelled E-l-i-z-a-b-e-t-h E-v-e-r-e-t-t, and I'm the director-- deputy director of First Five Nebraska. So thank you again, Chairwoman Howard and members of the Health and Human Services Committee for taking the time to listen on this important issue. First Five Nebraska is a public policy organization focused on promoting quality early care and learning opportunities for Nebraska's youngest children throughout the state. And I'm here today to offer our, our organization's insight on Nebraska's current early childhood industry. So much of First Five Nebraska's work is based on the recognition that the decisions we make about the care and learning of young children directly and indirectly impact the economic stability and growth of our state. Quality childcare programs play a key role in helping parents guide the early development of children so they are more likely to become successful, productive members of our communities and state. But quality childcare is also a crucial element of the infrastructure that enables parents to participate in the workforce to better provide for their families. It improves workplace productivity for employers, generates revenue for the state, and contributes to economic activity on a broader scale. Despite the obvious importance of childcare, there are very few supports, unfortunately, that make owning a childcare program or working in this industry a viable career for existing or aspiring educators and entrepreneurs. High employee turnover, low-profit margins, and burdensome operating costs represent a serious challenge to the sustainability of many childcare providers. Demand for childcare typically exceeds the number of providers and slots available in our communities. In most recent statistics that we have

is that 75 percent of children under the age of 6 have all parents in the household working full time jobs. Yet, we have an increase of 91 percent of counties that don't have enough childcare slots to meet current demand. Last year, First Five Nebraska commissioned the University of Nebraska-Lincoln Bureau Business Research to study the economic fallout of inadequate childcare options on family income, employer profitability, and state revenues. The findings of that study published in August under the title The Bottom Line offer an alarming snapshot of what the gaps in our childcare infrastructure cost Nebraskans directly and indirectly. And this was pre-COVID. So Nebraska's working parents depend on stable care arrangements that align with their professional schedules and allow them to present and be productive at work. Similarly, these employers depend on the workers to be punctual, reliable, and fully engaged with their jobs. Short-term disruptions in childcare, such as a provider for instance being unable to open due to an illness are a serious issue when there is no redundancy available for the families who depend on them. Long-term disruptions such as the permanent closure of a childcare program, can result in even more severe financial setbacks for families and employers. The Bottom Line study accounted for direct losses from both short-term and long-term disruptions in childcare access. Those losses were linked to abbreviated paid hours due to tardiness or early departure from work, full day employee absences, lost opportunities for professional advancement, lost workplace productivity, and cost of employee turnover, among other factors. The Bureau of Business Research found that gaps in childcare availability cost working parents around $489 million and employers $234 million annually. Combined with the related effects on tax revenues, the total estimated direct loss due to inadequate childcare access in Nebraska exceeded $745 million annually. Now this does not account for the ripple effect such losses create by reducing economic activity throughout our communities and state. Nor does it account for the additional strains that COVID-19 has placed on Nebraska's childcare professionals and the industry as a whole. We can say with confidence that the economic impacts of inadequate childcare across-- are, you know, in very most probability, is even more severe than those I've outlined for you today. Simply put, the childcare industry experiences significant challenges even in optimal economic conditions. But in the face of unprecedented challenges, such as COVID-19, it is more urgent than ever that we find ways to make our state's childcare system even more resilient and sustainable if we are to mobilize the workplace-- the workforce we need for economic recovery. Thank you again for allowing me to take-- to speak to you on this important issue. We are really excited, First Five Nebraska is really excited to work with

Senator Stinner and the Buffett Early Childhood Institute on this extremely important issue in this industry. We want to thank and express our appreciation for Senator Stinner for his leadership on LR390. And we look forward to working with members on the Nebraska Legislature to find solutions to help this much-needed infrastructure and industry. One thing I did want to mention before I, you know, turn it over for potential questions is we did on the hearing on LR390, we did get some statistics from the Department of Health and Human Services on current closure rates. So right now we have about a 7 percent closure rate of childcare programs across the state. At the very beginning of the pandemic, it was about 13 percent. Since the state of emergency in March 2020, about 675 licensed childcare providers have reported a closure of their, of their facilities for at least 1 day. And 63 childcare facilities have permanently closed and 224 childcare facilities remain temporarily closed. So meaning that they either can't have-- they don't have the financial stability to remain open, they don't have enough educators to meet the ratio requirements, or there's just not enough kids right now as well to remain open. So we're hoping that those numbers will obviously decrease and we're able to provide quality childcare options for all. But I'd be happy to answer any questions at this time.

HOWARD: Thank you. Are there questions from the committee? Senator Williams.

WILLIAMS: Thank you, Chairperson Howard, and, and thanks, Miss Everett, for being here. Several years ago, the Buffet Early Childhood Center did a, a survey that pointed out what some of us thought were fairly obvious things, low pay, low benefits, and stress as being involved with the problems in this. I think that survey was done at least three years ago. Pre-COVID, did you see any improvement in those areas or are we just-- were we just treading water up to COVID?

ELIZABETH EVERETT: I would say that we were, we were treading water. Unfortunately, this is a very tough industry with very few financial supports. Like I mentioned before, there's very high turnover and mental and physical health and-- can be really strained for a lot of these educators because-- especially for those family home providers where we actually have a large portion of our providers are family home providers. It's normally just one person doing this. They're not only caring for the children and providing quality early learning environments, but they're also running a business. And for them it can be really difficult to do so. COVID has only exacerbated that problem. And we've been hearing from multiple accounts, many stories about how they just don't see any end in sight. But for us, it's really

important to understand that there is no other industry to fill this void. So the childcare industry is the only thing that can provide the support that they do. Without it, you know, it's not like a manufacturing industry, for instance, where you decide to make one, one gadget and then you change to another gadget. Here, if there is no other option, there is nothing else for these working parents and these children.

WILLIAMS: It seems to me that one of the long-term solutions will be involving private business in, in this and, and the support of that. With, with First Five and getting all around the state and talking to a lot of different people, are you seeing any models out there with communities that are stepping up and finding solutions to these-- the same problems that everybody's having?

ELIZABETH EVERETT: Yes. So prior to COVID, there was an initiative called Communities for Kids, which worked with communities. It was from Nebraska Children and Families Foundation, and they work with communities to identify their early childhood gaps and then find solutions that meet their specific needs. So not every community is doing the exact same thing. Some communities are building, for instance, childcare centers. Some are even helping early childhood educators with scholarship opportunities so that they can become qualified to teach these young children. We are seeing an increase in the amount of communities that have interest in this type of program. I believe right now it's up to 30 and they're actually trying to increase it up to 40 different communities across our state. But because of COVID, we have also seen an increase in employers being really interested to find ways to get involved. And First Five Nebraska is actually going to bring up potential legislation next session to hopefully encourage some more of that private capital. Because, again, the industry is severely lacking in terms of sustainability with finances. So we're hoping that the private sector will be able to get involved.

WILLIAMS: Having some kind of an incentive to encourage that private investment could be helpful. Correct?

ELIZABETH EVERETT: Yes, I, I believe so.

WILLIAMS: That, that wasn't a loaded question at all.

ELIZABETH EVERETT: I believe it could be very helpful. Thank you, Senator.

WILLIAMS: Thank you.

HOWARD: Other questions from the committee? All right, seeing none, thank you for visiting with us today. Dr. Gallagher, you're welcome to start.

KATHLEEN GALLAGHER: Thanks. You can hear me?

HOWARD: Yes.

KATHLEEN GALLAGHER: Great. Thanks so much and good afternoon, Chairman Howard and members of Health and Human Services Committee, and, and thank you so much for the opportunity to speak with you today. I am Kathleen Gallagher, that's Kathleen, K-a-t-h-l-e-e-n, Gallagher, G-a-l-l-a-g-h-e-r. I'm the director of Research and Evaluation at the Buffet Early Childhood Institute at the University of Nebraska. And I'm the author of two studies for which I've been asked to provide testimony today. Earlier in my career, however, I was an early childhood teacher and director of childcare programs. As an employed mother of two, I was consumer of both family home-based and childcare center-based care. Quality childcare allowed me to work, to go to school, and build economic stability for my family while my children thrived. Today, I'm here to share with you how Nebraska childcare providers and their essential businesses are doing in the context of COVID-19 pandemic. I'll do that by highlighting some data around pre-pandemic childcare availability in the state, some of which you've heard today. And I'm going to say it again, because it's, it's, it's, it's important, how the pandemic has impacted that availability and how providers and their businesses are doing. First of all, Nebraska's families are hard working. Nearly three-quarters of children under six in Nebraska have all available parents in the workforce. That's compared with about two-thirds nationally. Quality childcare is essential to support that work. However, our state's childcare availability is defined by shortages. Roughly 11 of Nebraska's counties have no licensed childcare facilities at all. And of the remaining counties that do have childcare facilities, almost all, 91 percent, don't have enough slots to meet families' needs. In the context of the pandemic, childcare businesses have been particularly vulnerable. In fact, many licensed early childhood programs have permanently closed as, as Elizabeth just described. And depending on the local community context, one closure can leave families unable to work and upset the local economy overall. To learn more about our childcare providers and their businesses, the Buffett Institute collaborated with state and agency partners to administer two surveys, one in March and a second in June 2020. The first survey identified

the need for several practice and policy supports that were enacted in the following months. We learned the providers were stressed, uncertain about their ability to remain open, worried about the virus, and struggling to access cleaning supplies and information. Agencies mobilized supports and many providers were able to remain open due to policy shifts, private grants, federal assistance, and substantive community efforts. In the second survey released in June, we heard from over a thousand providers. That's roughly one-third of all the licensed providers in the state. Once again, they told us they were experiencing incredible stress due to economic health and social pressures. The economic impacts of the pandemic on childcare providers and businesses have been staggering. Almost all providers reported a reduction in income, and one in four experienced a 50 percent or greater reduction in their income. Many providers benefited from the available assistance. However, childcare center providers were three times more likely than family childcare homes to access federal assistance, such as the payroll protection and loans and unemployment benefits. So how are childcare providers in Nebraska doing? Less than a quarter have access to paid sick leave and the majority don't have employer-sponsored healthcare. So when they risk caring for children during the pandemic and become ill themselves, they don't have health insurance to cover treatment or a hospital stay. Keeping their businesses open comes at high personal risk for themselves and their family. Over half of them also reported symptoms of depression, and yet they soldier on performing their role. A majority reported that the stress of the pandemic was negatively affecting the quality of care children are experiencing. And we know the brain science is documented that when caregivers of children, parents or childcare providers aren't well, children don't learn and develop well. So what does this mean for Nebraska? As a sobering finale, we asked providers to estimate how their childcare businesses would survive in the current context. Over half said that without financial assistance, they would probably or definitely close if the pandemic worsened or continued. The financial support the childcare systems need to thrive has long been neglected. Providers are reporting that in the context of the pandemic, their businesses may not continue to provide the public good childcare for families, employers, and communities. As this committee and the Legislature wrestle with stabilizing the economy in light of the pandemic, we at the Buffet Institute are committed to working with you. In the attachment you received, you'll find my remarks and handouts that reference the, the data I mentioned. I want to thank Senator Stinner for his leadership in these efforts. Please let me know if I can provide any additional information. Thank you for your time and I welcome your questions.

HOWARD: Thank you, Dr. Gallagher. Are there questions from the committee? Senator Cavanaugh.

CAVANAUGH: Thank you. Thank you, Dr. Gallagher. It's great to see you again.

KATHLEEN GALLAGHER: Thanks, Machaela.

CAVANAUGH: If you were to advocate for or recommend a policy change for next session, what would be sort of a game-changing policy for childcare in the current state?

KATHLEEN GALLAGHER: We, we, we asked providers about, about the childcare subsidy access and the, the, the rules related to paying for enrollment versus attendance, and some providers told us that that made the difference of them staying open or not. So I know that that has a-- that has an end point that's planned. I wish we had the same end point for the pandemic. That would be really nice, wouldn't it, to have an end point for it. So without that, I really think providers need that ongoing relief. And in fact, to some extent, the-- our ability to continue that beyond the pandemic would-- could help stabilize our early childcare systems. Other providers gave us information about using childcare subsidy as, as a system and really pointed to some kinds of administrative benefits that they would receive. I think those would be two places to start. Yeah.

CAVANAUGH: Can you say more about using the childcare subsidy as a system, what is meant by that?

KATHLEEN GALLAGHER: Oh, I'm sorry, administrative systems. So, so a few, a few providers really said that they found the subsidy system, you know, if they found some complexities in using the administrative systems around it. So the applications and, and streamlining those systems, I think the administrative pieces, not necessarily the policy parts of that. Yeah.

CAVANAUGH: In Nebraska--

KATHLEEN GALLAGHER: Those would be places, those would be places I'd start.

CAVANAUGH: In Nebraska, the childcare subsidy, we actually don't maximize the federal program. Have-- is that something that you've heard from childcare providers, that increasing eligibility would be helpful?

KATHLEEN GALLAGHER: So I-- our Nebraska providers aren't always sophisticated using the financial systems that are available to them, quite frankly. As everyone here knows and doesn't need to be told, Nebraskans are powerfully independent. They are entrepreneurs. And people in childcare are typically entrepreneurs. And they are-- they take great pride in being independent. We expected fewer of them to wish for more financial assistance in the context of the pandemic. We expect-- we asked them how many of the-- if they would accept financial assistance in order to continue. Almost all, I believe it was 98 percent said that they wanted assistance. So this, this has really challenged the system in ways that they've never understood before. So to that point, if they knew of more ways that they could support their community by supporting childcare to families who could afford it without assistance and to families who did need assistance to afford it, I think they would jump at the chance. And so I, I think they aren't even aware of what to always ask for, quite frankly.

CAVANAUGH: OK.

KATHLEEN GALLAGHER: So we should, we should leverage that system fully. It is, it is a way-- honestly, it's a way to bring families out of needing the assistance and getting them their education, getting them advanced in their career so that they can leverage their personal assets and not need subsidy anymore. And, and I've known over the years of my working in the field, I've known hundreds of families who went literally from that point of needing subsidy to paying fully for their childcare expenses over time and, and, and not having to access other systemic support, such as, such as food stamps, housing, other kinds of things, because they were able to work and go to school and elevate their family's economic circumstances. Thank you for that question.

CAVANAUGH: Thank you. I, I know that childcare-- we have lots of childcare deserts, and so the fact that slots for kids are, are competitive, it is difficult for childcare providers to offer subsidized slot-- slots when they can have a waiting list of full-paying families. And so I would just be interested to know how that would impact their ability to serve more families in a lower economic status. So thank you.

KATHLEEN GALLAGHER: Yeah, thank you.

HOWARD: Other questions for Dr. Gallagher?

CAVANAUGH: I have one more.

HOWARD: Oh, Senator Cavanaugh.

CAVANAUGH: Another question would be about shared services and alliances and family care, family childcare. Is that something that you've heard about or is that something that we as a state should be looking at? Other states have put together collaboratives that help with that administrative side of work for childcares.

KATHLEEN GALLAGHER: So I've, I've been privileged to live in several states and become familiar with several, several childcare systems and Nebraska cares so deeply about children and families and has a lot of, a lot of supports, not of all are which connected. In my previous experience, and in most states, they have what's called a childcare resource and referral system. We have pieces of childcare resource and referral here, and childcare resource and referral can provide a shared system. They typically use public and private dollars. They can provide access to children-- to families and to programs including family childcare homes, and can access shared services' access to supplies. They can provide professional development, much as our ESUs do, right, for, for education they can provide us and, and on and on. They also often help with the childcare subsidy administrative system and childcare food system. So long story short, these kinds of shared services organizations can take some burden off of public organizations, they're organized and very focused at delivering to this population. It would be such a spectacular investment for the state, probably moving a lot of the resources we're already spending to a more focused analysis. In several places I've lived, and especially a model would be Madison, Wisconsin, that has an incredible shared services for family childcare providers. As I said, it is publicly and privately funded, and it, it allows family childcare providers to network and increase their business acumen and provide higher quality services and more profitable services. You should be able to do this for a living. Right? And so it really helps bring those, those pieces of the system together. So some examples. I'd be happy to talk with you more in the future about some of them and send you to some resources.

CAVANAUGH: Terrific. Thank you.

KATHLEEN GALLAGHER: Um-hum.

HOWARD: Thank you. Any other questions for Dr. Gallagher? All right, seeing none, thank you for visiting with us today.

KATHLEEN GALLAGHER: Thanks so much for the opportunity.

HOWARD: Senator Stinner, would you like to make any closing comments?

STINNER: Yes, I would. And I want to thank you, Sara, for your service, [INAUDIBLE] fantastic eight years. It's been great to be associated with you. You've done a great job. So thank you very much. Merry Christmas to everybody, and hopefully I'll see you all after year end. See you later.

HOWARD: Perfect. Any final questions for Senator Stinner with that closing? OK.

CAVANAUGH: Merry Christmas, Senator Stinner.

HOWARD: Merry Christmas, Senator and Rita Stinner. OK. All right. Senator Stinner, Dr. Gallagher, Gallagher, Miss Everett, thank you for visiting with us today. We're going to invite you to leave the Zoom and then we're going to start our next hearing. Thank you. OK, Paul, we can let other people in. I'm going to grab a cough drop while you're doing that.

JENNI BENSON: Daddy-- uh-oh, I'm getting on the other one. Got to go, bye.

HOWARD: Sorry, we're just making sure everyone's here. And then we'll get started in a minute. OK, we're going to get started. Colleagues, you're going to hear the opening again, we're going to treat this like a separate hearing, so from the, from the previous one. So even though we're on the same Zoom, we're going to do a whole, a whole new hearing with a whole new introduction. OK. So good afternoon and welcome to the Health and Human Services Committee via Zoom. My name is Senator Sara Howard and I represent the 9th Legislative District in midtown Omaha and I serve as Chair of this committee. I'd like to invite the members of the committee to introduce themselves, starting alphabetically with Senator Arch. He was here just a minute ago. OK, he might have stepped away. Senator Cavanaugh, would you like to introduce yourself?

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

HOWARD: OK. And Senator Hansen indicated that he'll be in and out this afternoon. Senator Murman, would you like to introduce yourself?

MURMAN: Hello, I'm Senator Dave Murman, District 38, 7 counties in south central Nebraska.

HOWARD: Senator Walz.

WALZ: Hi, I'm Senator Lynne Walz. I represent District 15, which is all of Dodge County.

HOWARD: And Senator Williams.

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

HOWARD: Thank you. And we'll circle back to Senator Arch.

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

HOWARD: Thank you. All right, also assisting the committee are our legal counsels, T.J. O'Neill and Paul Henderson. They'll be taking notes and moderating the Zoom meeting. I'd also like to thank the Legislature's Technology Office and the Clerk's Office for their assistance in putting together these Zoom meetings. This is a new, a new world for a lot of us. And so these are some of the first hearings that are being conducted virtually and live streamed. I also want to personally thank the folks at NET Nebraska, because this is the first day that our hearings are being live streamed on NET, which is really exciting. OK, a few notes about our policies and procedures. This hearing is being recorded. A live stream of the proceedings is available on NET's website at netnebraska.org and a link for that can also be found at the Health and Human Services Committee's page on the Legislature's website, nebraskalegislature.gov. We ask that you keep yourself muted, yourself muted unless you're testifying. There's an icon at the bottom of your Zoom window that looks like a microphone, which you can click to mute or unmute yourself. This afternoon we're going to hear one interim study, LR406, and we'll be taking it in the order that was listed on the agenda on the legislative calendar. If you're planning to testify today, please ensure the introducer of the interim study has your updated contact information, including name, email, and phone number. This will help us keep an accurate record of the hearing. If you also 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 handout submitted by testifiers will also be included as part of the record as exhibits. Please provide a copy of your handout to the introducer of the interim study and a copy to our committee clerk, Sherry Shaffer. Her email address is in the chat. If you have an electronic copy of your handout and would like to try your hand at screen sharing, you are welcome to do that. But you still need to stay

within your five minute time limit. Each testifier does have five minutes to testify. When you begin, the timer will start and when you have one minute left, T.J. is-- we're analog. We're still learning. T.J. is going to hold up a yellow sheet of paper. So keep an eye out for that. And then when your time is up, he'll hold up a red sheet of paper and we'll ask you to wrap up your final thoughts. When you testify, please begin your testimony by stating your name clearly into the microphone and then please spell both your first and last name. The hearing on each interim study will begin with the introducer's opening statement. After the opening statement, we'll hear other testimony. The introducer of the bill will then be given the opportunity to make closing statements if they wish to do so. We do have a very strict no prop policy in this committee. And with that, we'll begin today's hearing with LR406, which I'll be presenting on behalf of the committee. And Senator Arch usually cues me in and then we'll actually trade back after I've done the opening. So, Senator Arch, do you want to open us up?

ARCH: Senator Howard, we look forward to introducing this LR. Please proceed.

HOWARD: Fabulous. Wonderful. All right. Good afternoon, 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'm presenting to you LR406, an interim study to examine issues under the jurisdiction of the HHS Committee. And one issue that continues to require the committee's attention is the COVID-19 pandemic. So far, Nebraska has had a total of 149,000 positive COVID cases since the pandemic began, along with over 1,300 deaths. As of yesterday, December 14, 2020, our hospitals statewide had only 1,407 of their hospital beds available and 176 intensive care unit beds available. Health experts believe that nationally we have begun to see cases that occurred during the Thanksgiving holiday, and it's anticipated COVID positivity rates will increase after the Christmas season. Nebraska's response to COVID-19 and the impact of COVID-19 on Nebraska's hospitals, healthcare providers, schools, and citizens will require oversight and monitoring by this committee in the upcoming session. To that end, I've invited a broad range of testifiers today acknowledging that this is the first time that this committee has held a hearing on this very important topic. These testifiers range from hospitals, frontline providers, rural and urban public health departments, educators, long-term care facilities and more in order to help the committee's awareness of this critical issue. This virus has impacted all of us. It doesn't care about race, religion, wealth, or age. And my hope is that with the information and insight gained through this

hearing, the Legislature will be able to fulfill their constitutional obligation to provide oversight of the agencies spearheading efforts to fight the pandemic in the state of Nebraska. So, colleagues, I'll, I'll be repeating what we, what we talked about last week. So one testifier that will be notably absent today is the Department of Health and Human Services. The agency has refused to attend three important hearings before this committee on major issues and shared a letter which outlines their three reasons for not attending. While all members of the committee have a copy of this letter from last week, I want to read into the record their specific reasons. First, they're working to finalize the DHHS portion of the Governor's budget for presentation to the Legislature early next year. Second, they are disbursing CARES Act emergency funding payments for state and local partners while ensuring appropriate federal accountability. And finally, their team is in the midst of responding to the COVID-19 pandemic. Colleagues, in the 16 years that a Howard has served on this committee, the agency has never once refused to come in. Our role as the elected representatives of the citizens and taxpayers of Nebraska, and in particular, our service on this committee means that we are guardians of the health and welfare of Nebraskans. But without the ability to speak with the agency we oversee, we are unable to truly do our jobs on behalf of the people we represent. When the state is facing issues such as a new major program like Medicaid expansion, a global pandemic where over 1,300 Nebraskans have died, or embezzlement allegations of the contractor that works with Nebraska Children and Families, that's an appropriate time to exercise our constitutional duty, right, and responsibility to bring the agency in and speak with us. I truly believe DHHS's refusal to appear before us sets a dangerous precedent for our oversight role and sends a clear message to our constituents. I have said in the past that when you disrespect a senator, you are actually disrespecting the 40,000 people they represent, as well as all Nebraskans that we serve. And that's what's occurring today. So in light of their absence, we're going to proceed a little bit differently than we normally do today. In order to make sure that everyone is on the same page in regards to what the agency is sharing with the committee, when I conclude this opening and before we bring up invited testifiers, Senator Arch, I'm going to have you kick it to T.J. and he'll read the information provided by DHHS into the record. If there are questions from the committee, we'll draft a letter to the agency as a follow-up. We are following the same process as well for the other two LRs where the agency has chosen not to attend. Since this is a committee resolution, once I've finished the opening, I'll continue to preside for the duration of the hearing. I

do appreciate your time and attention to LR406. I'm happy to try to answer any questions you may have.

ARCH: Are there any, any questions for Senator Howard? Seeing none, T.J., could you read the letter, please?

T.J. O'NEILL: Thank you, Senator Arch. The Department of Health and Human Services submitted a letter to the Health and Human Services Committee. It is an information sheet and I will read that information sheet now. Overview: In January 2020, the department-- the Nebraska Department of Health and Human Services, DHHS, and its partners were carefully monitoring the unfolding outbreak of respiratory illness caused by Severe Acute Respiratory Syndrome Coronavirus 2 or SARS-CoV-2. The virus that causes COVID-19 disease. The virus reportedly originated in China and spread beyond the country's borders with cases being reported in multiple other countries, including the United States. Nebraska identified its first case of COVID-19 on March 6, 2020. Over the next week, a dozen cases were identified originating from travel or close contact with someone who had COVID-19. An emergency declaration was signed on March 13, 2020. The following day, Nebraska officials announced the first case of COVID-19 acquired by community spread. Three weeks after identifying its first case, Nebraska reported the first deaths related to COVID-19. Directed Health Measures: Beginning March 19, Directed Health Measures, DHMs, were issued by the state's chief medical officer to help protect Nebraskans by limiting exposure and reducing COVID-19 transmission. The first DHM covered the four-county area surrounding Omaha, Nebraska's largest city and only metropolitan area. Additional counties were added in the following weeks. To combat community spread of COVID-19, public gatherings were restricted to no more than ten people in accordance with the Center for Disease Control and Prevention, or CDC's guidance. Restaurants and bars were closed to in-person dining, schools were directed to operate virtually and cancel all extracurricular activities, elective medical and dental procedures were suspended. Those with symptoms or who tested positive for COVID-19 were required to stay home for 14 days. By April 3, all of Nebraska's 93 counties were covered by a DHM. Throughout the pandemic, DHMs have evolved to help prevent further spread of disease. DHMs were part of a phased reopening plan in the spring and are now part of a phased color-coded system to determine restrictions based on the state's hospital capacity. DHHS Data Dashboard: In March 2020, DHHS launched its COVID-19 data dashboard and began providing daily case updates via the new dashboard. The dashboard serves as a central reporting measure to help gauge the level of COVID-19 activity in the state at a glance. The information reported has grown in response to

changing data needs as public health experts learn more about the virus. Currently, the dashboard reports a daily total of positive tests in Nebraska, as well as the total number of tests conducted, hospitalizations, ventilator availability, deaths, recoveries, and more. It has expanded to report cases by age, race, and ethnicity. Now, the number of active hospitalizations and total staff beds are also viewable on the main page of the dashboard, alongside a graph that shows which color phase of the DHM the state is in. Testing: In April, the state of Nebraska launched TestNebraska, a public-private partnership designed to increase Nebraska's COVID-19 testing capacity to help identify cases, better understand the scale of infection in the state, and track those who are affected. Test sites are now available in more than 30 locations statewide, with lab capacity to run approximately 6,000 tests per day. TestNebraska is one of many entities providing COVID-19 testing in Nebraska with numerous pharmacies and clinical providers also offering tests. From the-- from November 29 to December 5, 2020, an average of 15,000 tests were completed each day with a median turnaround time of two days. As of December 10, 2020, 784,000 people have been tested in Nebraska, totaling 1.5 million tests completed. Earlier this year, Disability Rights Nebraska and other advocates raised concerns that Nebraskans with disabilities have not been adequately served by TestNebraska. Concerns included a screening process that was limited to Nebraskans with limited access to the Internet, leaving behind those without such access. In addition, concerns were raised regarding the accessibility of drive-through mobile testing sites. Advocates noted they are often inaccessible for Nebraskans without access to adequate transportation. To accommodate citizens seeking COVID-19 testing, TestNebraska offered a telephonic option for screening and appointment scheduling in the early days of its operation. However, this number was rarely used and was therefore discontinued. Additionally, community-based providers for participants received services from our Division of Developmental Disabilities are reporting adequate access to testing and transportation. Local public health departments will triage calls from citizens needing assistance for testing. The department continues to work with partners and other government agencies to address the needs of Nebraskans with a disability and others to ensure equal access to community testing programs. Contact Tracing: As COVID-19 cases are reported, DHHS and local health departments swiftly initiate contact tracing to prevent further spread by identifying and assessing people who have come into close contact with a person who tests positive. Trained contact tracers conduct comprehensive interviews identifying where an individual has been and who they may have had contact with to construct a detailed history. Those identified as potentially exposed

to COVID-19 through this detailed history are contacted and asked to self-quarantine for 17-- for 14 days. Both state and local health departments have increased their contract-- their contact tracing capacity significantly. Currently, there are more than 1,000 trained contact tracers. The number of people actively completing contact tracing fluctuates with case counts to ensure a nimble response to positive cases in Nebraska. Coordination with Partners: The Department of Health and Human Services has worked closely with many partners in the public health system throughout the pandemic, local health departments, LHDs, federally qualified health centers, FQHCs, professional associations, and academic institutions, among many others, have been key partners throughout the department's pandemic response efforts. DHHS holds regular meetings with these partners to keep them apprized of the evolving situation, provide key updates from the department, and keep lines of communication open. Recognizing there are major disparities in COVID-19 infection and death rates for communities of color, the department gathered a group of key partners to form a multidisciplinary health equity task force. This task force provides recommendations to mitigate the impact of COVID-19 among minority populations and to advance health equity in Nebraska. Task force members include individuals representing community organizers, community-based organizations, LHDs, FQHCs, Heartland Workers Center, tribal representatives, hospitals, University of Nebraska Medical Center, education, and the faith-based sectors. It is critical that community voices are included and uplifted as part of this process. The task force is providing immediate and long-term recommendations to include strategies in the areas of targeted communication, improving trust and access to care, implementing effective widespread testing, contact tracing and case management, building community infrastructure, and addressing policies and practices to advance health equity. Lessons Learned: The COVID-19 pandemic is an unprecedented event, unlike anything the world has seen in a century. The public health field has flexed to respond and adjust to changing demands throughout the response efforts. Many lessons have been learned throughout Nebraska's response, and DHHS has responded nimbly to update processes and make changes to ensure a better response for the people of Nebraska. Examples include expanded testing capacity, an expanded contact tracing program, implementing directed health measures and restrictions based on hospital capacity, and the development of a health equity task force, to name a few. DHHS continues its response efforts and is currently planning for COVID-19 vaccine distribution. The immunization team has developed a plan in cooperation with federal partners and key stakeholders in Nebraska to allocate the vaccine across the state. The current iteration of the

plan is available on the DHHS website at dhhs.ne.gov/pages/covid-19vaccineinformation. In the coming weeks and months, DHHS will continue to respond to the COVID-19 pandemic, collecting data, expanding testing and contact tracing, providing support to and interacting with partners, and issuing Directed Health Measures to prevent further transmission. DHHS will continue to be nimble in its response making adjustments to updated information to prevent transmission of the virus and mitigate the impact for Nebraskans. That is the end of the LR406 information sheet. Thank you.

HOWARD: OK.

ARCH: Thank you, T.J.

HOWARD: Thank you, T.J. All right, we'll now invite our first testifier up, Leslie March-- Marsh from Lexington Regional Health Center.

LESLIE MARSH: Hi, good afternoon, thank you so much for inviting me here. My name is Leslie, L-e-s-l-i-e, Marsh, M-a-r-s-h. And as, as you said, I'm from Lexington Regional Health Center and we experienced a surge earlier this spring with about 42 people requiring admission to the hospital over about a three and a half week time period. One pressure point that very quickly emerged was the PPE burn rate, particularly given the supply chain disruptions. While the state and eventually angel flights provided much needed supplies, there are still supply shortages: gloves, some N95s, mostly smalls and gowns, are now the items that are of concern if we have another surge of the same type. Today, while we see some cases that look more traditional with respect to age, race and ethnicity, staffing is the most serious concern. At Lexington Regional Health Center, we had 46 people actually test positive, staff members, and an additional 120 had to quarantine or isolate at some point over the past 5 months. As you think about staffed beds, it's clear that staffing shortages for any reason, and particularly over a pretty significant length of time, can quickly become critical barriers to care. Existing workforce challenges, limited [INAUDIBLE], excessive rates for professional travelers, and challenges with H-1B visa renewal processes have all proved to be difficult to navigate. Even as I write this, we're going to be losing a med tech, a lab med tech, because his visa renewal was denied. Testing in general has been problematic. Initially, there weren't enough testing supplies and shortages were the primary concern. But PPE, staff sensitivity, that is the true positive rate, and workflow processes remain considerations that require diligent monitoring and adaptive management. One testing factor that we

recently had to address involved the time it takes to actually run the test after collecting the specimen. This issue only became a consideration once we've begun the monoclonal antibody infusions. But all told, it is, it is something that this group may want to consider as they move forward. TestNebraska-- I apologize, I just-- here-- TestNebraska did help to relieve the testing supply shortages. They offered an opportunity for more people to receive testing. But one of the things-- and we've participated since the beginning, but one of the things that our team noticed was that, you know, there wasn't very many of the lang-- the language is, is, is English is very limited language offered-- offerings on the website. And also the information that we pass out to the, to the people that get the test is in English. So that's a problem because you want to make sure everybody's understanding it. So if you have limited English proficiency and you also have maybe even just limited health proficiency, this might not be the best avenue to get your testing. Other issues are weather-- there's really not-- while-- with this particular testing, weather is, is, is a problem right now as we move into winter, finding a site to do that. And, and really it's just the time that you, you, you know, collect the sample and then they get the result that, that is, is still a problem. Elective procedures, even under the strictest DHM this fall, considered the same items that we have since the first-- and we first experienced COVID in our community. Resource allocation was really the, the number one issue. PPE, licensed staff, census, and necessity of the procedure were all considerations and remain so to this day. So if the person is going to have a worse outcome or if they are going to deteriorate, then that's certainly something that we would take into consideration. This fall, we were glad to be able to help our neighbors that had-- that those that had helped us in the earlier surge. And so we've mostly been seeing patients from other communities that require the, the hospitalization. Although that is not to say that we haven't had people that have required hospitalization now, too. Still, with staffing shortages and travelers making $100 more an hour than we paid them-- then we would have had to pay them before, this is a real issue moving forward as we think about the very items that Senator Howard mentioned with respect to travel and holidays and what will happen in the future. So we're really glad to be able to have all of you looking at this so closely and always being strong supporters and taking, taking the issues that you do head on and helping us to do a better job out here in, in, in whatever community we're, we're helping to serve. So with that, I think, you know, as fatigue set in, resiliency began to wane. And what-- we're in it for the long haul now and the, and the recent spate of cases has

really refocused us, I guess. So thank you and thank you for allowing me to testify.

HOWARD: Thank you for your testimony today. One, one thing I'd like you to clarify, if you can, when you say travelers, can you make sure the committee understands what that means? And then can you talk a little bit about the use of travelers?

LESLIE MARSH: Sure. So travelers, travelers are like somebody that you'll hire, locums-- locum tenens maybe is how you're more familiar with them. But you call a company and then you'll get a registered nurse or a lab med tech or some-- or somebody to come in and help to shore up your staff. And, and those are really difficult to even secure at all right now. And plus, what's happening is they're, they're making $150 to $175 an hour. So, so sometimes nurses are wanting to leave here to go work for a traveling company because they can make so much money. So it's really using another company to secure people to staff your own organization.

HOWARD: Thank you.

LESLIE MARSH: Thank you.

HOWARD: All right. Are, are there questions for Miss Marsh? Senator Williams.

WILLIAMS: Thank you, Chairperson Howard, and thank you, Leslie, for all you do in Lexington and all that you do for the hospital association. When, when you look at the, the larger view from the hospital association and especially from critical access hospitals, what is this doing financially to you? You know, we talk a lot about the, the staff and the personal things, but how, how are, how are the hospitals holding up financially?

LESLIE MARSH: Senator Williams, thank you for all the-- again, for all of your support all these years, but I'll tell you that it has been a drain on our financials as well as just, you know, on, on, on people in general. The CARES Act, the way that they've been distributed, we would think that-- we, we don't really know yet how we're going to be able to use those funds. And, and so we don't know if we're going to have to give all of it back and how that's going to be looked at. So that's-- if that were to happen, if we were to have to give all of that back, I think most of us would be in some-- you know, that have taken care of COVID patients over this time period have been-- will, will be in, in a pretty dire situation because critical access

hospitals as a whole are operating in the red, often about 40 percent of, of, of critical access hospitals are operating in the red. So you get something like this and, you know, we're all about coming together to help one another. But we definitely will be hit by this financially. We'll feel this for, for a while, particularly if we have to secure teams to treat patients at a, at a much higher rate than we normally do. So, so I think we're going to be needing to consider moving forward all of those things and how, how we remain, you know, just the cornerstone of the community that we have been for so long. So thank you. I hope that helped a bit.

HOWARD: All right, other questions from the committee? All right, seeing none, thank you for your testimony today. Our next testifier is Jacob Dahlke from the Nebraska Medicine Healthcare Ethics.

JACOB DAHLKE: Yes, good afternoon. I'd like to share my screen. And I believe that you should all have a copy of these slides. So thank you for the opportunity to, to talk this afternoon. I'd like to share just a little bit of high level information about crisis standards of care. That is a term that has been used a lot, both regionally, nationally, internationally. And I want to just sort of talk about some of the ethical underpinnings that go along with that type of concept. Just as a bit of background about myself. I manage the office of Healthcare Ethics and the Clinical Ethics Consultation Service for Nebraska Medicine. I've been doing that for about five years. I am a certified Healthcare Ethics Consultant through our predominant professional society, the American Society for Bioethics and Humanities. And I have a master's degree in bioethics. Just as a bit of context and from a public health perspective, of course, we have various types of public health emergencies as they occur, and depending on the type of crisis or emergency, different mechanisms are, are needed to be in place. And so, of course, what we're dealing with in this type of public health emergency with the pandemic is an ongoing one. It's one that has, has in a sense, an indefinite amount of time with which we have to experience it. As it relates to healthcare and how it affects healthcare and healthcare resources, there's a general sense that there are three sort of buckets of, of resources with which there's a type of a disruption. That would be space, you know, physical spaces within a hospital or healthcare facility, the supplies that we use to participate and provide that healthcare, and then the qualified people to actually provide the healthcare itself. As that relates to COVID-19, of course, this springtime, we had very different problems and very different concerns as it relates to those resources. There was a lot of discussion around access to ventilators and access to personal protective equipment. As things have progressed into the fall

and, and here we are coming into the winter, the question around resources has been different, partially because we understand more about the disease itself, how to manage it, how to treat it, but also for other reasons we don't need to go into today. As hospitals and, and healthcare systems change the way that they operate within these public health emergencies, it's what we generally consider to be this continuum of care. And the conventional capacity, of course, is quote unquote, normal or usual circumstances. It's consistent with what you would expect to see as you would go to a hospital or clinic or any other type of healthcare facility once we reach what's known as a contingency capacity. What that means is that there is some sort of an anticipation of a shortage. And as a result, we are having to adapt or change slightly the way that we tap into those resources while still being able to provide functionally equiv-- equivalent care to our patients. As that continues to wane in terms of the access to the resources, we reach what's known as the crisis capacity. And that's where the need for those resources actually outstrips the availability of those resources. And so the, the simplest example in the context of COVID would be the, the ventilator shortages that we were concerned about. I won't spend any more time with this. Like I said, you have access to it. But this is more of a visual representation of what I was just describing. As we consider how do we take care of our patients in the best way possible given the difficult circumstances? We, we have various-- we have different ethical standards that we need to consider most-- first and foremost, ensuring fairness. But also there's just generally a, a duty to care for our patients, to steward the resources that we do have, however short they may, may be, and, and to provide some sort of transparency with the public to maintain that trust. And so the, the primary difference when it comes to these crises where when we're in these crisis capacities is not the ethical standards themselves, those do not change. If you'll notice that the list is the same, however, it is in a different order because typically in a, in a typical encounter, you would have patient autonomy being primary. And in a crisis, we have to think about the majority of the people providing the most amount of benefit for the most amount of people. And, and as such, we, we have to adjust how we go about making our decisions. This is a little bit more into detail about the actual decision-making framework. Just for the sake of time, like I said, I believe you have access to this. And so I'll, I'll skip that for now. And so, in summary, like I said, this is a broad, systemic response to these types of situations where otherwise available resources are no longer available.

HOWARD: OK, thank you, Mr. Dahlke. Can you stop sharing your screen now? OK.

JACOB DAHLKE: Yep.

HOWARD: All right. Are there questions from committee members for Mr. Dahlke about crisis standards of care? All right, seeing none, thank you for visiting with us today. Our next testifier is Dr. Steve Doran from MD West ONE.

STEPHEN DORAN: Good afternoon, Senator and fellow committee members. If it's OK, if-- thank you very much. Mr. Dahlke is going to share his screen again. I'm, again, Stephen Doran, D-o-r-a-n. I'm a clinical associate professor from the Department of Neurosurgery at the Med Center. I'm also chief medical officer for Midwest Surgical Hospital. I'm also the bioethicist for the Archdiocese of Omaha. And if you could do the next slide, please. Basically, I want to just kind of talk to you a little bit about the history of the current plan that has been developed for the state. Back in the spring, the chief medical officers of the Omaha metro area met frequently. And as a part of our conversations, it became clear that developing a crisis plan would be appropriate, as there was not one at the time in Nebraska. So I authored a plan in conjunction with the other CMOs that we all signed off on, and that became a, a template for crisis standards in the various metro hospitals. And in the spring, as we've known, the, the numbers were not as high for hospitalization. So, so by and large, the, the, the, the plan never really needed to be used, fortunately. Well, as the summer went and now we come into the fall, it became apparent that, you know, that the possibility of larger numbers of patients in the hospital was, was very apparent. The Nebraska Medical Emergency Operation Center was established in November. And one of the tasks of this group was to create and implement a crisis standard of care plan for the entire state. And so this initial committee had representation from clinical, legal, and ethical perspectives and I was part of that committee they-- that was formed. Next, please, Jacob, thanks. So we chose the state plan from Massachusetts for a couple of reasons. Number one, you'll find that by and large, many of these plans are very similar, have very-- and so the concepts and how triage is performed and those sorts of issues are very similar across states. So we took a plan that had already been vetted well. We took a plan that was comprehensive, yet concise. I mean-- and so one that I thought-- one that we thought was user friendly. And so that's where we started from. And then using this plan, we modified it to meet the specific needs of Nebraska, as you can imagine, with a rural population, critical access hospitals that have different staffing and

equipment capacities than what you might see in more urban areas. And so that we, we made some initial modifications of the Massachusetts plan to make it more appropriate for Nebraska. Next, please. So then this working group, as I mentioned, of ethical, clinical, and legal perspectives revised this plan. And then we sent the plan out for review by over 40 individuals representing a statewide constituency of people from various backgrounds. Comments were made, revisions suggested. Then a committee of another 14 was reconvened, which authored the current version of the Nebraska crisis standard of care. This has been endorsed by the Nebraska Hospital Association, the Nebraska Medical Association, and has received widespread acceptance amongst the various healthcare coalitions and healthcare entities and facilities throughout the state. Next, please. There's some ongoing efforts going on. Educational seminars are being held by representatives from this group educating healthcare centers about what, what it takes to build a triage team, for example, what's involved with that. And how, how can you operationalize something like that in a more rural setting, for example, versus a more urban setting where you have more people and more support. We're looking at the pediatric guidelines, for example, that, again, were written primarily for larger hospitals, urban hospitals, yet recognizing that in a crisis situation that pediatric patients in smaller hospitals may have different levels of staffing or equipment and things like that. We're also having this review by Nebraska disability advocacy groups. The Massachusetts plan was reviewed by their disability advocacy organizations in that state. But we really wanted to engage people from Nebraska. In fact, in about 15 minutes, I'm on a call with that group. So some disability advocacy groups we're meeting with here just very shortly. So, so we have some ongoing efforts to continue to work with the document. And, and that's in its current state right now. So be happy to take any questions or concerns anybody, anybody has about the document or about the process of where we got to that-- this place.

HOWARD: Thank you. Are there questions for Dr. Doran? All right, seeing none, thank you for visiting with us today. Our next testifier, it looks like we're going to have to wait for Dr. Boucher, so we're going to-- oh, are you here? Oh, Dr. Boucher, you're here.

PHIL BOUCHER: Yeah.

HOWARD: OK, great, thank you.

PHIL BOUCHER: You bet. I was lurking because I'm in clinic and I wasn't sure if-- I don't want to interrupt, so. Thank you all for

having me. I am-- my name is Phil Boucher, B-o-u-c-h-e-r. I am a pediatrician in Lincoln and was asked to come and speak on kind of what the experience has been like from the primary care standpoint during the pandemic. I am a pediatrician in private practice in Lincoln and I have been, been on the front lines and talked with a lot of physicians in Nebraska about what their experiences have been like, and so I wanted to share those with the group. I thought of a few different kind of mountains that we've, we've come over as we've gone through this pandemic and I will just reflect on those briefly. First was the logistical mountain, which when we started, one of the biggest things was getting appropriate personal protective equipment, making sure we had enough for our staff and for ourselves, and then getting very scrappy really quickly about how we can keep seeing patients while protecting our staff, protecting our patients, getting telemedicine up and running, continuing to provide vaccinations in an on-time manner in the midst of the pandemic and everything that's going on to, to keep everybody safe, keep bringing patients into the office so that we can provide patient care, we can get vaccines done. All of those things were kind of logistical issues that we faced. Quickly, we were able to start telemedicine visits. We started doing visits in the car. We did an outside flu clinic this fall where instead of having patients come into the office, they, they, they were-- they showed up and basically like a drive-through, got their flu vaccine and it was hugely successful, kept kids in the car, kept parents happy, kept our staff safe and our exam rooms from having to be cleaned and sanitized and everything like that. And now we're doing COVID swabs outside. So there's been lots of logistical issues that we faced where right now outside my window they're, they're erecting a huge tent so that over the winter we can keep doing swabs of patients without having to bring them into the office, but have them and our staff protected from the elements. So the logistical mountain was one that, that took a lot of innovation. And I'm really proud of the way that we've solved it and from hearing from many primary care physicians in the state who addressed it in similar ways and figured all these things out over many, many Zoom meetings, as you've all experienced as well. The second mountain was the financial mountain. And really nobody in any business is prepared for a precipitous drop in revenue. Primary care physicians are among the lowest reimbursed amongst physicians. And we have a lot of overhead with our staff and facilities and everything that we do. And the drop in visits resulted in decreased revenue. And certainly we're, we're shooting ourselves in the foot by saying, please stay home. We want you to stay safe. But at the same time, we have to continue to pay our staff and keep the lights on and everything like that. And I know that many clinics

around the state and around the country faced financial ruin and many closed or laid off or furloughed large numbers of their, their clinical staff. And fortunately, we, we did not have to face that ourselves. But it's, it's difficult when you have people that are ready and willing to fight this pandemic that, that we are, you know, at the financial mercy of keeping everything going in the midst of not getting the reimbursement. Luckily, we had PPP, which has helped. One thing that, that interfered from a local standpoint was the NSAA decision to forego the requirement for pre-participation physicals, and, and that was detrimental to us both from a patient care and a financial standpoint, because we in the summer are typically very busy with well-care for athletes. And the NSAA kind of made the decision without a lot of input on making it so that athletes don't have to have a pre-participation physical. And so we lost out on the opportunity to see those patients, make sure they're up to date on their vaccines and most importantly, look after their own mental health. Because as we know, in the midst of this pandemic, that mental health has been a huge issue for everyone, especially teenagers who rely very heavily on the social component of their lives, that they, they haven't been able to get that. And so we really want to be able to care for those patients. And it actually does continue to provide, you know, revenue for insurance companies for those well visits. So that was, that was another hurdle that we climbed over. The communication mountain was a large one that we have faced, too. Everyone is aware of the massive communication issues related to the pandemic, and it's been faced by physicians, by scientists, by, by public health officials. And, and again, this became a chance for us to innovate and show up. But it's been an uphill battle against misinformation online and even from the information provided by elected officials and, and the-- those with the authority and influence to speak at large, talking about the seriousness of the, seriousness of the illness, the importance of simple safety measures, convincing the public to do the right thing when many elected officials aren't taking it seriously or supporting the public health officials who are trying to convince people to do the right things, giving up holidays and convincing people that are otherwise healthy to, to not go to Halloween and Thanksgiving and Christmas and to make those sacrifices. That's a communication hurdle that we faced. And now, as, as the Coronavirus vaccine becomes available, convincing people on the safety and importance of getting the vaccine and what we can do between now and when the, the vast majority of the public have the vaccine to try and convince people of that. And that's been another hurdle that we've all faced and tried to face, you know, providing good information to the community, but also in the exam

rooms, it takes up a large amount of time trying to work through and, and, and un-- or pack-- "unpackage" all of the information that people are reading online about truths and misinformation about that. So that's, that's been a hurdle. And I think the, the biggest hurdle of all is the health and, and wellness component of it. It's, it's certainly taken a personal health toll on healthcare workers, the risk of exposure, the illnesses, the seeing patients that, that were previously healthy seriously injured by Coronavirus, seeing thousands of healthcare workers around the country die while on the job in service of patients, having inadequate PPE and the worry of ourselves. Everyone-- you know, there's so much uncertainty with it and that certainly is not-- healthcare workers are not immune to that, the uncertainty, the burnout, the, the lack of care and compassion and support from elected officials, certainly disheartening. And it makes it, it makes it really hard when you're seeing the effects, but then hearing the message that's being communicated to the public and, and the difference between those. So those are, those are certainly the mountains that we've, we've all faced in, in public health as primary care physicians. But I think, I think the, the bottom line is that there's so many helpers out there, we've been able to innovate and there's been so many that have such a spirit to willingly give to put themselves in harm's way without asking for anything except for perhaps, you know, support on public health measures and the tools and the personal protective gear to care for patients. And so I think that the local efforts and especially the, the very local in Lincoln, Nebraska, efforts that we've been able to install and get the support behind have really made a difference in this pandemic for healthcare workers. But, but that's kind of what I, I think after reflecting on it myself and talking with a lot of other physicians that are on the front lines, in the trenches, seeing patients in the office and telemedicine-wise right now that we're facing. So I appreciate the time to kind of share this with the committee. And welcome to any questions or clarification that would be helpful.

HOWARD: Thank you, Dr. Boucher. Are there questions from the committee? Senator Cavanuagh.

CAVANAUGH: Thank you, Doctor, for being here today and for sharing that perspective. What can we, as elected officials do to support primary care physicians? You, you said that elected officials have and sometimes not been as helpful as, as they could have been. So you have an audience right now of elected officials. What, what can we do to support you and your colleagues?

PHIL BOUCHER: I think the, the biggest thing is helping spread the public health awareness message that, that the simple, the simple measures that we have in place are effective and safe. And it, it might, you know, the higher up obviously the, the chain of elected officials, I think the more gravity everything carries. And so if, if there's a large call for support for the measures that we know, masking, physical distancing, you know, limiting gatherings, all those things. And then as, as more information is, is available about the vaccine and safety and everything like that, just helping promote science and, and, and make sure that the public is aware of the message of the scientists and the public health officials and, and that the loud voices of dissent are not the ones that, that are running the show. So I think those are, I think those are the main things. But I think from a local level, at the Unicameral level, I think there's been a lot of support behind the public health officials and the message of, you know, how to keep everybody safe and, and move through this pandemic.

CAVANAUGH: Well, certainly from our Chairwoman today, because she is a pioneer--

PHIL BOUCHER: Indeed.

CAVANAUGH: --in the Nebraska Legislature with us doing this hearing virtually. So thank you so much again for your time today.

PHIL BOUCHER: Thank you.

HOWARD: Thank you. Other questions from the committee or accolades? I'll take those. All right, Dr. Boucher, thank you for visiting with us today. We really do appreciate your time and, and we appreciate you taking some time away from your patients as well.

PHIL BOUCHER: Thank you. I actually love virtual, you know, usually like the only times that I wear a suit and tie or a jacket and tie are weddings, funerals, and trips to the State Capitol. And so this is a nice opportunity to get in front of people, you know, and still have clinic going on in the background, so.

HOWARD: Yes, we, we appreciate you glamming up for us when you [INAUDIBLE].

PHIL BOUCHER: Thank you.

HOWARD: All right. So our next testifier will be Gina Uhing from the Elkhorn Logan Valley Health Department. Welcome, Gina.

GINA UHING: All right, thank you. My name is Gina Uhing, G-i-n-a U-h-i-n-g, and I am the public health director for Elkhorn Logan Valley Public Health Department in Wisner, Nebraska. Today, I'm testifying on behalf of Friends of Public Health in Nebraska and wanted to thank Senator Howard for the invitation to testify today and to the entire committee for holding this important hearing. I also wanted to thank you as committee members for your support of local public health departments as we navigate our way through this pandemic. Your ongoing support provides optimism and morale boost for all of our departments during the most professionally challenging time that we've ever faced. If we rewind back to a year ago today, we were beginning to hear pieces of information of a virus overseas, and while the general public watched a pandemic unfold from afar, your public health workers here were warming up and training rigorously for what we believed would be the biggest challenge that we would ever face. Our intuition was correct. Prior to that, I acknowledge that there was a portion of the population that never had an encounter with their local public health department. In fact, some may not have even known that we existed, and for others they may have known that our health department existed, but they may not have known why or for what purpose. Today, I believe that the number of unaware people has drastically declined. The pandemic has impacted every person, household, and business in the state. Whether the impact was in terms of personal illness or illness of a family member or friend, a quarantine order, a change in routine, or way of life, or a work-related effect, we've all felt it. The pandemic has put a bright light on the infrastructure needs of our departments. About two weeks into the pandemic preparations, we all realized that we at the time did not have the staff or the resources that would be needed to meet this virus head on and the critical resources that we were going to need to fulfill our mission. And this was the responsibility that we took very seriously. But we didn't know how we were going to rise to the occasion without the infrastructure that was needed, nor did we know how we would come out at the end. For me, it was the equivalent to flying a plane without a pilot's license and bearing the weight of having to land the plane safely with all passengers on board alive and well. Moving ahead to April 5 of 2020, when I had to announce the first COVID-19 death in my jurisdiction, that was the day that I felt defeated. And every single one of the 54 deaths that I've announced from that point forward is a death that I've taken very personally, a let down, if you will, that I wasn't able to land the plane. Serving in this role is more than a job. It's a passion, a calling, and a public health workers truly care about every one of the people that we're called to serve. Simply speaking, we would not have been able to

do what we've done for the past 12 months without your critical support. Each day presents new challenges with changes in details coming down the pike faster than we can absorb them. The workload and stress is unimaginable. Most public health department workers were in our positions prior to the pandemic. We knew that a pandemic was always a possibility and yes, we signed up for it. Yes, we planned for pandemics and yes, our career choices were ours. We know that all choices come with consequences, however. Behind the scenes, the personal price that we've paid is in the form of sleepless nights, being on-call and having to be available and able to respond to callers 24/7, the stress of having to bear the burden of worry, seeing our children only after they've been tucked into bed at night and leaving home again before they wake up in the morning. And for many public health staff, this has been going on for close to a year. In addition to the COVID-19 cases, we have the interviewing and quarantining element, the tracking of hospitalizations and deaths, the community-based element that has to be satisfied, including helping businesses, schools, churches, childcare centers with recommendations for safe operation while at the same time satisfying requests of the media, responding to outbreaks in long-term care facilities, organizing, testing, providing public information, writing letters for employers and employees, and linking businesses and individuals with assistance programs. Then there's the healthcare coordination element, which includes inventorying, receiving supply requests and delivering those supplies. And now it's the vaccine element that is the major component that we have to keep moving. It is truly a challenge to adequately summarize and describe what we're all juggling. It is absolutely unimaginable. We show up to our departments each day to boost our staff and to get on countless calls and meetings to boost our peers, the ones on the front lines that are not always treated with grace and respect. We remind them that we are doing this because this is what we were called to do and we care about the people. Again, I can't thank you all enough for your support. With your continued support, we can continue helping Nebraskans. We miss our families. We're tired, but we're going to keep on doing this and we hope that we can see you all through to the end. I would be happy to answer any questions that you have.

HOWARD: Thank you, Miss Uhing. Are there questions from the committee? You know, while there aren't any questions from the committee, just on behalf of the committee, we want to thank you for everything you've been doing for our state. I think our public health workers are sort of the unsung heroes, heroes. We talk a lot about our healthcare workers and our frontline staff. But you guys are boots on the ground

in doing so much for our state. And so we're very, very grateful. So thank you for taking the time out of your day to talk to us about the work that you're doing and the breadth of the work that you're doing. So thank you.

GINA UHING: Thank you.

HOWARD: OK. All right, our next testifier is Andrea Skolkin from OneWorld Community Health Centers. Welcome, Andrea-- or Miss Skolkin.

ANDREA SKOLKIN: Thank you, Chairwoman Howard and members of the Health and Human Services Committee. As you heard, my name is Andrea Skolkin, and I'm the CEO of OneWorld Community Health Centers, which provides medical, dental, behavioral health, and pharmacy services to over 50,000 patients, primary care across 16 locations in Omaha, Bellevue, and Plattsmouth.

HOWARD: Can you spell your name for the record?

ANDREA SKOLKIN: Pardon me.

HOWARD: Can you spell your name for the record?

ANDREA SKOLKIN: Oh, I apologize. A-n-d-r-e-a S-k-o-l-k-i-n.

HOWARD: Thank you.

ANDREA SKOLKIN: Apologies. I'm here today on behalf of the Health Center Association of Nebraska and Nebraska's seven federally qualified health centers who together care for 115,000 patients annually with 90 percent of our patients at or below 200 percent of poverty and 67 percent racial or ethnic minorities. And about half of all of our patients are uninsured. We are safety net providers in the state. Since the beginning of COVID, Nebraska's community health centers has served as circuit breakers in the health-- healthcare system. Through patient education, triage, testing, and treating symptomatic patients, health centers have played a pivotal role in reducing hospital strain and freeing up scarce resources for the severely ill. This work came with the same compassion, dedication to, to mission, and commitment to providing the highest quality care possible for patients. It also came with the anguish which you've heard about, knowing that our patients are also disproportionately impacted because of their backgrounds, race, or ethnicity. We are experiencing firsthand how COVID has magnified the racial and ethnic disparities and hinder access to healthcare. Individuals falling ill are disproportionately minority and lower income, and face greater

barriers to be literate in healthcare and access to care. Today, the health centers have tested nearly 23,000 individuals. Of those tested, 76 percent are racial or ethnic minorities. However, nearly 90 percent of our positive cases are racial and ethnic minorities. Our patients are more likely to be deemed essential workers and work in facilities like the meatpacking plants and service industries, which have been hot spots for outbreaks. They do not have the luxury of staying home. They need to work to support their families, and often it takes multiple jobs and others living in the same household to pay the rent. Many care for their parents or other relatives in their home, and these circumstances contribute to close quarters and one way the disease is being spread. From March to present day, we've tested thousands of individuals at OneWorld, experiencing a positivity rate as high as 50 percent, this past week at 38 percent, meaning last week. Our home location being in south Omaha, we are in the heart of the packing industry and many of those coming for care work there or their families do or they're hard working laborers. There have been so many ambulances coming to the health center. It does bring you pause to think about the lives and the people that are seriously ill. We have had a pregnant individual coming to the health center as one story, but there are multiple where her husband was at home and not feeling well. And while she was at the health center, the husband passed away. We've seen immense fear in the faces of workers and in families and worried that they'll lose their income if they test positive but want to protect their families. In response to COVID, health centers have completely, as you heard from others, redesigned how care is provided. Telehealth is now, well-- widely used for medical and behavioral health and being used in dental services for some. Workflows, clinic hours, patient care has been restructured, including care outside to protect the safety of patients and our staff and providers, including pharmacy delivery of medication and walk-up as well as drive-up services, separating the well from the not so well and testing and vaccinating patients in their cars. At OneWorld, patients who test positive are sent home with pulse oximeters and blood pressure cuffs so we can monitor their oxygen and blood pressure at home given that so many are at risk. They are provided also two weeks of food to help them through the economic and social impact of having to isolate while healing. And right now, as others have testified, we do have two winterized tents, tents that have been installed. One is for testing and one is for the vaccine when it comes. The triage, testing, and care of underserved populations in the midst of this pandemic align with the role of health centers and what we are here to do. We are the only healthcare providers who provide care regardless of insurance status, ability to pay, the language

spoken, cultural background, or, or a country of origin. As our state begins to pivot to vaccine distribution, it's imperative that health centers be included. In addition to overcoming vaccine hesitancy, the care and vaccine for low-income and minority populations should be in the forefront. In many communities across the state, health centers are the only source of care for these vulnerable populations, especially the uninsured, the homeless, and minorities. The very fabric of the health center model is woven around the needs of the community, and we do understand how to adjust and to educate our patients and have respect for cultural norms. We will continue to be at the forefront of COVID-19, diverting healthcare demand as best we can for the hospitals and addressing community needs. And we will continue to ensure that all Nebraskans have access to safe, culturally appropriate, compassionate care. And I, too, would be happy to answer any questions that you may have.

HOWARD: Thank you. Are there questions from the committee? All right, seeing none, thank you for visiting with us today.

ANDREA SKOLKIN: Thank you.

HOWARD: OK. Our next testifier will be Annette Dubas from NABHO. You're on mute.

ANNETTE DUBAS: Think we would know by now, wouldn't you?

HOWARD: Thank you.

ANNETTE DUBAS: It's a big sign. Thank you very much. Thank you, Senator Howard and members of the Health and Human Services Committee for holding these hearings during these very trying and challenging times. I'd also like to take a point of personal privilege, if I may, and just thank you, Senator Howard, for your leadership over the last eight years. It was a joy for me to serve for a couple of those years with you and to watch you grow into your position and into your leadership and the, the causes that you championed over the last eight years. I just thank you and your mom for your service to, to Nebraska. The, the Howards will leave a lasting legacy for all of us. So thank you so much for your service. My name is Annette Dubas, A-n-n-e-t-t-e D-u-b-a-s, and I am the executive director for the Nebraska Association of Behavioral Health Organizations. We are a statewide organization advocating for behavioral health providers, hospitals, regional behavioral health authorities, and consumers. Our mission is to build strong alliances that will ensure behavioral health services, including mental health and substance use disorder services are

accessible to everyone in our state. One of my members stated that we have moved ten years in two months when COVID forced us to change the way we provided behavioral healthcare. He was, of course, referring to telehealth. Every indicator demonstrates that of all the healthcare services, behavioral health leads the way in the use of telehealth. So while there have been and continues to be many challenges facing us due to COVID, there will be some positive changes that come from all of this. Our members responded very quickly when we had to move to a telehealth way of delivering services. They wanted to make sure that there were no lapse in services and their, their clients and their, their staff were kept safe and able to access what they needed. I provided you with a report including results of several surveys that were conducted last spring and summer regarding telehealth. And we have appreciated the relaxation of many of the regulations, especially the ability to use the telephone as a billable option to check in with clients. I won't repeat information shared with you during last week's telehealth hearing, but do want to reinforce that using telehealth will continue to evolve. It is not an either or delivery system. We foresee a blending of in-person and remote service delivery, which will require us to revisit and change policies and regulations to accommodate such changes. We will also continue to work to ensure parity between in person and telehealth rates paid by both public and private payers. It's also vital that we have a statewide reliable technology infrastructure that is available to all. Losing your signal or experiencing constant freezing during a-- during an appointment is not good for the client or for the provider. Early on in the health emergency, we found behavioral health providers not always able to access the needed personal protective equipment. With so much focus on the physical aspects of COVID behavioral health providers, such as those who do residential and crisis services, which are not conducive to telehealth, struggled to get the needed PPE. And I've noticed with some of the other testifiers that continues to be an ongoing issue. I'm not receiving as many concerns from my members, but we worked really hard to make sure that they are connected with public health departments and other resources to make sure that they are getting the, the PPE that they need. We appreciated the additional emergency funding that was made-- that has been made available during this emergency. Many of our members applied for and received paycheck protection funding, as well as other state and federal COVID dollars. There were problems related to federal COVID funding, especially with the provider relief funds. The initial rollout was confusing, with some of our members receiving money that they hadn't even applied for. Later, the program was opened up to those who serve Medicaid clients. Just, just a lot of confusion. Many of the questions went unanswered

about auditing and reporting, which led providers to hesitate to apply. And while we can appreciate the need to have accountability as to how those funds are being spent, many of our providers are already stretched to the max administratively. And so you find businesses weighing the costs versus the benefits of applying for those funds. Again, I want to stress most of these concerns apply to the federal programs, not to the state funding. And we had many of our members apply for those state dollars and receive those dollars of which, again, we are appreciative. Keeping lines of communication open during emergencies is vitally important. Things were moving so fast and in so many different directions during those early months that we needed to have access to accurate information. Having weekly calls with state agencies was very helpful. It allowed the different associations to network and we could ask questions or be directed to the best person to help find answers and solve problems. The pandemic has taught us many lessons, chief among them is the importance of our public health departments and their staff. These individuals have worked nonstop to help with testing, contact tracing, working with schools and businesses, and countless other duties. If ever there was a case for prioritizing public health in our state, it has been made during this past year. They deserve our sincerest gratitude and support. Similarly, the importance of mental health and addiction services. Once we are through this emergency and spend time reviewing our state's response, I strongly encourage including how to meet the mental health needs of those frontline workers and other support staff of a part of any disaster response plan. There should be no separation between providing behavioral healthcare and mental healthcare. Our state and nation will need time to heal and recover from the impact of COVID, people lost their jobs and businesses. Teachers struggle to keep their students on track and meet their educational needs through virtual classrooms while worrying about their kiddos health and safety since they couldn't physically see them. Parents have had to figure out how to balance their work and become their kids' teachers too. Compassion fatigue and exhaustion with any of the caring professions is very real and very debilitating. Our behavioral health professionals and support staff will be the ones who help put us back together, making sure the caretakers are also taking care of themselves must be a priority and a conscious and visible part of disaster preparedness. So, again, I thank you for the opportunity to visit with your committee today and would be happy to answer any questions you may have.

HOWARD: Thank you. Are there questions from the committee?

WALZ: I don't--

HOWARD: Senator Walz.

WALZ: I don't have a question, but thank you, Annette, for being here. That was, that was very informational. Do you know, and I'm so glad that you mentioned mental health for our healthcare workers and the need for it, do you know, just offhand, has there been any mental health support for healthcare workers during this last few months?

ANNETTE DUBAS: I know the Nebraska Medical Association has put together a program making it available to their, to their, their members through the Division of Behavioral Health, there are vouchers and other programs that have been made available to behavioral health workers. I can't say how many have taken advantage of those, but I do know that there have been different programs and, and different things put out there. Some compassion fatigue training. Unfortunately, caregivers are the last people to seek care for themselves, and so I know as a part of my role, I am almost weekly encouraging my members to please reach out for help if you need it, network with each other. I don't really have a way of tracking that. The Division might have some understanding of how many vouchers maybe they've made, made available to, to people, but it's something that we're just constantly working to keep in front of our members. And, you know, I constantly tell them you can't take care, care of others if you aren't taking care of themselves. But I wish I could give you more a definitive answer about how much-- how many of them are actually taking advantage of the help that is available.

WALZ: Well, thank you. And again, I'm so glad that you mentioned that goal of making sure that we provide mental health to our healthcare workers. Thanks.

ANNETTE DUBAS: You bet.

HOWARD: Thank you. Any other questions? All right, seeing none, thank you for visiting with us today. All right, our next testifier is Heath Boddy from the Nebraska Health Care Association. Welcome, Heath.

HEATH BODDY: Thank you. Chairwoman Howard, members of the committee, my name is Heath Boddy. That's H-e-a-t-h B-o-d-d-y, and I'm privileged to lead the Nebraska Health Care Association. If you're not familiar, we're a statewide association representing 423 nursing facility and assisted living facilities across the entire state. And as you've heard from many of the testifiers today, needless to say, 2020 has been an incredibly impactful year for our providers. In fact, the most impactful in at least 100 years. Our providers have been battling this

invisible monster that gets into their building. And as you've heard in the news or maybe firsthand, has an incredible impact on the elders that they're serving. So my goal today is to give you an update on, on COVID-19 in the nursing facility and assisted living facilities. And I thought I might start with vaccination. Surely you're aware that we have vaccination-- a vaccine on the ground here in Nebraska starting its way across the state for distribution. I thought you might find it interesting that in the long-term care space, specifically nursing facilities and assisted living, we'll be working with three pretty large partners here to start. So Walgreens and CVS, you've heard of those national partners and then a sizable partner here in Nebraska and a bit of the Midwest called Community Pharmacy out of Gretna. And most of our facilities have been matched with one of those three providers. There are providers who were not matched. And so if you would hear from one of them, the instructions that we give for them is to contact and start working with their local public health department. Facility clinics with the vaccine should begin in nursing facilities the week of December 28, and then assisted living the following week. And we at the Association are working on messaging and a campaign to encourage healthcare workers to consider the vaccine. And I heard Dr. Boucher talk earlier, I, I think that was him that said something that senators might be able to do is to weigh in, in that conversation. And I, too, would encourage you in that way. When I think about testing, you may know that nursing facilities continue routine testing of their staff and the rate is determined by their county positivity rate. So for the two- week period ending December 2, you might find it interesting to know that 78 of our counties were red or 2 times per week testing. Thank goodness we've got antigen test now, which our nasal swabs as opposed to the nasopharyngeal or as I like to call the brain scrub. If you've not had it done, it's an interesting experience and I don't make light, it's just a much different experience than the nasal swabbing. We have five counties that are yellow and that would be one testing-- one-time testing per week and ten counties which are green, which would be one time per month. The rest of the nursing facilities and many of the assisted living are doing what they call outbreak testing. So if there is a staff or a resident that becomes positive, then they go into different levels of testing. Some facilities have supply of the antigen tests and others do not. The state has been great at trying to get that supply and I guess the federal government as well. And then in some cases, facilities are having to locate that themselves. Senator Dubas was talking about PPE. And I think when the last time we chatted with you all that you might have heard that we had assisted living members that didn't even have three face masks in their building. And so

that's all gotten a lot better. It's not perfect, but it's gotten a lot better. And really it's gotten to be a shift in what was hard to get. So we went back then from couldn't get masks and then we couldn't get gowns. And now the pressure becomes nitrile gloves, which is huge because every healthcare worker, many of the, you know, police and fire, they all use them. And so that will be a pressure that we'll want to pay attention to in my mind as a state. And state and local public health departments continue to provide PPE, much of that comes through the state. And frankly, our Association-- I think I heard one of the other associations, maybe it was Senator Dubas talking about locating PPE for their members, and we did that as well. When we think about funding, of course, a big thing in a congregate living environment would be the census. How many people are living there? Nursing facilities and assisted livings have had a real struggle with that. It's-- the range that we see is between 10 and 17 percent drop in census or the number of people that live with them. They have received some additional federal and state dollars from funding, but it clearly has not covered all of their expenses. And so it will be a bit of a challenge. You might have heard from visitation from people in your district. We-- many are unable to offer indoor visitation right now because of the county positivity rate and outbreaks. We hope this will start to change as vaccinations take hold. A big thing coming forward that you'll likely hear about is if you haven't already is liability protection, providers are seeing at least 50 percent or often 50 percent increases. Sometimes it's hundreds of percents of increase in their premiums for liability protection, some of them aren't able to get that, that is simply a reflection of what's happening in the space. We'll be working with the Nebraska Chamber this year on some legislation that you might see us, whether it's the Rotunda or on Zoom, I guess we'll wait to be seen. And I just wanted to highlight as I wrap up my time with you before T.J. puts up the wicked red card, the healthcare heroes, and I, I think you know it. You've heard people allude to it. I just want to make sure that we just pay a second of homage to the people that get up every day knowing what they're facing, putting on their suit of armor, if you will, which is PPE and doing it again and again because they're here to serve. And I'm so proud of them. I'm so proud that we get to represent them. And I just thank you for your leadership and your service to make sure they had what they need to serve Nebraskans across the state. So, Senator, I'd be happy to answer questions, but I thank you for the time today.

HOWARD: Thank you for visiting with us. Are there questions from the committee? Can you-- I was, I was trying to catch in your testimony,

you know, what percentage of long-term care facilities do you think have been impacted by COVID or have had an infection of a staff or a resident?

HEATH BODDY: That's a great question. I don't know the actual answer. I'll, I'll give you a spitball answer. I would say there's not many that haven't been.

HOWARD: OK.

HEATH BODDY: There-- for a while when we went through that first wave, I would say it was maybe 50 percent or less. But it is just been-- you know, one, one of the things that we've learned is that the ability to keep the virus out is a reflection of what the behavior in the community around that facility is doing. Said differently, if people aren't willing to wear a mask and socially distance and do those right behaviors, the facility is at a complete weakness to have the virus get in. Remember, we have team members that have to go home. They have to go get groceries. They have to stop by and get gas. And that's where that breakdown happens.

HOWARD: Thank you. Senator Murman.

MURMAN: Yes. Thank you for your testimony, Heath. I heard a lot of complaints early-- earlier in the pandemic about-- from families that couldn't visit their loved ones, especially at the end of their lives. I know that has improved recently. Could you address that just a little bit?

HEATH BODDY: You bet, Senator Murman, thank you and I'm sorry that you've had to field those calls. But you're absolutely right, this, this has been as trying of a time on the elders that live in these environments and their families as probably anyone. Pretty early things got shut down pretty hard, much like we saw in business. And there was-- I, I don't like the word lockdown, but tightened them up to a point. In early June, there was starting to be some consideration about how might we allow some visits, how can we do it safely? And a lot of that's around frequent testing, as I alluded to earlier, with these antigen tests and then making sure that we're aware of what's happening in that larger community. So the struggle now is, as we've seen Nebraska spike with our numbers, 78 of our 93 counties being red, they've really, as a provider, have really had to be careful about how many people are allowed into a building because they'll bring the virus with them. One thing certainly we've gotten better at as a policy, which is unfortunate when you're talking about somebody at the

end of their life, Senator, is that compassionate care visits, people at the end of the life, especially, people have found ways to make those happen. That was a big struggle pretty early on. People weren't sure what to do. Just like you, our providers, we're learning right alongside the epidemiologists saying, "geesh," we tried that last week. That's not working, we got to move to this this week. So I, like you, Senator, feel like it's gotten a lot better, probably not perfect, depending on someone's perspective on it.

MURMAN: Thank you.

HOWARD: Thank you. Other questions from the committee? OK, seeing none, thank you for visiting with us today.

HEATH BODDY: Thank you, Senator.

HOWARD: Our next testifier is Janet Seelhoff from the Home Healthcare and Hospice Association.

JANET SEELHOFF: Thank you, Senator 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, and I serve as executive director for the Nebraska Association for Home Healthcare and Hospice. Our members include home health agencies, hospice agencies, and personal care home care companies across the state. They employ nurses, home health aides, hospice aides, physical therapists, occupational therapists, speech language pathologists and social workers who are all delivering medical care and support in the home for recovering disabled, chronically or terminally ill adults and children who are in need of medical, nursing, social or therapeutic treatment and assistance. During this pandemic, our home care home health and hospice workers have been on the front lines, just like all of our healthcare providers. Hospitals have turned to our home health and hospice agencies to provide services to patients who otherwise would have been treated in the hospital to allow for the capacity and the rise of COVID-19 patients. We've always emphasized how critical the role is that home health providers are playing and helping patients avoid rehospitalization. And during this time of crisis, the actions and care of our home care providers in doing that has been even more critical to help keep those hospital beds available for COVID-19 patients. Our stay-at-home health patients are some of our most vulnerable and fragile citizens that have complex, long-term care needs. This includes Nebraskans that have COPD, which is chronic obstructive pulmonary disease, asthma, multiple sclerosis, cardiac conditions, cancer and other ailments, and those who are receiving

rehabilitation for joint ailments, surgeries and other injuries. Home care bridges that gap between hospitalization and outpatient clinics and the public health emergency has reinforced that Nebraskans want to remain independent and safe at home, and they are relying on home care and hospice providers more than ever to help them do that. When the COVID-19 public health emergency was declared, our members' inventory of PPE was based on their anticipated needs of home care patient admissions and needs for visits. Our members were accustomed to ordering PPE when they needed it and they could count on timely delivery. It quickly became challenging for our home care and hospice providers to secure PPE and cover the unexpected and rising costs of that, no different than what many others have shared with us today during the hearing. The supply chain and distribution has improved, but there are some concerns that remain about PPE availability and ongoing costs. After the public health emergency was declared, there was a small percentage of home care and hospice patients in our state that refused services because they were afraid of allowing nurses, aides, and therapists into their homes as well as caregivers. As patients became more comfortable and were reassured that home care and hospice providers were conducting daily screening and that they were following their infection control plans and practices, they were more willing and comfortable in resuming services. For some patients that are not comfortable in receiving services in their home, telehealth has been a great option for them, and we're extremely grateful to our state for the waiver that was granted so that telehealth services can be used in the home in place of an in-person visit when it's feasible to do so. In the home care world, we refer to telehealth as remote patient monitoring. Patients have a need for consistent monitoring of vital statistics, including blood pressure, oxygen level, weight, and temperature. Being able to take these vital signs at home and collecting that data over time helps identify challenges and changes in a patient's condition and helps prevent trips to the doctor's office and the hospital. You heard a lot more about this last week when one, one of our members, Amanda Holst, testified during the LR350 hearing. So I won't go into great detail about that. But I just wanted to reiterate that we really do support expansion of use and reimbursement for remote patient monitoring. It supports being proactive with the patient's healthcare needs. It reduces the state's costs for in-person visits, and it helps deliver care in areas where there are provider shortages. And that, as Senator Dubas said, is one of the positives that has come out of this pandemic is the great need for more telehealth services. One challenge that has been exacerbated during the pandemic is the shortage of nurses, aides, and therapists. It's been even more difficult for our members to fill these positions

knowing that additional staffing has been needed in hospitals and other healthcare settings. Once the pandemic ends, the nursing shortage crisis will continue in our state. And as we know, our elderly population in Nebraska is expected to grow another 35 percent by 2030. We're anticipating that the need and demand for home care services will grow significantly. And we do need to address the low reimbursement rates for skilled nursing services for Medicaid home health beneficiaries to help support the needs for staffing of services and to help compensate our providers. Our members are greatly appreciative of the resources that have been available through TestNebraska for testing their employees, and we're also grateful that home health and hospice has been included in Phase 1A of the vaccination plan. As workers on the front lines, it will be critical to protect our healthcare professionals and our home health and hospice patients. And they are working very closely with their local health departments on the vaccination plans. Our home care home health and hospice providers are steadfast and diligent and continuing to deliver high-quality care services and support to keep our citizens safe, independent, and comfortable in their homes and communities through the duration of the public health emergency and to continue meeting the growing need for healthcare delivery at home. Appreciate the opportunity to be here today and to provide a very brief update for you and happy to answer questions that you may have.

HOWARD: Thank you. Are there questions from the committee? All right, seeing none, thank you for visiting with us today. All right, our next testifier is Justin Hubly from NAPE/AFSCME. Welcome, Justin.

JUSTIN HUBLY: Well, good afternoon, Senator Howard and members of the HHS Committee. Thanks for having me today. My name is Justin Hubly, J-u-s-t-i-n H-u-b-l-y, and I'm the executive director of the Nebraska Association of Public Employees/AFSCME Local 61. Our union represents over 8,000 frontline state of Nebraska employees, including around 3,000 who work for the Department of Health and Human Services. And like most of us, our members have had a challenging time during the past ten months navigating this pandemic. But our members understand the importance and critical nature of the work that they do and have proudly continued to serve their neighbors and fellow citizens throughout the pandemic. I just wanted to take a little bit of time today to provide you with some insight into the challenges that DHHS employees have faced over the last ten months, which aren't wholly unsimilar from other state employees, but we'll focus on DHHS. The unknowns at the beginning of the pandemic were unsettling to many of our employees. They understand the vital nature of their work, but also have a right to be safe and protected while carrying out their

work. Initially, there was a lack of guidance, lack of training, lack of PPE across most areas of DHHS. Information was slow and often contradictory and ever changing, and it left the employees feeling very unsettled and oftentimes undervalued. Many of the employees had concerns for their health or the health of a family member. And for some employees, the potential exposure to COVID-19 in the workplace could lead to severe illness or even death. And DHHS was initially very slow to deploy workers to work from home who were able to. And our members could not always get responses from the HR department, especially critical requests that seemed to be ignored. The agency also seemed to have a lack of faith in the workforce that they would be successful working from home and granting such requests to work from home were often viewed as some kind of detriment to the agency rather than an action because of an emergency. For those employees who remained in offices, the challenges were many. Except in our 24-hour facilities, there is still no mandate for employees to wear a mask, nor is there a mandate for members of the public receiving services from our employees to wear a mask. We know that wearing a mask is the simplest way to prevent the spread of COVID-19, but our members frequently have to assist "maskless" members of the public or "maskless" colleagues in the office. This is especially challenging in smaller local offices in rural Nebraska, where social distancing is often more difficult because of the size of the local office. When there was close contact with COVID-19, employees were left to speculate about their potential contact because the agency wasn't forthcoming with its employees when a member of the public or a colleague that they interacted with tested positive. In the Child and Family Services Division, our CFS specialists still must make home visits. And of course, they understand the critical importance of ensuring the safety of the children or vulnerable adults on their caseload. They are frequently sent to a house with nothing more than a mask and the assumption that no one in the household has been in contact with COVID-19. There's been very little training provided to our CFS specialists, and most of the instructions have only come by a written memo. And due to the overwhelming demand for services and staffing shortages, and some of those staffing shortages predate the pandemic, our social service workers have been working mandatory overtime for the past two months, but because our members are dedicated to their fellow Nebraskans, there have been very few complaints regarding the assignment to get through the backlog of applications for economic assistance during the pandemic. The Public Health Division continues to work overtime to meet the demands of the pandemic, and overtime in our 24-hour facilities continues to be a significant problem. Nurses and care technicians have been hit

especially hard by mandatory overtime during the pandemic. And simply put, it's just exhausting to work 16-hour shifts one after the other, especially when you have to be in PPE most of the time. We recently had COVID-19 outbreaks among staff at the ACCESSNebraska Customer Service Centers in Fremont and Scottsbluff. And sadly, just two weeks ago our first member passed away from COVID-19. He was a social services worker assigned to the Scottsbluff Customer Service Center. And right up until the day he passed away, he was calling into his supervisor to make sure that his caseload was being supported so that his neighbors were taken care of during the pandemic. His passing was a stark reminder of how indiscriminate and dangerous this disease can be. With all that said, we've begun to see some improvement and I do want to give kudos where they're due. I think the DHHS HR department has become much more responsive to requests to allow workers to work from home, especially those with medical conditions that make it particularly dangerous to be at work. And at this point, most workers needing those accommodations have been accommodated. And the agency has significantly improved the way it alerts its employees when someone has tested positive in the workplace, and communication is crucial and we've become to see-- we've begun to see some improvement. And while there's hope on the horizon with the shipping of vaccines, the pandemic, I think, is going to be with us for the foreseeable future. And with that, I just ask that you continue to support state employees and keep them safe so that they can continue to provide critical services that Nebraskans need. We need support in order to attract and retain employees. We've got to cut down on the number of mandatory overtime hours and we need a fresh batch of emergency COVID sick leave, which is scheduled to expire at the end of this year. So I'm coming to you today from a very snowy Kearney, Nebraska, and saw the roads already across the street from our hotel was up bright and early to plow snow. And I'd like to thank you for the opportunity to share these experiences with state employees. And if you have any questions, I'd be happy to answer them.

HOWARD: Thank you. Are there questions from the committee?

WALZ: I'll ask.

HOWARD: Senator Walz.

WALZ: Thank you. Thank you, Justin, so much for coming today and for your testimony. I live in Fremont and I had several calls from employees at the call center with a lot of concerns regarding, you know, the amount of staff that were in the building at one time, the amount of staff in the break room, the, the fact that they weren't

able to, you know, be six feet apart and people coming in sick, not, not being aware of people who were coming in sick. Can you talk a little bit about has that improved? Was there a, a plan in place to remedy that situation, did they end up letting people go home to work?

JUSTIN HUBLY: Sure, I can address that a little bit. It really was a troubling situation. You know, those call centers have anywhere between 100 and 150 employees that work at low-rise cubicles. You're, you're within six feet of your neighbor. And the agency for the longest time was really unwilling to socially distance them or let more of them work from home, even when they were able. Since then, there was an outbreak that you are aware of. I know some of our members contacted your office directly, and it's sad that we had to have an outbreak to kind of make change happen. But yes, more employees were allowed to work from home. The agency, nine months in now has installed some higher Plexiglas shields on those smaller cubicles. And frankly, what I've been told from the, from the call center is that more employees are wearing masks. And we continue to encourage that. It is difficult to work at a call center wearing a mask because you have to talk on the phone with folks. So I think it's improved a little bit, but I wish the improvement was from leadership from DHHS and not a reaction to something that shouldn't have happened in the first place.

WALZ: Right. And apparently there was a, a plan in place from DHHS. Do you know if that plan is still in place? Is it being followed?

JUSTIN HUBLY: Yeah, I, I would tell you from my perspective, there was no plan at the beginning. There is a plan now. And what's being followed is they're letting half the employees, it's like a rotational schedule, so they kind of work every other day and cycle in and out of the office. And I think the, the agency's position is that that's kind of an equity piece. But we really don't understand that because you still have everybody cycling in and out. And maybe-- I'm not a doctor, I know there are doctors on the call today, but it would seem to me that that just cycles the germs more. I wish there was a set, you know, this is the A team and this is the B team and one's at home and one's in the office seems to be better, but they are following that plan right now so that at least there are-- it's not at full capacity each day.

WALZ: Thank you, Justin. Thanks for your work.

JUSTIN HUBLY: You bet.

HOWARD: Thank you. Other questions from the committee? I just want to make sure that I heard you correctly, so they're-- for DHHS employees, they're not asking them to wear masks at the office?

JUSTIN HUBLY: They are strongly recommending it, but I think, like you see in most parts of society, some people are adamantly not going to do that and others are. And in the workplace, I just don't think that's a very fair thing, because if you both have to be there, we have to protect each other. And if we're not going to listen to suggestions, it's time for a mandate.

HOWARD: And then that, and then that applies to people who are visiting the offices as well, they don't have to wear masks either?

JUSTIN HUBLY: It is. I was in western Nebraska, I was up in Chadron and Valentine last week, and those, those local DHHS offices at the county courthouses are like a tiny room. And so if a member of the public or two members of the public shows up, you're on top of each other. And the mask wearing wasn't there, at least while I was in the facility.

HOWARD: All right. Thank you.

JUSTIN HUBLY: You bet.

HOWARD: Senator Cavanaugh.

CAVANAUGH: Thank you. This is just a follow-up on the question about the masks. Are they not wearing masks in offices that are located in cities that have an ordinance requiring a mask?

JUSTIN HUBLY: That's correct. The ordinance from the Lincoln-Lancaster County Health Department does not apply to state office buildings or those seeking government services. So we have about 1,100 employees that we represent at 301 Centennial Mall right across from the Capitol and masks are not required in that building. It's the same at the Omaha State Office Building at 1313 Farnam. There's a carve-out in the local ordinance for state office buildings.

CAVANAUGH: There's a carve-out in the local ordinance, not--

JUSTIN HUBLY: That's my-- I can speak-- I probably shouldn't speak about the Omaha one. I'm less familiar with it.

CAVANAUGH: That's OK.

JUSTIN HUBLY: But, yeah, the Lincoln-Lancaster County Health Department specifically says in, in their order, their directed health measure order, that those seeking government services or in a gov-- a state office building or state facility that masks are not required.

CAVANAUGH: Thank you.

HOWARD: Thank you. Any other questions from the committee? OK, seeing none, thank you for visiting with us today from Kearney. We appreciate it.

JUSTIN HUBLY: Yep, thank you. I'm off to Grand Island. Have a great day.

HOWARD: All right. Have a safe trip. OK. And our final testifier today will be Jenni Benson from the NSEA. Welcome, Jenni.

JENNI BENSON: Good afternoon, Senator Howard and members of the Health and Human Services Committee. For the record, I am Jenni Benson, J-e-n-n-i B-e-n-s-o-n. I am the president of the Nebraska State Education Association and I have taught special education for over 30 years. Thank you to all the testifiers today. I said, when I'm listening, that's a good thing about being the last testifier is that you get to hear everybody else's testimony. And I just want to say that, you know, nothing is clearer than that we are all in this together. Nebraska teachers and their students have been courageous throughout this pandemic. Our teachers and school personnel and parents are doing all they can to help teach students to keep their learning alive and keep students safe and in school. Our state and nation are battling a huge surge in COVID-19 cases, and we will likely face another surge following the holidays. I am so proud of the educators and the staff across the state. This past spring, teachers, students, and parents turned on a dime to safely and successfully roll out remote learning, which has now transitioned into just a variety of different blended online and in-person learning, various models where students are in school on a differentiated schedule. We have teachers who are expected to teach simultaneously in person and via remote, which is akin to a doctor doing surgery while holding office hours. Much of this has taken place without any authentic input from real experts in education, the teachers. We now know that the work is coming at a very steep price for teachers, students, school support staff, and parents alike. Those who wish to destroy public education have used this difficult time to ramp up their efforts to cast blame and doubt about teachers and public education and public schools in order to garner support for their own narrow political agenda. In

November, NSEA reported the results of our statewide survey, which more than 6,500 teachers responded. The results included alarming news that more than 20 percent of educators in Nebraska are considering leaving the profession at the end of this school year. This is especially true not of our teachers ready to retire, but our teachers who are just entering the profession. And we don't have a deep bench of highly qualified educators to fill these positions. In fact, the ability to attract even qualified substitutes has led to an overuse of an emergency substitute certificate, escalating the use of unqualified, although well-meaning, substitute teachers. The bottom line is our students, our teachers, our staff, and our parents are at a breaking point despite, despite the best efforts of all. Too many of our students are learning far less than they might during the typical year. The Legislature must quickly address three crucial areas in order to give our students a fighting chance for the quality education they deserve. To date, neither the Governor nor the State Board of Ed have stepped up to meet their obligations. After hundreds, if not thousands of Zoom calls, emails, phone calls, online town meetings with teachers, there are three needs that have come through loud and clear. And our educators are asking our elected officials to step in and help them advocate for the following: slow the community spread of the virus. Fully 92 percent of those 6,500 NSEA members responding to the survey support a mask mandate. In one case, the Commissioner of Ed had to intercede in a school district to have them comply with our local health department. NSEA called on the Governor to issue a statewide mask mandate and we all know that was declined. NSEA petitioned the State School Board to impose a mask mandate in schools, and the res-- response was oddly similar to that of the Governor. It declined. Thankfully, cities across the state, at the prompting of senators, at the prompting of the public, have issued mask mandates to help slow the community spread. Senators, we need a thorough review of this process, which policies and procedures that promote health and safety of our staff and students statewide can be implemented and enforced. School districts need resources and budget authority to address the increased cost of educating during a pandemic, whether it's PPE, technology for remote learning, mental and behavioral health, overtime pay for staff, and, yes, additional pay for teachers. School districts cannot continue to carry this burden without significant investment from the state. School districts are under a 2.5 percent budget lid, and there's those who want to make it even more strict. Nebraska ranks 49th, almost dead last in the nation for per-student state funding for education. The state must address these two issues immediately to provide the districts resources they need to reduce class size to prevent the virus spread, engage in extended

school learning for those students who have fallen behind, and to provide any mental healthcare needed for students and for staff. And we had also heard from teachers and personnel that they feel out of touch with the decision-making process that most affects them from their classrooms and their students. The staff that work directly with students every day are the experts, and they know what's best for their students, for their parents, and their community. But their voice has been locked out. Teachers need more time to collaborate and plan with their colleagues and even for themselves, not more directives, not more staff development, not more state mandates. Teachers want to teach in the manner they know most effective for their students, but currently they're being blocked from those real conversations. Right before I came on this Zoom, I had a message from a teacher who's currently suffering from COVID. She has moderate symptoms. She was on her way to drive through to get a blood thinner to hopefully prevent strokes is what they told her. She's 50 years old. She doesn't have a lot of health conditions known. But during this time she's been gone from school, she's been required to test her students remotely. She's been required to do all of her substitute planning. She's been required and her class is on their fourth substitute in the ten days she's been out of her classroom. And she's not recovered yet and she's burning all of the COVID leave and now she has to use her own personal time. These are stories I hear every day and all of the stories that we just heard from everyone else directly affect one another. And I just appreciate all your work and your continued dedication to the safety and this-- and the security of our students and our public schools. Thank you.

HOWARD: Thank you. Are there questions from the committee? Senator Cavanaugh and then Senator Murman.

CAVANAUGH: Thank you. Thank you for being here today and for sharing the perspective of our educators. I want to start out by saying that I was attending an in-person hearing for the other committee that I sit on, Transportation and Telecommunications. It was a joint hearing with Appropriations and there were eight members not wearing a mask in the room. And because my children go to public school and direct health measures state that you should not be in a room with person for more than 15 minutes unmasked, I did not stay in the committee hearing room because our teachers deserve better than that. And I find it audacious that we, as elected officials, think that we are better than what is recommended to protect our citizens. So thank you for bringing this up. And I just wanted to ask you if you could share one thing that we could do in this upcoming session to support our educators. What would you like us to do?

JENNI BENSON: Oh, gosh. Just one thing?

CAVANAUGH: You can say more than one.

JENNI BENSON: I'm teasing. I appreciate that. I say that quite frequently when people say, oh, distancing and PPE and, you know, Plexiglas. And my kindergarten teachers are, please, give me a Plexiglas so I can teach my reading groups. Please, you know, give me more masks because a kindergartner gets their mask wet within 20 seconds. Right? So, I mean, all of those things are important. And I think that school districts are being really tasked now with continuing this and not getting burnt out and saying, oh, you know, let's, let's back off a little bit. We can't back off because if we back off, then we're going to have more difficulties. And I think that one of the biggest things that I'm hearing right now is the concern about learning, especially in those areas where you have online and in person at the same time. And so having resources to do extended services would be fabulous, because I think we all have to look at how do we-- this is not done if the, if the virus is under control. This is not done because children learn and grow in a systematic way and we need those resources in order to keep them, keep them going. My teachers would ask that we figure a way to be able to, you know, who, who wants to say this isn't going to happen again? I don't want to say that. A year ago I said we wouldn't have another meeting virtually, you know, and, and we are still doing that. Right? So I was totally wrong. And I think that one of the things teachers want is to say, we want to be safe, we want our students to be safe, and we want to keep them in school. And the only way we can keep them in school is to make sure everybody else is doing what they're supposed to do and that's not happening.

CAVANAUGH: No, it is not, unfortunately.

JENNI BENSON: But our teachers are getting blamed. This teacher today I talked to or was messaging with, she said they told me to be quiet and to not tell anyone why I was home for two weeks. Really? Because they can't figure that out. You've been gone for two weeks like, you know, I'm sorry, her third graders know why she's been gone for two weeks. Right?

CAVANAUGH: Yeah. Yes, they do. Well, thank you so much. I will say my children just got home from their last day of in-person learning for the school year. And this is my opportunity to say that the teachers at Westside Sunset Hills are amazing and very much appreciated.

JENNI BENSON: You know, I was-- you know, Justin was saying he was out traveling. You know, I, I put-- I did about 3,500 miles in the first few weeks of school, going to schools and seeing and I faced a lot of those same things, walking into a building where not one person was masked, not a teacher, not a student. And now I just face a lot of people writing me a lot of hate mail saying, why would you ask for a mask mandate? Like-- and one told me I shouldn't ask for a mask mandate because I just care too much. I was like, well, that wasn't why I asked for one but thanks. I do care.

CAVANAUGH: Thank you.

HOWARD: Thank you. Senator Murman.

MURMAN: Yes. Thank you for your testimony and I truly appreciate what teachers and parents, students, what everyone has done to continue, especially in-class learning during this pandemic. I'm wondering are there any-- does NSEA or anyone keep statistics on how many teachers have became seriously ill or, you know, what percentage or unfortunately have died during this time from COVID?

JENNI BENSON: Unfortunately, that's one of the problems that we have is good data. Right? Each school district is supposed to once a week update their dashboard of how many folks, you know, have tested positive, how many folks, students and, and educators and support staff have tested positive. But there really isn't any other. No one else has been running a statewide data point. We have a former actuary, retired gentleman from Hastings, who does that kind of work. And he, he sent me an email last week and said, where's the data? I want to take that data and I want to tear it apart and I want to do. And I was like, the only way to look at it is to go through every school district's dashboard and figure that out. But no one has said, you know, we know anecdotally what, what we know about people who have passed away. We've had custodians, we've had members, we've had retired members, of course, and we've had students that also have, have succumbed to COVID-related deaths as well. So unfortunately, there isn't that. And that's really sad because I don't know how you get better. You know, in a, in a profession like school where data is what we work with and accountability, it's very sad to me that there's not that same accountability elsewhere.

MURMAN: Yeah, I agree that would be very useful information. I, I know it would be-- wouldn't be easy to come by, but thank you very much.

JENNI BENSON: Yeah. Thank you.

HOWARD: Thank you. Other questions from the committee? OK, seeing none, thank you for visiting with us today and, and taking the time to stay on our Zoom until the very end. We, we appreciate it.

JENNI BENSON: I appreciate you all. Thank you so much. Bye-bye.

HOWARD: All right. I'm going to just close very briefly and remind the committee that any questions that we have in follow-up for the agency, we'll send out an email on Thursday. And so if you have questions from the Medicaid expansion resolution, from the COVID resolution, or from the St. Francis conversation that we're going to have tomorrow, we'll collect those and put those in a letter for the agency so that they have something in writing in regards to our follow-ups. I think we've heard a lot today about COVID, and I appreciate the committee hanging in there for the entire afternoon. It's such a big issue and it's such a big issue for our state. And being the best committee in the Legislature, obviously, we were the ones who paid the most attention for the, for the entire day. But there were some takeaways that I just want us to, to remember. And they're things like the struggle to get PPE to make sure that every provider is protected, concerns about their CARES Act funds and if they have to return them, and issues around low reimbursement rates. We heard about crisis standards of care, which you'll definitely be working on in the next session. We heard about the use of telehealth, which this is-- this would be our second conversation about telehealth, especially for mental health and especially for home care services. We heard about the challenge of serving unique populations, especially minorities and individuals living in poverty in our state with this pandemic. We also heard about liability issues, which is, I think, something that you'll be dealing with pretty in depth in January. But I think the, the two things that struck me the most were, were the overall and the overwhelming weight of the pandemic on our healthcare workers and our public health workforce. And so if they have a takeaway from this, from this conversation that we're having today, it's that we heard them and that we're very grateful for their service to our state. We know that we would not be-- we couldn't get through this without them. And then finally, I was truly struck by how resilient and innovative Nebraskans can be. I think we're very fortunate to live in a state where we're willing to try anything to fight something that is so much bigger than ourselves. And some days we're winning and some days we're struggling. But I think it's, it's the Nebraskans who are going to get us through this pandemic in this state. So with that, that's my closing. I doubt there are any questions from the committee. Questions? Senator Cavanaugh.

CAVANAUGH: Very quick question. Will our questions to the department and their responses be part of the permanent record for these hearings?

HOWARD: You know, they won't, they won't be. Letters generally, they get sent later, but we'll make sure that every member of the committee gets their response and then you can use that as you continue your work in January.

CAVANAUGH: OK, thank you.

HOWARD: Sure. All right. If there are no other questions, this is your friendly reminder from your friendly Chair that tomorrow we start at 9:00 a.m. Tomorrow is our child welfare marathon day so 9:00 a.m. It's going to be briefings in the morning. So Foster Care Review Office, Inspector General, Children's Commission, and then we'll take a break for lunch. And then at 1:30, we'll talk about St. Francis and then we'll talk about the impact of COVID on our child welfare system overall. So I appreciate all of your time today. We've, we've just done such, such good work this afternoon. And I'm very grateful for your time. Have a great evening, OK?

MURMAN: Thanks, Sara. Goodbye, all.

HOWARD: Bye, Dave.