STINNER: [RECORDER MALFUNCTION] --the hearing. My name is John Stinner. I'm from Gering and I represent the 48th Legislative District. I serve as Chair of this committee. I'd like to start off by having members do self-introductions, starting with Senator Erdman.

ERDMAN: Thank you. Steve Erdman. I represent District 47. That's nine counties in the Panhandle.

CLEMENTS: Rob Clements, District 2, all of Cass County and eastern Lancaster.

HILKEMANN: I'm Robert Hilkemann, District 4, west Omaha.

STINNER: John Stinner, District 48, all of Scotts Bluff, Banner and Kimball Counties.

WISHART: Anna Wishart, District 27, Lincoln and Lancaster County.

STINNER: Assisting the committee today is Tamara Hunt, and to my left is Liz Hruska, our fiscal analyst. Our page today is Jason Wendling. At each entrance, you will find green testifier sheets. If you are planning to testify today, please fill out a sign-in sheet and hand to the committee clerk when you come up to testify. If you will not be testifying at the microphone but would want to have-- go on record as having a position on a bill being heard today, there are white sign-in sheets at each entrance where you may leave your name and other pertinent information. These sign-in sheets will become exhibits in the permanent record at the end of today's hearings. To better facilitate today's proceedings, I ask that you abide by the following procedures. Please silence or turn off your cell phone. Order of testimony will be introducer, proponents, opponents, neutral and closing. When you come up to testify, we ask that you first spell your first and last names for the record before you testify. Be concise. It is my request that you limit your testimony to five minutes. Written materials will be distributed to committee members as exhibits only while testimony is being offered. Hand them to the page for distribution to the committee and staff. When you come up to testify, we need 12 copies. If you have written testimony but do not have 12 copies, please raise your hand now so the page can make copies for you. With that, we will begin today's hearing with LB867. Good afternoon, Senator Morfeld.

MORFELD: Thank you, Senator Stinner, members of the Appropriation Committee. For the record, my name is Adam Morfeld, A-d-a-m M-o-r-f-e-l-d, representing the Fighting 46th Legislative District,

here today to introduce LB867. LB867 would appropriate $500,000 from the federal funds allocated to Nebraska pursuant to the Federal America Rescue Plan Act of 2021 for state aid to Department of Health and Human Services for the Human Immunodeficiency Virus Surveillance and Prevention Programs for Education on the benefits of pre-exposure prophylaxis medication for the cost of such medication. I introduced LB867 in response to an interim study resolution, LR207, that I introduced last fall that looked into making pre-exposure prophylaxis, otherwise known as PrEP medication to individuals who are at high risk of contracting HIV. A constituent brought the idea to me with information on what other states are doing with prescribing and dispensing PrEP medication in a timely manner to those who need it. The hearing on that bill was well attended, and several people testified and told their stories about living with HIV and the importance of education and medication. PrEP meds have been found to be 99 percent effective in preventing HIV infections. I want to say that again. Ninety-nine percent effective in preventing HIV infections. LB867 addresses disproportionately impacted communities in our state, those who are suffering from HIV or at risk of contracting it. There are several people behind me that will go into more detail on why this is a good idea and how the investment of this relatively small amount of money would pay big dividends for vulnerable citizens of this state and ensure that all Nebraskans who need it, no matter where they live, will have access to this lifesaving preventative medication. I also have the ARPA eligibility checklist. I'm told that I should hand that out as well, but I urge your favorable consideration of LB867 and I'd be happy to answer any questions. That being said, there's a bunch of experts behind me on how this works and how this would actually be disbursed as well.

STINNER: Very good. Questions? Senator Clements.

CLEMENTS: Thank you. Thank you, Senator Morfeld. Have you been made aware of whether insurance companies mostly cover this as a prescription drug benefit?

MORFELD: Yeah, some people behind me would be able to answer that, but I know there's a lot of folks that-- that's if you have insurance, so yeah.

CLEMENTS: OK, we'll wait for that.

MORFELD: Yeah, but they'll be able to talk about the coverage or maybe difficulty of that.

CLEMENTS: OK, thanks.

MORFELD: Yeah. Thank you for the question.

STINNER: Additional questions? Seeing none, thank you.

MORFELD: And just so you know, Senator, I've got this bill that's next and another bill in Government, so I'll see what happens.

STINNER: OK, very good. Thank you. Good afternoon.

LUCAS PETERSON: Greetings, members of the Appropriations Committee. I didn't have any time to type out my testimony, but I did handwrite some notes here, so I apologize for not handing out anything. My name is Lucas Peterson. That's L-u-c-a-s P-e-t-e-r-s-o-n, no relation to the Attorney General. You can call me Luke. I am a resident of Lincoln here. I live in LD 46. As my state senator mentioned, I was the one who talked to him about PrEP access. I've lived in Lincoln for about 17 years, but I'm originally from rural south-central Nebraska. I want to thank Senator Morfeld for introducing originally LR207, the interim study that has resulted in today for LB867. I'm here today to ask for your support. I find it's helpful to go back to the first memory of how I was introduced to HIV. I'm 37 today, but I still remember vividly the day I learned what HIV was and I was just a child of, like, 11 or 12. It's helpful to know that today is a very personal day for people who are going to testify. So it's been 12 years now since I've been HIV undetectable, and I still also remember the day that I was diagnosed HIV positive. But the first memory of me learning what HIV was, was when I was in confirmation class when I was in sixth grade. Like all good Christian students back then, we would be ushered to the church for confirmation and today, or that day, someone had moved back to the small town that I come from and people were very curious about why he had to move back. This was a grown man, moved back to his parents' house and everyone was talking about how sick he was. They weren't calling him by his name and I was really disturbed by that. So in the pews of confirmation class, I kept persisting: What's his name, what's his name? And then, I'm not going to say who turned around and retorted. I'm not going to call him by his name but he said to me, we don't call that fag by his name anymore. He has no name because AIDS is God's punishment. Do you want to have AIDS, is what he said to me. That's when it got personal real fast. I didn't know who I was when I was 12. I was just a kid in confirmation class. However, I do firmly believe that LB867 will not only prevent the spread of HIV, but also save lives. You're going to hear from others behind me that are professionals in the field of HIV prevention and

healthcare. I'm just a patient. I know that this bill is not really meant for me because it's a little after the fact for me. But I'm thinking of the loved ones today that have the ability to stay HIV negative. And if we can prevent one more infection in the state, if we can work towards the goal of an AIDS-free generation that had started back when Bill Clinton was President-- it has been a bipartisan agreement ever since for every President, including the last one-- I think it's a worthwhile endeavor and we can start here and we can start now in Nebraska to work towards that goal. So that's all I really have to say today. If anyone has any questions, I'll gladly answer them.

STINNER: Any questions? Seeing none, thank you.

LUCAS PETERSON: Thank you.

STINNER: Good afternoon.

CINDY WHITE: I'm totally black-blind, so yeah, until I get my bearings, I can look a little funny. If I'm talking to people over here and there is no one, just let me know, just sling back ahead. Hello, my name is Cindy White, C-i-n-d-y W-h-i-t-e. I was born here in Omaha, Nebraska, and I am 61 years old. I say that because I've been a long-term voter and citizen of Nebraska. I chose to come here after living a short period of time in Denver, Colorado, to raise my son. To me, this is the Good Life State, and I'm proud to be a Nebraskan. I'm careful about how I bring it up because not everybody agrees with me. They think they live in the best state. I know better. When I contracted HIV back in Denver, Colorado, I did not know I contracted HIV. I moved back to Nebraska and after a series of events, was told to test for HIV. And in fact, October of 1990, I was determined to be HIV positive. If it weren't for the Nebraska AIDS Project, I would have had nowhere to go. I would have had no one to talk to. It still gives me goosebumps to know that they were an entity that was already established here since about the mid '80s or so and doing the hard work of caring for people as they got sick and died. Back then, HIV/AIDS was a death sentence. I'm here today as proof that it no longer is a death sentence, that if you do things the right way, if medicine works for you, if you're able to take medicine, you can live a long life with HIV. But I also represent a dinosaur age of HIV today. I've been AIDS-classified since six months after my HIV diagnosis. Found out about HIV in about October of 1990 and was found AIDS about six months later, around April of 1991. I had a going on four-year-old son, and all I could think of was I might not get to see him grow up or go to school. Medicine is what changed my life, and

that's why I'm here today because PrEP takes one of the most important medicines that I take every day religiously, that keeps me alive to help prevent the spread of HIV. I did not think I would be here for this day. I did not ever think that besides me using my jaw and telling people, anybody can get HIV. AIDS doesn't discriminate, people do. People make up who can get HIV and who can't. Anyone who puts themselves at risk can put themselves at risk for this STD too. But I'm a grandma, and so I wanted another answer like a cure. The fact that PrEP is here today, to me, is a godsend. It puts control back into people's lives. Not everybody needs PrEP, but for those people who would have met me, if PrEP were an answer, I would have not contributed to at least two of my lovers' deaths. I believe that without knowing me, my son's biological father would still be alive. He contracted HIV from me shortly after we met in the mid '80s, and my latest lover who died in my arms 21 years ago who did not know I was HIV positive when I met him. I believe if we would have had other options, we would have exercised those. And PrEP is one way that I know for sure is a proven intervention to help people not get HIV. You know, I've spent a lot of years trying to convince people not to do what I did. It's embarrassing to talk about your sex life. It's embarrassing to talk about maybe contributing to someone's death. But I'm also here to tell you that there are ways that we can decrease the population living with HIV. The last thing I really want to say is that since I'm a long-term survivor, this $500,000 that is needed to get this PrEP working for everybody in the most populated part of the state at least, giving people the opportunity to get this lifesaving medicine. Because I'm HIV positive and I also have lived with the Acquired Immunodeficiency Syndrome moniker for most of my last, what, 30 some years now, one of the medicines that I take as a direct result of being HIV positive is a sleep-weight disorder drug. Fancy name, Hetlioz, H-e-t-l-o-i-z [SIC H-e-t-l-i-o-z]. It gives me back my life again because I don't see light. That medicine costs $25,410.87 a month for 30 pills taken one a day before bedtime without food. Because it keeps me living a real life is all because of HIV complications. That's close to what, $300,000 in one year? And it won't take very many months to be to that $50,000 [SIC] within a year and a half of treating me just for one illness that's because of HIV. Now, granted, we've come a long way in HIV, and we know a lot more about people getting HIV than we ever did. We also know that this is a proven intervention that will greatly decrease the amount of people contracting HIV in the state of Nebraska. Thank you for your consideration, and please consider this $500,000 as a drop in the bucket compared to the long-term illness and amount of medicine that someone like me might take to live a life here in Nebraska.

STINNER: Thank you.

CINDY WHITE: I'd be happy to answer any questions.

STINNER: Questions? Seeing none, thank you very much--

CINDY WHITE: Thank you.

STINNER: --for your testimony. Afternoon.

JERRY KOHLHOF: Hello. Jerry Kohlhof, J-e-r-r-y K-o-h-l-h-o-f, from Norfolk, Nebraska, which is primarily a rural community, but HIV is there. Our numbers have doubled in the past few months, and that's why PrEP would be extremely beneficial. It's everywhere. Cities, rural communities, small towns, it's everywhere. I have dealt with HIV for quite a number of years. I was diagnosed in 1986. I was exposed here, diagnosed. Lost a lot of friends to HIV and I feel that PrEP is a big, huge step. My medicine costs are $34,000 per year on what I have to take, and it's working. For some reason, I'm still here and it is working, but PrEP would save a lot of people from having to go down that road. And I-- that's why I feel it's extremely important and I wanted to talk to you a little bit about it today, and I welcome any questions that you might have. Anybody?

STINNER: Any questions? Seeing none, thank you very much.

JERRY KOHLHOF: OK, thank you. Have a great day.

STINNER: Yes.

STEPHEN JACKSON: Good afternoon.

STINNER: Afternoon.

STEPHEN JACKSON: My name is Stephen Jackson, S-t-e-p-h-e-n J-a-c-k-s-o-n. I am a veteran of the United States Air Force, and when I was in the service there was no education related to HIV and AIDS. When I got out of the military, I tested positive for HIV. That was in 1987 so I'm a long-term survivor and I'm here to talk about HIV from the perspective of individuals who are not insured. I appreciate your question about the cost for the individuals with insurance. I don't need any assistance, but I spent 27 years with the state of Nebraska as an employee, and I ran the Ryan White program, which pays for medications for people living with HIV and AIDS. I know that there are a number of people of all colors, all races, all corners of the state of Nebraska that need assistance with this medication. PrEP removes a

barrier for people who don't have the insurance and don't have the funds to pay $3,000 or more each month for PrEP. Five-thousand dollars, again, is a starting point, and it would be very beneficial. Not only do we need that medication to stop the treatment, but in addition to that, we need education. Education is important because without taking that medication religiously the same way that each of us who are living with HIV has to take our medication religiously, PrEP can't be-- won't be as effective as it would be if people don't take it daily the way that they should. I'm also here to represent communities of color, Latinx communities and African-American communities. Women who don't necessarily have the power to tell a partner that they want them to wear a condom or they don't want to be exposed to HIV, that happens every day. It doesn't matter whether they're white, black, brown, red, green or yellow. Women don't necessarily have the power, and I'm also a proponent of women's rights. So that is why I'm here. If you have any questions for me, I'd gladly answer those questions.

STINNER: Any questions? Seeing none, thank you very much. Afternoon.

TOMMY DENNIS: Good afternoon, Chairperson Stinner and members of the Appropriations Committee. My name is Tommy Dennis, T-o-m-m-y D-e-n-n-i-s. And while I am a public health professional, I come to you today simply as an advocate in the community. I am here today in support of LB867. I, as well as the others that have spoken before me, also identify as someone who has been living with HIV. I was 23 years old. That's been 12 years ago. In that time, PrEP, which is pre-exposure prophylaxis, has been approved by the FDA for prevention in HIV transmission. However, that has not been nearly enough. There are still communities, namely black and Hispanic, that struggle from disproportionate impact of HIV. That is why improving access to this preventative medication is needed so that communities that have felt the undue burden of this virus no longer have to. In the 12 years since my diagnosis, no less than five of my close friends and family have also received positive diagnoses, and I often think that had PrEP been readily available, that those cases could have easily been prevented. I have also witnessed the benefit that access to PrEP has provided to members of the community through the efforts of the Nebraska AIDS Project, who has not only been a staple in Nebraska providing testing services, but since 2019 has been providing access to the medication known as PrEP. We are at a critical time where now we have more tools than ever to prevent the transmission of HIV. We now need to expand how it is accessed and more importantly, who can access it. So my story, so our story doesn't become someone else's

story. Again, I am here in support of LB867, and I would be happy to answer any questions from the committee at this time.

STINNER: Any questions? Seeing none, thank you.

TOMMY DENNIS: Thank you.

LACIE BOLTE: Afternoon.

STINNER: Good afternoon.

LACIE BOLTE: Chairperson Stinner, members of the Appropriations Committee. My name is Lacie Bolte, L-a-c-i-e B-o-l-t-e, and I'm a representative of Nebraska AIDS Project. Nebraska AIDS Project is a nonprofit organization that leads our community in fighting HIV and its stigma. We do that through supportive services, education and advocacy, and I'm here to ask for your support in LB867. Thank you to Senator Morfeld for introducing this important legislation. It's not often that we get to talk about HIV in the Nebraska Legislature, so I'm just thrilled to be here today to talk with you. COVID-19 is rapidly deepening inequality and health disparities in the United States and around the world, and has thrown the HIV response into a deeper crisis. The pandemic has raised barriers to health and wellness for marginalized populations living with or at risk of acquiring HIV even higher. LB867 provides Nebraska an opportunity to respond to this crisis. In fact, Nebraska would not be alone in designating ARPA funds towards HIV prevention. Colorado, Illinois and Georgia have already set-- set funds aside in a similar manner. LB867 is providing additional funding and support to the already existing HIV surveillance and prevention programs in Nebraska. HIV, although it's a manageable illness, is still costly. It's a chronic health condition and it currently affects about 2,500 Nebraskans. New infections of HIV disproportionately affect black and Hispanic/Latinx individuals. Despite only making up 5.2 of Nebraska's population, black individuals accounted for 25 percent of all new HIV diagnoses in Nebraska from 2016 to 2020. These populations are disproportionately impacted whenever our healthcare systems decline, as they have during the COVID-19 pandemic. LB867 provides the funding opportunity for Nebraska to build a strong tool box to prevent HIV. We know that treating HIV as a prevention method is extremely effective at reducing transmission, and this is the largest part of what we do at Nebraska AIDS Project. But in our toolbox, we also have access to an HIV preventative medication called PrEP. PrEP, or pre-exposure prophylaxis, is a once-daily medication taken orally by individuals who are HIV negative to prevent HIV transmission. PrEP also provides

people living with HIV the comfort of knowing that they can avoid transmitting the virus to their partners. Without health insurance, PrEP can cost upwards of $1,500 a month, and we know that some of the Nebraskans most-- who most need this probably can't afford that monthly cost. Insurance does cover it, but we know expensive-- expensive pharmacy copays exist as well, and this program would help with that. Unfortunately, accessing PrEP can be a confusing and complicated process. It's more complicated than simply going to your doctor and requesting that medication. At NAP, we do strive to provide to make PrEP easy and affordable and accessible, especially to our underserved communities, such as individuals without insurance, black and brown, Hispanic, Latinx individuals and young adults. CDC research has found that while two-thirds of people who could potentially benefit from PrEP are black or Hispanic Latinx, they account for the smallest percentage of prescriptions to date. Nebraska AIDS Project currently serves 130 individuals through our PrEP programs in Kearney and Lincoln and in Omaha, and our operations have only been in existence since 2019. NAP's PrEP operations, while mighty and small, it's one of our biggest challenges is expansion across the state for our most rural impacted communities and as well as expansion of awareness and access. PrEP, HIV testing and treating people with HIV are the tools in our toolbox to prevent HIV. LB867 makes this toolbox more accessible in Nebraska, particularly for our black and Latinx populations who struggle to access it. I'd be happy to answer any questions.

STINNER: Any questions? Senator Hilkemann.

HILKEMANN: You said $1,500 a month for the medication. I-- I was just looked ahead here on, like, GoodRx.

LACIE BOLTE: Um-hum.

HILKEMANN: What-- what kind of a range of price can people get--?

LACIE BOLTE: Like, with the GoodRx coupons and--

HILKEMANN: Yes.

LACIE BOLTE: --things like that? I can get you that information. I don't know off the top of my head.

HILKEMANN: When I looked it up-- when I looked on a computer--

LACIE BOLTE: It didn't come up? I know, like, just straight out of pocket that it's about $1,500 a month, but I could follow up with you.

HILKEMANN: OK. And then if-- if this were to be allocated, would it be-- go to organizations like you then? Did this-- just who-- how-- how will it be that the choice of--

LACIE BOLTE: Yeah.

HILKEMANN: --who gets the medication?

LACIE BOLTE: So the funding is for the Department of Health and Human Services. The $500,000 grant is to them for the HIV prevention and surveillance programs, which are already in existence. Nebraska AIDS Project does receive some funding through that program, so potentially, but there's other organizations across the state as well.

HILKEMANN: OK, thank you.

LACIE BOLTE: Um-hum.

STINNER: Additional questions? Senator Erdman.

ERDMAN: Thank you, Senator Stinner. Thank you for coming.

LACIE BOLTE: Yeah.

ERDMAN: So $500,000, according to what Senator Hilkemann just said about being cost per month, why isn't this an ongoing program because at the end of the $500,000, the need is still going to be there, right?

LACIE BOLTE: I agree. I think that's a really good question and maybe a good point to put it in the budget moving forward.

ERDMAN: But it doesn't make any sense that you ask for $500,000 and then in six months or whatever, it's used up and goes away.

LACIE BOLTE: I think-- I think $500,000 is a really great start for us to start these efforts to give Nebraska a kick-start. At Nebraska AIDS Project, we don't have this funding for this medication and we've been working with other grant programs to try and help people pay for them. There's other grants through the federal government, but I think this helps get Nebraska a leg up to really expand to larger communities, because, like, at Nebraska AIDS Project, we're about at max capacity of what we can offer, but the need is so much greater than what we can provide.

ERDMAN: OK, thank you.

STINNER: Additional questions?

DORN: Yeah.

STINNER: Senator Dorn.

DORN: Thank you, Chairman Stinner. Thank you for being here. Mine's a little bit maybe piggybacking--

LACIE BOLTE: Sure.

DORN: --off of theirs. So, but this PrEP medication, that still-- you still have to go through, I call it the doctor part of this. You still have to be approved and all of that or whatever. So it's-- so, I mean, even-- even to administer it for your, your group or whatever group, they would still have to have that part of it.

LACIE BOLTE: Absolutely. That's a big part of what we do is we have a physician that we work with and then we have what we call PrEP navigators to help people navigate that complex insurance system and get payments, but you're right.

DORN: And-- and several times you or Adam-- Senator Morfeld talked about not having insurance. I guess, I'm just curious, is our expanded Medicaid program beneficial to this or is that something that hasn't been--

LACIE BOLTE: Absolutely. Expanded Medicaid has definitely helped many folks access PrEP, yes.

DORN: OK, thank you.

STINNER: Any additional questions? Seeing none, thank you.

LACIE BOLTE: Thank you.

STINNER: Good afternoon.

ABBI SWATSWORTH: Thank you, Senator Stinner and senators of the Appropriations Committee, for allowing me to present testimony today. My name is Abbi Swatsworth, A-b-b-i S-w-a-t-s-w-o-r-t-h. I'm the executive director of OutNebraska, a statewide nonprofit working to celebrate and empower lesbian, gay, bisexual, transgender and queer or questioning Nebraskans. OutNebraska is in support of LB867. If a medication existed that could reduce cancer among those at risk for cancer by as much as 99 percent, Nebraska would want everyone who is

at risk to understand the benefits of that medication and have access to it. PrEP is that medication for HIV. While people can and do live long lives with HIV, it is costly both in terms of public health dollars and in the emotional toll that HIV stigma exacts. Doing all that we can to prevent HIV infection is humane, and it is a good investment in public health. We respectfully ask that you include this funding request as you craft to [INAUDIBLE] ARPA bills, and I'm happy to try to answer any questions. Thank you, everyone.

STINNER: Any questions? Seeing none, thank you very much.

ABBI SWATSWORTH: Thank you.

STINNER: Thank you. Any additional proponents? Any opponents? Anyone in the neutral capacity? Seeing none, Senator, would you like to close?

MORFELD: Yes, thank you, everybody, for your time, and I really appreciate everybody coming to testify to talk a little bit about this. To Senator Erdman's question on this, one use of this could be for the medication, but the other use for this would be going to the program for education and awareness as well. And I think that what we find out a lot is there's a lot of folks that are in situations where they're not aware of this being an option and this being something that can prevent HIV if they're in high-risk types of situations. And so, yes, just like we said yesterday and like everybody else that comes to you for the ARPA funds, you know, obviously it'd be great for this funding to-- to go into perpetuity and be included in the budget after the ARPA funds are gone. That'll be a decision for a Legislature in the future. But if we can dedicate $500,000 just even now to educating people, it could save a lot of lives. And not only that, it would save a lot of money from the state in the long run for folks that can't afford this and that the state would end up paying for that type of medication for their treatment down the road because they don't have the resources. So I'd be happy to answer any questions.

STINNER: Do we have any questions? Seeing none, thank you.

MORFELD: OK, thank you.

STINNER: OK. Well, we have five letters of support for LB867, none in opposition, no neutral. We will now-- and that concludes our hearing on LB867. We will now open on LB1221.

MORFELD: Chairman Stinner, members of the committee, my name is Adam Morfeld. That's A-d-a-m M-o-r-f-e-l-d, representing the Fighting 46th

Legislative District, here today to introduce LB1221. And my handouts have half of my Diet Coke on them so I apologize, in any case. Yeah, so I'm here today to introduce LB1221, a bill that would appropriate federal funds allocated to the state from the federal Corona-- Coronavirus State Fiscal Recovery Fund to the Department of Health and Human Services for the purpose of purchasing remdesivir for use in patients suffering COVID-19. I introduced this bill after consultation with infectious disease doctors who treat patients who are seriously ill with COVID-19. During the recent Omicron variant, they found that many of the seriously ill patients they were caring for were not helped by available treatments that worked for the Delta variant. A recent study has found that the FDA-approved drug, remdesivir, while found not to be effective for seriously ill hospitalized patients, was quite effective for outpatient use for people who weren't yet-- yet as seriously ill. In fact, recent studies have shown that the use of this drug on an outpatient basis can prevent serious illness and death for patients by 87 percent. That is an amazing in a state that we can do whatever-- it's amazing and as a state, we should do whatever we can to make sure those who need it have access to it. Remdesivir is a drug delivered by infusion over a three-day period and costs about $5,000 per treatment. Remdesivir is FDA approved so is not eligible for emergency use at no cost to patients. Doctors have found that many patients would benefit from this drug cannot afford it. Recently in Nebraska, Blue Cross and Blue Shield has announced that they will cover the costs, and Medicare has made a similar statement. However, other payers have not made similar commitments and this cost will be cost prohibitive for many patients who are uninsured or have high deductibles. That is where the Legislature comes in by allocating ARPA funds to purchase remdesivir for those who need it. Thank you for your consideration of this bill, and I-- I hope that you'll support the legislation. Thank you.

STINNER: Senator Erdman.

ERDMAN: Thank you, Senator Stinner. Senator Morfeld, when I seen this bill, I went back to look at information that I looked at early on when this drug was first announced and I had to refresh my memory on that. The WHO, World Health Organization, had made a recommendation not to use remdesivir because of the side effects on that drug. Are you familiar with those side effects, what they discovered they were?

MORFELD: No.

ERDMAN: Let me list those. The most common ones-- these are the most common-- back pain, chest tightness, chills, coughing, dark-colored

urine, difficulty swallowing, fast heartbeat, fever, flushing, headache, hives, itching, colored stools, light-colored stools, nausea, vomiting, puffiness and swelling around the eyes, the eyelids, the tongue and the mouth, stomach pain, continuing trouble breathing, unusual tiredness or weakness, yellow eyes or skin. Those were the common ones and then there was more uncommon ones. So some of the treatments that people in my area have gotten are ivermectin, hydroxychloroquine and some of those very common treatments, which have worked tremendously. Ivermectin is probably $5 a pill, so to treat a complete patient is, like, $15 for five days-- or for three days. So I don't see any purpose for allowing or having the state pay for a drug that's not recommended by the World Health Organization or others who have studied this. And the studies that I've seen, the ones that really explain what remdesivir does doesn't show that there's any real benefit from giving this drug to anyone when in fact we have other treatments that are far more effective and a lot less costly. That's-- you know, if you haven't seen those, I'll give you that report so you can look at those.

MORFELD: Yeah. So in working on this, it was actually infectious disease experts that are treating patients on a daily basis that came to me and said that this was a very effective treatment and it would save lives. So I have no doubt that there's probably some side effects, like any medication, but I trust the experts at UNMC and other places.

STINNER: Any-- is that-- is that your last-- would you like to ask another question? OK. Senator Dorn.

DORN: Question that-- and thank you, Senator Morfeld, for being here, but in the fiscal note, it just lists $5,000 per person. And maybe somebody later can get us a better answer of any idea on numbers or what we're looking at here maybe have a total amount or-- and, you know, somebody somewhere, one of the hospital people or something will have some kind of an idea of a number because in the fiscal note, it doesn't really listen-- list any total dollar amount.

MORFELD: Yeah. And you know, it's one of those things where I introduced the bill a month ago and we left a-- we left the amount blank mainly because we didn't know the extent of what the problem would be at that time. So yeah, I'd be happy to work with you.

DORN: Well--

MORFELD: Obviously the thing with the Delta variant or the Omicron, I can't keep track of all the variants now, it's kind of-- I wouldn't say it's gone. It's dissipated a little bit, but I do think that there needs to be some funding available for this if obviously we get another spike. And I'm sorry, I interrupted you, Senator.

DORN: No, I-- and that's why I said maybe there's some people that are going to be here testifying or have a general idea or something.

MORFELD: I think there's at least one person that's going to be testifying who I'm sure is an expert on the WHO and everything else.

DORN: I'll wait.

MORFELD: OK, thank you.

STINNER: Additional questions? Seeing none, thank you.

MORFELD: I'll try to be available to close. It depends on what's going on in Government. Thank you.

STINNER: I agree, OK.

ANDY HALE: Good afternoon, Senator Stinner, members of the Appropriations Committee. My name is Andy Hale, A-n-d-y H-a-l-e, and I am vice president of advocacy for the Nebraska Hospital Association and I'm here to testify in support of LB1221. Remdesivir is safe and effective. It resulted in a 87 percent success rate that was measured as a lower risk of hospitalizations and death. Remdesivir is an early treatment and the only treatment for children under 12. It is one of four early treatment options, but is it-- it is expensive, as Senator Morfeld noted. It is administered intravenously and in a clinical setting. It's the only treatment that isn't controlled by the United States government. It is available on the private market and the cost is upwards anywhere from $3,000 for a two-day-- or three-day supply to $5,000 for a five-day supply. And there's also an additional cost to administer this, as it's done in an infusions type setting. The cost obviously provides hurdles. Hospitals spent more money on remdesivir last year than any other antiviral medication to treat COVID. And as Senator Morfeld mentioned with the Omnicron [SIC] variant, remdesivir seemed to take a backseat early on and then proved extremely successful with the last variant that we saw that was extremely deadly and gave us our spike. It proved to be extremely effective, in particular with higher-risk patients. So with that, we want to thank Senator Morfeld and his staff for bringing this bill and ask to move it, and I will take any questions.

STINNER: Any questions? Senator Dorn.

DORN: Thank you. Thank you for being here. I guess I don't know it kind of looked like you're going to maybe be the person to answer my question of approximate cost, or--

ANDY HALE: I will-- I will try. Yeah, so your question overall, how much and how often?

DORN: What will the total dollar amount look like, yeah, or what-- what have you seen the past six months or just general type thing, what are we expecting for numbers?

ANDY HALE: So as we're seeing with the testing, the positivity rates decreasing, the hospitalization rates decreasing not only here but across the country and presumably the world, Senator Morfeld talked about the-- the experts, and we're very fortunate to have those at UNMC and those are individuals we rely on. And so it looks like this is-- is waning, but we've-- we've seen it before. And so our concern, as what Senator Morfeld touched on, is if there's another variant, what happens? What happens then if we've seen it? As far as use, it is still used today. I don't have the numbers. It's not something the association has tracked. But the big concern and I think if you just have a little bit of knowledge of it, as Senator Morfeld mentioned, it's only covered by Medicare and Blue Cross and Blue Shield, and so people don't even want it. And that's a problem because of the effectiveness of it. And Senator Erdman to-- to your point, the only main side effect that I'm aware of and I'm-- and not to doubt your study, but it was-- it was nausea was the big component with it that seemed to be the top complaint. You know, I don't have a list of all the others. But, you know, as Senator Morfeld indicated, there isn't a direct ask for this. It would be nice to have some of this if it-- if it continued, if things got worse, but probably to answer your question, I just don't have those numbers right now to give a direct ask.

STINNER: Additional questions? Senator Erdman.

ERDMAN: Thank you, Senator Stinner. Thank you for coming, Mr. Hale. So as you mentioned that as the hospitalizations are dropping off, this is basically maybe just a comment. I seen an article this morning, a doctor in Wyoming, his license was revoked because he was treating people with hydroxychloroquine and ivermectin and those things that the health organizations say you shouldn't treat with. And they were-- he's 75-years-old, practiced medicine for 43 years. He's out. So there

are other treatments who-- that work that are at a fraction of this cost, but we can't use those. It almost gets a person to the place where they trust lawyers more than doctors. Thank you for coming.

ANDY HALE: Thank you, Senator.

STINNER: Additional questions? Seeing none, thank you.

ANDY HALE: Thank you, Senators.

STINNER: Any additional proponents? Any opponents? Afternoon.

ROY ZACH: Good afternoon, senators. My name, for the record, is Roy Zach, R-o-y Z-a-c-h. I got a letter that's going to be handed out to you shortly. I will simply read from that. Dear senators, I rise in opposition to LB1221, which would appropriate federal funds to the Department of Health and Human Services for remdesivir for patients suffering from COVID-19. Remdesivir, despite all of the media hype surrounding it, has not been proven to be the most effective treatment for COVID-19. On the contrary, according to Truth for Health Foundation, remdesivir actually causes kidney damage and/or failure within about a third of the patients receiving it. Thereby, in these patients, excess fluid around the heart and lungs, which helps cause pneumonia, cannot be properly drained out of the human body because of kidney damage caused by remdesivir. It can be logically concluded that many patients have died from CDC protocol of an interstream remdesivir and not from COVID-19. Unfortunately, COVID-19 has received excessive media hype compared to other causes of deaths. In recent years, on average, the leading cause of death has been abortion. There are about 42 million abortions worldwide per year. There are about 18,500,000-- excuse me-- 18.5 million deaths from cardiovascular or heart diseases. About 11 million people die yearly of hunger and starvation. There are nearly 10 million deaths from cancers. There are approximately 4 million deaths from various respiratory diseases. COVID-19 generally falls into this respiratory disease category. The spike protein of COVID-19 is what is causing the most significant health problems. The spike protein can be detoxified from the human body through several natural remedies according to World Council for Health. It is wise and practical to put things in the proper perspective, and more importantly, to tell the truth as it is. It is exceptionally curious to note that of the 226 countries or territories listed on the Worldometer website, which is tracking COVID-19 statistics, that about 208 of these currently have a lower death rate per capita from COVID-19 than the United States of America. What conclusions might you draw from these statistics? It seems a little odd that a country

that's supposed to have such a great healthcare system is failing so miserably. Every country in Africa is doing a better job of dealing with COVID-19 than the United States of America. So what is really going on here? Let us also remember that the fact that vaccination rates are higher in the United States than in Africa. Maybe we need to rethink everything we've heard from so-called experts at the Centers for Disease Control. Maybe they are not really working for the best interests of citizens. The whole neuro-- narrative around this pandemic is rife and feeble. Wear a mask, a lot of good that does. Any military expert can tell you that you need tight-fitting, rubberized military-grade masks in avoid to getting sick. I'll kind of cut this a little bit short, but at the bottom of my letter, you kind of see I suggest the-- several different references to medical information that should be considered, as well as some of the economic and financial incentives that hospitals are receiving to receive the expensive remdesivir, as opposing to using early treatment options such as ivermectin or hydroxychloroquine. To me, this whole pandemic is more of a financial scam than anything. The pharmaceuticals want us to use expensive treatment options rather than treating COVID-19 early in the first four or five days, as it should be property treated. Any questions?

STINNER: Any questions? Senator Erdman.

ERDMAN: Thank you. Senator Stinner. Thank you for coming. I appreciate your testimony. You mentioned Africa having less mortality than the United States. Have you an indication or idea why that is?

ROY ZACH: I would presume it's the way we're treating it. If you look at, you know, India is in Asia, not Africa, but India gives out hydroxychloroquine because it's cheap and effective, and I presume that some of the African countries are probably doing the same thing. I don't know that for sure. Maybe it's just a statistical thing. Some of it deals with latitude, where you're at on the earth. Northern countries seem to suffer COVID-19 a little more severely during the winter seasons. Perhaps Africa's tropical climate lowers their risk of dying from it. That I don't know, but I presume that it's mainly in the treatment methods that we're using, which are ineffective.

ERDMAN: Have you seen in some of your reading and research that in the country of Africa, they normally give ivermectin for parasites? Have you seen that?

ROY ZACH: I think I have seen things similar to that. It is very effective in treating parasites, which probably effectively helps

people become healthier and resist certain things like COVID more, I would suspect.

ERDMAN: So they very well could be using ivermectin as a prophylactic?

ROY ZACH: I would expect it since it is a very reasonable drug. I think it costs less than $1 a treatment in all actuality.

ERDMAN: And then they probably also give them hydroxychloroquine for malaria, protecting against that?

ROY ZACH: I would presume so. I'd have-- I think I've read that, yes.

ERDMAN: So I appreciate your testimony. Thanks for coming.

STINNER: Any additional questions? Seeing none, thank you very much.

ROY ZACH: Thank you.

STINNER: Any additional opponents? Afternoon.

JENNIFER HICKS: Hi. My name is Jennifer Hicks, J-e-n-n-i-f-e-r H-i-c-k-s, and I oppose this because it's my money that you're trying to spend and I don't think that it should be going towards remdesivir. I don't believe that remdesivir is the most practical solution for a problem that we continue to create. And I believe the gentleman that just spoke was right that this is about money and it's about social control with the masks and there are other treatments, so why are we not-- why are you not asking to spend my money on more cost-effective treatments, the ones that have been shut out? I have family in Arkansas that were on plaquenil. That's hydroxychloroquine. They were on plaquenil the summer that everyone panicked and plaquenil, which has been used for hydroxychloroquine. It's been used for over, like, half a century and then all of a sudden it became deadly dangerous. It was going to cause you heart problems. My aunt was taken off of it. She took it for rheumatoid arthritis. My grandmother was taken off of it. She was taking it for lupus. And these were-- these were medicines that they had been taking for those conditions that other people have taken for years and-- and they're taken off of that so that we can push these other more expensive drugs and you want to spend my money on them and I object to that. And there are other natural treatments and the ivermectin, I will tell you, I have experienced healing with ivermectin myself and you're pushing people towards taking drugs in ways that we really shouldn't be doing. Because the ivermectin that I took was from the hard-- from the hardware store. It was in the-- it was-- it was meant for a horse. It was paste and I began to-- to feel

suddenly ill one day. My neck got stiff, my head started hurting and I got chills and I thought, OK, well, maybe I'm having COVID, I don't know. So I took this horse paste and within an hour and a half, I no longer had a stiff neck. I no longer had a headache and I didn't get sick. Now I am telling you that I would-- I would much rather try that than to-- to have taken remdesivir. With the side effects and the warnings against remdesivir, it's less tested than ivermectin and hydroxychloroquine. When there's a reason that the World Health-- World Health Organization said, you know, hey, back off, don't use this. And-- and so it's a lot less safe than the drugs that we're not using. And I believe our Attorney General was kind of a little late to the game, but he at least did, you know, make it so that our doctors can prescribe ivermectin and hydroxychloroquine off label to patients. But there's no reason we shouldn't be trying other approaches that are less costly and-- and more safe-- and more safe. And so, yeah, I just-- I oppose putting money towards that, especially when-- especially when we're told during this COVID-19, our response to that, how-- how careful we have to be over everything because it might be dangerous to us. That, you know, wear your mask because of the great risk that could-- could occur to you or to others if you don't wear that mask. It's not proven. When you go to the CDC website, alongside the guidelines that tell you that you should wear a mask, if you read every study that's there, it doesn't support why you should do it. It doesn't. I've read them. I've read them. And so we need-- we need to-- to be smarter about-- about how we respond to this and maybe get a little more inquisitive about why it is we're-- we're being asked to do what we're doing because I believe that the masks are social control. Absolutely. We didn't-- I never in my lifetime did we put on masks to take our kids to the doctors when we thought they had the flu. You didn't go to the doctor and everyone there said, oh, you need a mask on and the doctor puts on a mask and the staff puts on a mask, and everybody in the waiting puts on a mask so that they don't get the flu from your kid because they don't protect against viruses. And we all know that. It says so right on the box. So the entire COVID response is nonsensical. It's-- it's nonquestioned. It's nonquestioned and-- and you want to spend $5,000 a pop on remdesivir of my money? No.

HILKEMANN: Are there questions? Thank you for coming here today. Additional opponents?

MICHAEL CONNELY: Hello, my name is Michael Connely. I suppose most of you probably know me. Spelling is M-i-c-h-a-e-l C-o-n-n-e-l-y. Before I begin, let me mention I'm not a dullard when it comes to science. I'm a Bausch Lomb Honorary Science Award winner. I was ranked number

one in biological sciences in my college. I've been accepted to various different medical schools, which I did not attend because I conflicted with the profitability that they pushed in the medical schools. And remdesivir, now, I was actually out taking care of some goats and I got a phone call that this was going on and so I rushed up and I didn't have time to print any papers or documents to bring up to you or I would have given you a lot of enlightening paperwork. Remdesivir was previously used when they had an Ebola outbreak, and it was one of the drugs that they used for the Ebola outbreak. They stopped using it because it was by far the most dangerous of all the drugs they were using. It caused massive kidney failure in a large number of the individuals who've taken it. Now there is someone running-- a candidate running for a Senate seat out in the North Platte area who just lost her father for kidney failure because of remdesivir-- remdesivir. And there's another GOP leader up in the northwestern corner of the state who lost her son, also from kidney failure; same treatment. Now let me hop over on ivermectin. You mentioned that-- oh, by the way, answering your questions about the why do they have a lower mortality in Africa and some of the other areas? Yeah, they take the "hydrachloroquine" for a malaria deterrent, and it also works against the-- the coronavirus as well. And as far as the anti-parasitic, in Japan there was a researcher for 40 years. He took soil samples all across Japan and there was one soil sample that he took from a soil in a golf course near Tokyo, and they isolated an organism that made a compound called avermectin. It's using that compound, they invented ivermectin. They have been using it for antiparasitic. First, they used it in the animals and then they started using it in humans. They have almost eradicated elephantiasis. And like, if you know the story of the Elephant Man, that was elephantiasis. They've almost eradicated that because of ivermectin. They've almost eradicated river blindness. So a lot of these tropical areas that are having the very low mortality are taking ivermectin constantly in order to eradicate all these parasites that they have in the area. The-- the inventors of ivermectin won a Nobel Prize in the year of 2015. If you look on the National Institute of Health, you will now find that ivermectin is being considered in a lot of cancer treatments because it is starting to wipe out various types of colon cancer. It is a wonder drug that is more effective than penicillin ever was. And as you mentioned, it costs, what, $5 to $10 for the treatment of that. Yes, remdesivir will kill some of the coronavirus, but the, the side effects are extreme and severe and most of that is based on profitability. It is not based just on how well it cures it. Now, as far as ivermectin, I had a friend that was in very bad shape from coronavirus, and he tried to get ahold of the doctors, the very

few doctors that would prescribe ivermectin here in Nebraska. And they were so backlogged and they had such a short supply of ivermectin that he could not get any. He called me up and he said, tomorrow, I'll have to go to the hospital. I think I'll need to have them tube me. We had to bring him-- we had to bring him horse paste, the other stuff you read about that you can buy at the tractor, farm and supply, put it at his doorstep. He took it. Within hours, he was better. The next-- the day after that, he was back to work and he thought he would have to go to intensive care. I have met several people up in Broken Bow. There's a veterinarian there who makes his own vaccines. Every time he has a cow that comes in that's sick, he takes whatever virus or bacteria that is and he cultures it. He makes his own vaccines. He was taken to court by Big Pharma. They lost. So they leave him alone now because he's, yeah, he-- he won in the court cases. He had a coronavirus vaccine before this ever started. I said, how effective is yours compared to the vaccine there is now? He said, oh, mine is better, but I wouldn't recommend it. I said, why is that? He said ivermectin is much more effective. You take ivermectin, within eight to ten hours, it wipes out most of the symptoms of coronavirus so long as you get it within the first few days. If you've gone past five days, sometimes it won't be effective. He said you wait four or five days, get another dose, it's gone. And I ran into another doctor that had 1,200 patients with a 100 percent cure rate and not a single death entirely from ivermectin. But this remdesivir, this is extremely dangerous. Do not appropriate money for this wasteful remdesivir.

STINNER: Thank you. Questions?

ERDMAN: Thanks for coming.

STINNER: Thank you.

MICHAEL CONNELY: Thank you. If I wouldn't have been out taking care of the goats [INAUDIBLE].

STINNER: Any additional opponents? Anyone in the neutral capacity? Seeing none, I don't see Senator Morfeld. Has he waived? Senator Morfeld waives his closing. We have two letters of support and two letters in opposition. That concludes our hearing on LB1221.We'll now open on LB959. Afternoon.

McCOLLISTER: Good afternoon. I've been here nearly eight sessions and this is my third time in front of this committee this session.

STINNER: There you go.

McCOLLISTER: So it's been my honor to come here this session.

KOLTERMAN: Flattery will get you nowhere.

McCOLLISTER: Excuse me?

KOLTERMAN: Flattery will get you nowhere.

McCOLLISTER: Uh oh. Good afternoon, Senator Stinner and members of the Appropriations Committee. My name is Senator John McCollister, J-o-h-n M-c-C-o-l-l-i-s-t-e-r, and I represent the 20th Legislative District. Today, I'm introducing LB959, a bill that appropriates $9 million from the American Rescue Plan Act, or ARPA, funds to Department of Health and Human Services for use by CyncHealth, the statewide designated health information exchange. First, LB959 appropriates $5.9 million for the development of a statewide patient portal. Patient portals allow patients to access their current medical records within the system at a single point of contact through a website or a mobile application. A statewide patient portal will allow individuals to access their own personal health records contained within the state health information exchange, including any COVID vaccines and treatment received during the treatment for COVID-19. This promotes interoperability and ensures that patients can control and take a more active role in their healthcare. It can also access the records of several providers at once, lab data and other traditional patient records. To be clear, this would improve an individual's access to their healthcare records that already exist. Second, LB959 appropriates $3 million of federal funds for the purposes of infrastructure development and operations of a research database for healthcare delivery and quality improvement, more specifically to study the long-term effects of COVID on the population in Nebraska. This research portal will address the COVID pandemic in the following areas: public health response, prevention and mitigation. CyncHealth now has data to support addressing long-term decision making targeted strategies and further identification of areas of population disproportionately impacted by the COVID-19 pandemic. Following me to testify will be the CEO of CyncHealth, who will be able to answer your technical questions and substantive questions and better address the benefits of both these initiatives. Thank you for your time and attention to this important matter, and I would urge you to pass and advance LB959.

STINNER: Good, thank you. Senator Erdman.

ERDMAN: Thank you, Senator Stinner. Good to see you again, Senator McCollister.

McCOLLISTER: The same.

ERDMAN: So this is a one-time deal?

McCOLLISTER: Yes, sir.

ERDMAN: So maybe you've seen the fiscal note. If you haven't, I'll just read it to you, what it says. The bill would appear to create a fiscal-- fiscal split when the federal ARPA money funds run out. So it's a one-time ask today, but your intention is for this to go forward beyond when this runs out or else you wouldn't introduce this, would that be correct?

McCOLLISTER: It's my understanding it's a one-time fiscal expense. And so once that infrastructure is built up, there should be no major cost to continue the program.

ERDMAN: Why would the Fiscal Office write in there that this creates a fiscal cliff then?

McCOLLISTER: Well, I think I would define fiscal cliff as maybe a one-time expenditure.

ERDMAN: I would consider a fiscal cliff is when there is no funding to continue the operation of a, a program.

McCOLLISTER: That's--

ERDMAN: That's what it looks like this does.

McCOLLISTER: OK, well, if I'm mistaken about that, the folks that testify after me can--

ERDMAN: OK.

McCOLLISTER: --correct the record.

ERDMAN: Thank you.

STINNER: Additional questions? Seeing none, thank you. Afternoon.

JAIME BLAND: Ready?

STINNER: Yes.

JAIME BLAND: Good afternoon, Senator Stinner and members of the Appropriations Committee. My name is Dr. Jaime Bland, J-a-i-m-e B-l-a-n-d, and I am president and CEO of CyncHealth, the statewide designated health information exchange. I'm testifying in support of LB959. We're requesting funding through the Department of Health and Human Services for two distinct purposes. First, CyncHealth is requesting funding to enable continuous improvement to the Consumer Patient Health Records portal. This project supports COVID-19 response efforts through advancement of the availability of public health and health data in near real-time to citizens. This support enables access to test results, immunization records and gives citizens the ability to access and download their longitudinal health information into health applications as determined by the citizen. To be clear, this puts citizens in control of their health information. Our consumer portal allows patients to easily access secure data to share confirmed test results, immunizations data and it enables citizens to navigate any requirements and bureaucracy COVID has created in their lives. The second funding request addresses construction of comprehensive health database used for-- to inform providers and post-pandemic health of communities across the state. A comprehensive database allows Nebraska providers and researchers to define what long COVID looks like for Nebraskans. In order to build public sector understanding of factors that have contributed to unequal impacts of the pandemic on populations, the research database, coupled with governance of the HIT board, ensures that CyncHealth will develop data infrastructure to support providers, citizens and policymakers that are managing the COVID-19 pandemic response. By supporting both of these initiatives, database research and portal access for the citizens of Nebraska, we ensure data follows the person through the care journey and information is available to providers and researchers to plan for future and understanding now. I would like to thank you for your time and attention to this important subject and your consideration of our request. I would be happy to answer any questions.

STINNER: Senator Kolterman.

KOLTERMAN: Thank you, Senator Stinner. Welcome, Dr. Bland.

JAIME BLAND: Thank you.

KOLTERMAN: What was the name of your organization before it was CyncHealth?

JAIME BLAND: It was the Nebraska Health Information Initiative.

STINNER: NeHII.

JAIME BLAND: NeHII.

KOLTERMAN: OK. I was trying to--

JAIME BLAND: Yes.

KOLTERMAN: --put that together. So, so really, correct me if I'm wrong, what I'm hearing is you want to create a portal that if I have medical records at, say, three different locations, I can access all of them through one app--

JAIME BLAND: Yes, Senator.

KOLTERMAN: --through NeHII or--

JAIME BLAND: And if you--

KOLTERMAN: --CyncHealth.

JAIME BLAND: Absolutely. And if you decide to go to Minnesota for your care, you can take that information with you as well.

KOLTERMAN: And it gives me, as the consumer, immediate access.

JAIME BLAND: It is a consumer-citizen-directed interoperability of your healthcare records.

KOLTERMAN: When I was more familiar with NeHII three or four years ago on HHS, we-- you were a highly rated organization in the country, one of the best in the country. Is that still-- are we still the gold standard for that?

JAIME BLAND: I would say on any given day, we are number one or number two, depending on the context.

KOLTERMAN: OK.

JAIME BLAND: We should all be very proud of that.

KOLTERMAN: And you heard Doctor-- or Doctor-- Senator Erdman's question before. Will this just bring us up-to-date and not have to go forward with extra monies?

JAIME BLAND: So this is-- we're-- we're building this infrastructure using very cost-effective tools so that we can provide this at a

minimum operating cost ongoing. There is a, an initial build cost. And with that coupled with the other infrastructure that we support, are able to build that into our operational costs.

KOLTERMAN: And one last question: when I was more familiar with it and working in that arena, there were-- I would say there were a handful of organizations throughout the state, medical organizations that weren't participating. What kind of a participation rate do you have today as it pertains to providers in various communities or hospitals?

JAIME BLAND: We have all hospitals participating.

KOLTERMAN: So all hospitals--

JAIME BLAND: Correct.

KOLTERMAN: --even the one here in Lincoln that wasn't?

JAIME BLAND: Correct, sir. Yes, Senator.

KOLTERMAN: OK. And how about clinics?

JAIME BLAND: So depending on the clinic, we have a number of independent providers that are participating in the portal. There are some that are not. They're not required to for LB411. That was the participation bill. But we do have very broad participation across primary care, specialty care.

KOLTERMAN: So it's all-- it's all medical about-- is there anything like optometry or dental or?

JAIME BLAND: Yes, we do have a variety of specialty providers that do participate in the-- in the portal and we also have pharmacies that participate in-- in the health information exchange, as well as community-based organizations. So parish clinics and other community-based organizations, we actually provide them with software and a referral mechanism so that we can support the exchange of information between community and healthcare as well.

KOLTERMAN: Are federally qualified healthcare--

JAIME BLAND: Yes, they are.

KOLTERMAN: OK. Thank you. I appreciate knowing the background again.

JAIME BLAND: Yep.

STINNER: Senator Dorn.

DORN: Thank you. Thank you, Senator-- Chairman Stinner, and thank you for being here. I guess I got a-- just a curiosity question as much as anything. When-- when we get a bill that says $5,000-- or $5,920,000, that's kind of an exact number. So that's really for some kind of computer software or something or how is that type of figure arrived at?

JAIME BLAND: So it's a-- it's a budget of what we anticipate for cloud costs, for engineering costs, for data access and security controls and-- and some ancillary services that go with the patient access like identity verification.

DORN: And so your budget now, where do you get your funding from, most of your funding? Is it state funds or is it--

JAIME BLAND: It's a combination.

DORN: --cost? I mean, patient cost or doctor cost?

JAIME BLAND: It's a combination. We are a participant organization, so participating entities pay a participation fee. And then we also have contracts with the Department of Health and Human Services. The health information exchange policy in the state or in the country actually is through CMS or Medicare and Medicaid funds that do support portions of the infrastructure ongoing.

DORN: Thank you.

JAIME BLAND: Um-hum.

STINNER: Additional questions? Senator Erdman.

ERDMAN: Thank you, Senator Stinner. Thank you for coming. So my comment earlier about an ongoing program, I'll read from the bill. It's line 23 on page-- on the one page. It says the Department of Health and Human Services shall use the funds appropriated in this section for a statewide designated health information exchange for infrastructure development and operations. If that doesn't sound like an ongoing requirement, tell me why it doesn't.

JAIME BLAND: So this specific portion of it, Senator, is not necessarily an ongoing requirement, but we do have ongoing-- so LB1183 and LB411 identified the relationship between the health information exchange and the department, so there's ongoing operational costs that

are supported through the department's budget to support through, like, Medicaid and public health-related activities. But this specific portion of it would not be part of that operating cost between the departments.

ERDMAN: So can I conclude from your comments that this is the setup, the portal will get us started and the operations or ongoing needs of finance will come from those other two bills. Is that what you're saying?

JAIME BLAND: No, Senator, it comes from a combination. So we're a public-private partnership that utilizes funds from the department, which come from public health like CDC funds, HRSA funds. We do a number of grants-writing activities through CDC. We put funding requests into CMS and then participants also pay a fee. Could there be a day where there's a fee passed on to an individual if they want to do something with the data, or that there would be, like, a $2.99 or $3.99 monthly access fee to the app? That's what we're trying to prevent with this money for now and then cover the cost with participation fees as well as those grants and other monies that we bring into the organization.

ERDMAN: OK.

STINNER: Any questions? Senator Vargas.

VARGAS: Have you seen other states go down this route of using funding for database, you know, longitudinal data, looking at patient health records and information?

JAIME BLAND: We also support the Iowa infrastructure. I think they're-- they're looking at very similar types of funding activities, not necessarily a patient portal, but I would say that a number of states are supporting data infrastructure. This is how we know how to respond the next time, right?

VARGAS: So you think Iowa is going to do it?

JAIME BLAND: I-- I have good indications that Iowa is going to do it, yeah.

VARGAS: OK.

STINNER: Senator Kolterman.

KOLTERMAN: Yeah. I forgot to ask you this one question. So if I want to subscribe to CyncHealth, would I go online at the app store and buy an app and then pay $3 a month to do this?

JAIME BLAND: Not at this time. This is what we're requesting monies for, so that-- that wouldn't have to be passed on to you. But you can use any-- really any app. You can use our application, our website access, or you can use Apple Health. You can use Commons Project, any real health application that's in the app store. We're not trying to tie you to CyncHealth's data. We're trying to provide data to whatever you want to power your health data through. So it really is to enable citizen choice and how you want to manage your app.

KOLTERMAN: Will you have a Cync app at some point in time?

JAIME BLAND: At some point in time, yeah.

KOLTERMAN: All right. Thank you.

STINNER: Senator McDonnell.

McDONNELL: Thanks for being here. Following up on Senator Erdman's questions, how much money have you been given in the past by the state of Nebraska?

JAIME BLAND: In total, I could get you that number. We have had a relationship with the state of Nebraska for ten years. So we support the PDNP, the HIE and a number of other activities.

McDONNELL: Thank you.

JAIME BLAND: Yep.

STINNER: Additional questions? Seeing none, thank you.

JAIME BLAND: Thank you.

STINNER: Additional proponents? Any opponents?

JENNIFER HICKS: My name is Jennifer Hicks, J-e-n-n-i-f-e-r H-i-c-k-s, and I oppose this because I don't believe that it's necessary and I think that it's questionable about what it would actually do. We don't need a patient portal, really, for people to access their medical records because we already have those. I mean, I'm signed up for my children. I can access all of their medical records through a healthcare portal. I can access my own through a healthcare portal so

I'm not sure what this provides that isn't already available and why we need to spend more of, again, my money on it, because that's where you get this money to spend is from the people. And so I would disapprove of spending the money on something that-- that is already available to people, access to their medical record-- records through the website or a mobile app. And-- and then also it says that this is-- this is to set up a research portal and this is data collection. And I don't-- I don't like the idea of not only having my information accessible to me, but have it being the subject of research. And so I mean, what does that mean? What are you-- it seems invasive to people of-- I mean, I think that there needs to be some questions as to what is it that you're going to do with this data? Because this is-- this is people's healthcare records and someone-- if there's a research portal and research is being done, someone is having access to your healthcare information. And so I think that's problematic and I oppose that as well.

STINNER: Thank you. Questions? Seeing none, thank you.

MICHAEL CONNELY: Michael Connely, M-i-c-h-a-e-l C-o-n-n-e-l-y. You may have noticed I carry my little ID here hanging around my neck. Besides a science background, I also worked in military intelligence. This research portal, what-- as Jennifer Hicks mentioned, people already have access to all of the medical records. What this looks like is trying to do is to make a database that is statewide. When that happens, when that happens and we get it so everyone is involved, it makes it so anyone can access the system in the future. I know because previously working in military intelligence, that's what we did. We found things like this that were widespread and we would access them and get any data we want. In countries right now where they're requiring vaccine passports, this is step one. This is step one before they require vaccine passports. And they have the research portal, that's what they're doing. They're researching the information. If we want to get some type of medical research data, if we want to get a lot of medical research data, all we have to do is contact the Department of Defense Epidemiology section. They have the very best data, as far as the medical data, if we want to do medical research to find out what is happening with various different things. For example, they just pushed out the information that the cancer rates, aggressive cancer has now shot up to 75,000 above the normal rate among our active-duty military after having taken the COVID vaccine. But if you want to get any information on medical, you can access the Department of Defense Epidemiology. Then we don't need to make that here in Nebraska. That is simply step one to giving us the data so we can initiate vaccine passports and it is a complete waste of money.

Everyone can get their medical records as it is right now. And even if it were something that were needed, you would want to have a very detailed list of every single expenditure. This is way overboard of what would be needed if you even wanted something like this. That's all I've got to say on that point.

STINNER: Thank you. Questions? Seeing none, thank you. Additional opponents? Anyone in the neutral capacity? Seeing none, Senator, would you like to close?

McCOLLISTER: Yes, sir. Chairman Stinner and members of the committee, thank you for an opportunity to open and close on this bill. Just like to give you a personal experience. I do a great deal of work for UNMC. They're my healthcare provider and I use a portal they have, called One Chart/Patient and it integrates my work with the diabetes center, their-- their eye clinic, and they do a great job. You can find out information on your prescriptions. You can find out when your-- when you have appointments and you can communicate back and forth with your doctor versus that-- through that portal. And it's very effective. And I understand that this CyncHealth that we're now discussing will integrate all of those portals. The portal I use with UNMC and all the stuff that I did with Mid-- Midwest Eye, [INAUDIBLE] Nebraska. So I think it's just a great program if we can integrate all of these portals into one-- one portal that patients can use. So I think this is a worthwhile endeavor and I would ask you to move, move the bill to the floor.

STINNER: Thank you. Questions? Seeing none, thank you.

McCOLLISTER: Thank you, sir.

STINNER: We have one letter in support of LB959 and 27 in opposition, and two neutrals. That concludes our hearing on LB959. We will now open with LB1075.

WISHART: OK. Go ahead.

STINNER: Good afternoon, members of the committee. My name is John, J-o-h-n, Stinner, S-t-i-n-n-e-r. I represent District 48, which is all of Scotts Bluff, Banner and Kimball Counties. LB1075 appropriates $1.8 million in federal funds from ARPA to the Department of Health and Human Services for telehealth technology related to pediatric mental health services. The bill stipulates that funding to-- be provided to any pediatric trauma center to support statewide pediatric mental health services. The influx of Fed funds coming into the state through

ARPA dollars presents a unique opportunity to leverage these funds to address immediate mental and behavioral health needs across the state. One critical need relates to the provision of mental and behavioral health services in pediatrics. LB1075 would allow Children's Hospital to significantly increase their reach through telehealth services across the state, especially in rural areas where telehealth could be used to consult with Children's Hospital pediatric trained mental health professionals. The strategic investment of $1.8 million would allow Children's Hospital to coordinate with primary care offices by providing the technology needed to facilitate a virtual visit. We're in the midst of a mental health crisis in the United States with very limited resources dedicated to the needs of children and youth. Children's Hospital has a vision to-- to dedicate funding to the mental and behavioral health needs of children in a new, innovative way that strategically leverages a limited pediatric trained workforce across the state of Nebraska. Our nation's pediatric behavioral health infrastructure is fragmented and lacks the necessary attention or support to make a difference. While the delivery of behavioral health continues to be people-intensive, which Children's is supported through generous donations from the community for mental health scholarships, the latest flexibility in originating the side of telehealth is one less barrier to access quality care. For a decade, Children's Hospital has integrated mental and behavioral health in their primary care offices, bridging any gaps Nebraska families would have to access mental and health-- mental health services. Their outcomes prove this model is beneficial and highly effective for patients and would like to support the state in making this a standard of care. With an investment from the Legislature, Children's Hospital could offer primary care offices across the state, with the resources and technology to be connected to the pediatric trained mental health professionals virtually, generating an efficiency to access-- accessing mental healthcare. Children's Hospital is in a position to partner with primary care offices as a trusted advisor and to coordinate the complex needs of children in Nebraska. Understanding the nationwide shortage of pediatric mental health providers and social workers, Children's Hospital proposes an opportunity for providers to partner for telehealth virtual visits. Children's Hospital is here to go into more detail about the program and what LB1075 would enable for the well-being of children across the state. Thank you and I'd welcome any questions.

WISHART: Thank you. Any questions? Senator Erdman.

ERDMAN: Thank you, Senator Wishart. Thank you, Senator Stinner. The question I have is-- and you'll probably answer yes-- this is a one-time ask, right?

STINNER: I made sure it was a one-time ask.

ERDMAN: OK. All right. So saying that, we're going to-- we're going to purchase equipment or set up offices where these people can be seen or they can have telehealth?

STINNER: Yes.

ERDMAN: So those will require more staff to do that. Would that-- would that be a fair assumption?

STINNER: More staff on whose side?

ERDMAN: On the side of the people who are offering the service.

STINNER: Actually Children's-- the Children's Hospital is going to offer the services.

ERDMAN: OK.

STINNER: They have their own source of funding. They need this type of funding to set up the program and they will pay for the rest of the operating. If they have to hire more people, they'll hire more people.

ERDMAN: That's not an obligation of the state to continue then.

STINNER: No, no, sir.

ERDMAN: Thank you.

WISHART: Additional questions? Seeing none, thank you.

STINNER: I hope I answered that-- probably.

[LAUGHTER]

WISHART: Proponents? Welcome.

JENNIFER McWILLIAMS: Thank you. Good afternoon, members of the Appropriation Committee. My name is Dr. Jennifer McWilliams, J-e-n-n-i-f-e-r M-c-W-i-l-l-i-a-m-s. I need a shorter name. I am the division chief of psychiatry and medical director for digital health at Children's Hospital and Medical Center. I am here in support of

LB1075 on behalf of Children's and the Nebraska Medical Association. I would like to thank Chairman Stinner for his support to expand access to mental healthcare across the state. We are in the midst of a mental health crisis in the United States with very limited resources dedicated to the needs of children. The COVID-19 pandemic has had a significantly negative impact on the mental health of children and adolescents. Symptoms of depression, anxiety and the risk of suicide among kids have increased over the course of the pandemic. Prior to COVID-19, one in five children had a mental health condition. Today, data suggests that number to be one in four. According to the Children's Hospital Association, from April 2019 to October 2020, Children's Hospitals have seen a 24 percent increase in mental health emergency room visits for kids 5 to 11 and a 31 percent increase for 12-to-17-year-olds. The first half of 2021 alone, the rates of self-injury and suicide in children's-- in children were 45 percent higher than during the same time period in 2019. These statistics also reflect how fragmented the pediatric mental health infrastructure is. Understanding that there's a nationwide shortage of pediatric mental health providers, Children's proposes an opportunity to partner with primary care providers using telemedicine. For over a decade, Children's has integrated mental health providers in our 13 primary care offices, bridging gaps that families would have accessing mental health. Primary care providers are already on the front lines. Prior to COVID-19, the American Academy of Pediatrics recommended routine screening of all patients 12 and older for depression to reduce suicide risk. We begin this as young as 10. Kids with concerning scores are then connected with the integrated mental health provider. Our outcomes prove this model to be beneficial and highly effective for our patients, and we would like to support the state in making this a standard of care. With a one-time investment from the Legislature, Children's could offer this standard of care to providers across the state with resources and technology to be connected to a pediatrically trained mental health provider virtually, creating an efficient statewide way to access mental healthcare. Telemedicine is a proven and innovative way to strategically leverage the limited pediatrically trained mental health workforce across the state of Nebraska. As a board-certified child and adolescent psychiatrist, I have been doing telemedicine in rural primary care settings since my residency ended in 2009 and at Children's since 2015. We see kids in Great Plains in North Platte, Regional West in Scottsbluff and a number of other sites. Children's has experienced tremendous growth in telemedicine visits within the past few years. In mental healthcare alone, we completed 500 visits. I completed 500 visits in 2017. By the end of 2020, we had completed over 21,000 visits in our department.

Much of this work has been in rural Nebraska already, but to further extend these opportunities, Children's is seeking this one-time support from the American Rescue Plan Act's funds to support access to early mental healthcare for children throughout Nebraska. In conclusion, Children's has invested in addressing the pediatric mental health crisis and is grateful for the opportunity to continue partnering across the state to meet the needs of the children where they live. There's no better investment to make as a state than to invest in the needs of children. I'd be happy to take any questions.

WISHART: Thank you. Any questions? Senator Erdman.

ERDMAN: Thank you, Senator Wishart, and thanks for being here, Doctor. I appreciated that. You know, the paragraph there where you describe one out of five children experience mental health conditions before COVID?

JENNIFER McWILLIAMS: Um-hum.

ERDMAN: Now it's one out of four.

JENNIFER McWILLIAMS: Yeah.

ERDMAN: That's a significant increase. What do you attribute that to?

JENNIFER McWILLIAMS: That is actually a multifactorial question that I could answer in hours, but there are a lot of components. I think the uncertainty of the pandemic-- you know, am I going to have school tomorrow? Am I going to have my band concert tomorrow?-- is part of it. I think the economic stresses that families have been under. I mean, if your mom and dad are stressed, kids get stressed. We don't live in a bubble. The social isolation of not being able to be in school, we know for a fact that, you know, being in the classroom is far superior to a lot of, you know, sitting in your bedroom, doing one worksheet and then playing a video game for the rest of the day.

ERDMAN: So do you see now that we're back in school, do you see that mental health is improving?

JENNIFER McWILLIAMS: I wish I could tell you that it was dramatically going back, but the-- the effects of the last 18 months have had a persistent effect and in 2021, we continued to have mostly virtual visits. Our number of intakes are skyrocketing. Kids that previously had graduated from treatment are still coming back.

ERDMAN: OK, so-- so as we analyze how we handled the pandemic with closing the schools and those things that we did, if we had to go back and do that over, do you think that was a mistake to take the kids out of school?

JENNIFER McWILLIAMS: I mean, hindsight is always twenty-twenty and I'm a child-level psychiatrist, not an infectious disease expert.

ERDMAN: Right.

JENNIFER McWILLIAMS: So I think given the data that we had at the time, decisions were made. Going forward, I think people in mental healthcare would be hard pressed to recommend that.

ERDMAN: Yeah, I would agree with that. So if this is-- this isn't going to be solved overnight because of the long, long-standing damage that's been done to people's mental health.

JENNIFER McWILLIAMS: I would love to be put out of work, but no.

ERDMAN: Thank you.

WISHART: Additional questions? Senator Dorn.

DORN: Yeah, thank you, Senator Wishart. Thank you for being here and thank you-- thank you for doing all that you've done through the COVID and everything. And I guess mine's more trying to get an understanding. During COVID, we-- we started to hear a lot about telehealth and I'm assuming Children's Hospital has-- using telehealth, but this is more for the mental aspect or the mental part of that equation?

JENNIFER McWILLIAMS: Right. So back in 2015 when I moved back to Nebraska, we started partnering with primary care offices throughout Nebraska to offer telepsychiatry with the thought that psychiatry and mental health is specifically positioned as a wonderful way to provide medicine because there isn't as much hands on. And so we work with these primary care offices who refer their patients to come and see me. So again, I initiated this project when I moved back. We have six sites. Prior to the pandemic, I was the only person in our department seeing patients using telemedicine. In the course of five days in March of 2020, our entire department, 15 psychologists, 6 therapists and 5 psychiatrists, all flipped completely to telehealth.

DORN: Thank you for that.

WISHART: Additional questions? Senator Kolterman.

KOLTERMAN: So you have five locations now. Are those Children's locations?

JENNIFER McWILLIAMS: No and it's actually we have nine locations; two in Iowa and seven in Nebraska. They are primary care offices, so it's Great Plains Pediatrics in North Platte, Community Hospital in McCook, Regional West in Scottsbluff, Boone County in Albion, Beatrice Women and Children's, and I'm forgetting somebody, so forgive me. And then Clarinda, Iowa and Shenandoah, Iowa.

KOLTERMAN: So this-- this-- are we purchasing the equipment for those locations-- other locations that might want to come on board?

JENNIFER McWILLIAMS: Right, so when I--

KOLTERMAN: Is that what this does?

JENNIFER McWILLIAMS: Exactly. So when I started doing this, the technology was rapidly advancing and we've reached kind of a static point where having HIPAA-compliant connections and equipment that allows us to adequately see the patients, proper camera, microphone, etcetera, is what we're looking at putting into these-- the pediatric and family practice offices where people would be interested in partnering with us.

KOLTERMAN: OK, thank you.

WISHART: Any additional questions? Senator Hilkemann.

HILKEMANN: When I think of the various medical specialties--

JENNIFER McWILLIAMS: Um-hum.

HILKEMANN: --I would think that psychiatry, or second, would be one of the very best specialties to deal with telehealth, am I correct?

JENNIFER McWILLIAMS: I tend to think so, yes, so.

HILKEMANN: OK.

JENNIFER McWILLIAMS: But-- but yes, we are working at growing our telemedicine departments in pulmonary medicine, endocrine, a number of other pediatric specialties, but by far, mental health and behavioral health have been the, the primary drivers for Children's.

WISHART: OK. Any other questions? Oh, another question?

HILKEMANN: I just want to make sure that other money doesn't go over to Iowa.

JENNIFER McWILLIAMS: Hey, you know what? I'm a proud graduate of the University Nebraska Medical School, but Iowa Hawkeyes are my team, so.

HILKEMANN: Oh. That just changed everything.

JENNIFER McWILLIAMS: I just killed the bill.

HILKEMANN: What's this number again?

JENNIFER McWILLIAMS: [INAUDIBLE]. Thank you.

WISHART: Additional proponents?

ANDY HALE: Good afternoon, Senator Wishart, members of the Appropriations Committee. My name is Andy Hale, A-n-d-y H-a-l-e, and I am vice president of the Nebraska Hospital Association and a Cornhusker and a Creighton Blue Jay fan, for the record, and I'm here to testify in support of LB1075. I want to thank Senator Stinner and his staff for bringing this bill and Dr. McWilliams did a great job, so I'll be brief. But behavioral health is-- is a significant problem in this state. As she mentioned, one in five children, that mirrors the same number of one in five adults are diagnosed with a behavioral health condition. And workforce is one of our top issues as well. And as Senator Hilkemann noted before in this committee as well, that we just don't have enough providers across the state. So what do you do? And so you look at telehealth. When the pandemic started-- or since the pandemic, excuse me, telehealth has increased over 2,500 percent, so 2,500 percent telehealth has increased. And we've seen some numbers that said over 50 percent of all telehealth visits now are related to behavioral health. And so you can see that that is a big issue. And when you talk about children and talk about pediatrics, early intervention is key. We often see many individuals come into our facilities, specifically our emergency room depart-- or, excuse me, our emergency departments and they present because of behavioral health issues. They have nowhere else to go. They either end up in our facilities or end up in jails and prisons and that's probably neither of where they should be. And oftentimes they end up stuck in our facility with nowhere to go and so this is a terrific idea. With telehealth, you also look-- you know, there's a reimbursement piece to this as well at doing this. People that are doing this are not making money from this. They're doing it to provide a service. And so we're

very excited, as Dr. McWilliams stated before, that our hospitals, other hospitals around the state partner with this. We're looking forward to having all of our providers, all of our hospitals, as well as all healthcare providers partner with this. And so again, I ask that you support this bill and I'll take any questions.

WISHART: Thank you. Any questions? Seeing none, thank you.

ANDY HALE: Thank you, senators.

WISHART: Additional proponents? Seeing none, any opponents? Seeing none, anyone in the neutral? Senator Stinner, you're welcome to close.

STINNER: I had to check to make sure I was right on this. Regional West and Scottsbluff is just brand new. That's a new location. This is my ongoing crusade trying to get access to behavioral and mental health. And actually, the pediatric side came to my attention this summer. And if we-- it came out of the nursing school and they said, we need access. We don't have it. We need-- we're taking our kids to Denver, but we have to get a waiver from HHS to go out of state for these types of services. So Lincoln and Omaha are too far away, right? So that really kind of put me on the track of trying to get some access and Children's was good enough to do that. They're experts in it. They obviously, along with CHI, along with Boys Town, are places that can hire a lot of the psychologists and the psychiatrists. And this is what we're left with because we can't hire them in western Nebraska. We have two slots open for a psychiatrist and there's months and years that go on without, without that person. So anyhow, it's-- I think it's a worthy bill.

WISHART: Thank you, Chairman. Any additional questions? Seeing none, we do have five letters of support, zero in opposition and one in neutral for LB1075. That closes our hearing for LB1075 and opens our hearing for LB1076.

STINNER: Good afternoon, Appropriations 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 Scott Bluff, Banner and Kimball Counties. LB1076 appropriates $600,000 in federal ARPA money to the Department of Health and Human Service to develop software related to children with medically complex conditions enrolled in Medicaid. The bill stipulates that the department shall contract with a Nebraska-based pediatric-- pediatric trauma center to develop the software. The bill was brought to me by Children's Hospital and Medical Center, which is the only pediatric care provider in Nebraska. Children's Hospital

provides high-quality care to the most medically complex children in the state and region. As a safety net provider, Children's Hospital has invested in unique needs in our medically complex patients who do not live near a specialty Children's hospital. In 2015, Children's Hospital officially adopted a program they named Project Austin in honor of a 15-month-old boy born with congenital heart defect and critical airways. Despite the family's extensive training and knowledge surrounding their-- their child, they were unable to save Austin following a desperate 911 call. Emergency medical personnel have the desire to provide excellent care to children with complex medical needs, but lack essential support, education, resources to do so. Project Austin was created to help prevent such catastrophic outcomes for families and emergency medical providers by providing patient-specific education and preparation skills to ensure that medically fragile children could survive within their community. Project Austin coordinators bring communities together by calling upon and training the local emergency medical systems, local primary care providers, schools and other caregivers invested in the needs of that child. Today, over 1,000 children with medically complex conditions participate in Project Austin at Children's Hospital. In addition, the Children's Hospital is actively collaborating with over 299 EMS and 147 emergency departments, offering individualized education, community awareness, and emergency plans to local medical communities for these children and families. Under LB1076, a strategic investment of $600,000 to develop a mobile app would allow emergency responders to scan-- to scan a QR code located on the child's bracelet, car seat, etcetera, for immediate access to their emergency treatment plan. This investment would enable Children's Hospital develop a mobile app for Project Austin to support the generation and availability of a QR code, delivering real-time patient emergency plans for the local EMS. Children's Hospital is here to go into more detail about Project Austin initiative. The mother of Austin and the co-founder of Project Austin, Tiffany Simon, will also be here to give her testimony. They will be able to answer more specific questions about how this app would work and showcase of how the expansion of the Project Austin capabilities will help fulfill its mission to prevent catastrophic outcomes, such as the one that Ms. Simon experienced. Thank you and I welcome your questions. I will say this: I've got to work some language out yet. There is a misunderstanding about what we're trying to get done here with HHS, so when they wrote the fiscal note, I've got to change some things, the word "different." That will reduce some of that angst. It'll be a pass through is what it's going to be, so in any event, I'll take questions.

WISHART: Any questions? Seeing none, thank you. First proponent.

HILKEMANN: You may begin. Go ahead.

TIFFANY SIMON: OK. Hi. Good afternoon, Chairman Stinner and members of the Appropriation Committee. My name is Tiffany Simon, T-i-f-f-a-n-y S-i-m-o-n. I am a registered nurse with critical care training and the manager and co-founder of Project Austin at Children's Hospital and Medical Center. I'm proud to be here before you today in support of LB1076 on behalf of Children's Hospital. This is my short testimony. My long testimony is in your packet. I want to personally thank Chairman Stinner for his support and dedication to this unique need of children I am here to advocate for today. At Children's, we are responsible for delivering the unique, high-quality care necessary for medically complex children across the state and region. Often these children spend weeks, months or even years at our four walls of our hospital and will be frequent visitors of our specialists in the outpatient world for the duration of their life. Growing up in a hospital is not the ideal way of life due to the lack of opportunity for social and developmental growth. Ideally, these children are raised and thrive in homes with their families surrounded by the community's support. Project Austin is a program devised to bridge the gap between hospital and home for children with medical complexity. Of our 1,400 patients enrolled in Project Austin, we collaborate with emergency medical systems over 160 emergency departments and 391 emergency medical services, or 911 systems. Of the 1,400 Project Austin patients, 1,100 of those patients reside in the state of Nebraska, spread across 197 communities and 74 counties. Due to the advances in technology and healthcare, children with medical complexity are not only able to survive but thrive in home environments. Children with medical complexity are at an increased risk for suffering acute illness requiring services provided by the child-- by the child's local emergency medical service and emergency department. Despite the increasing number of medically complex children in homes across Nebraska, there has not been adequate exposure and education for the first responders and emergency department healthcare workers to care for this vulnerable population, making these children at a very high risk for delayed medical care, medical errors and unnecessary costly tests and procedures. In addition, caring for medically complex infants or children without knowledge of their condition or treatment guidelines can be stressful for the healthcare worker, creating burnout and acute stress. In 2015, Natalie McCawley and myself at Children's Hospital created a solution to combat these issues by creating a program entitled Project Austin. Project Austin is a program designed to create emergency medical plans

that are specific to the medical child. We are-- we work one-on-one with the first responders and emergency department healthcare workers to educate and prepare them should the child have a medical emergency. The hallmark of Project Austin is the emergency information form. A copy of this form has been distributed for your reference. It is the orange paper on the back. With COVID-- COVID impacting the availability of pediatric beds across the state, many children with medical complexity are being cared for in their local hospitals for prolonged periods of time before a bed becomes available at Children's. Use of the emergency information form has enhanced the healthcare providers' knowledge of the patient, as well as recommended treatment guidelines while in their care prior to transfer. In addition to improving healthcare for this vulnerable population, in 2020, Project Austin partnered with the Nebraska Total Care to look at the total cost savings. Twenty-seven patients enrolled in Project Austin were randomly selected. The cost of care to these patients was compared one year prior to enrollment and one year after enrollment and demonstrated a $1.2 million savings. We know that Project Austin is not only improving the care for these medically complex children to the state of Nebraska, but also cutting medical costs for a population that primarily uses Medicaid for health insurance. To continue improvement in quality care and cost savings, we would like to convert the emergency information form from hard copies over to a mobile app. Currently, four copies of the EIF are kept with the child at all times, which is cumbersome for the family to maintain the integrity of the form and to keep it up-to-date with medical changes. As a solution, the Project Austin team would like to use these one-time ARPA funds to create a mobile app that would ease accessibility of the EIF for caregivers, first responders and emergency department healthcare workers. The app would also allow for real-time changes to the medical plan. I would like to thank Senator Stinner for introducing this bill to further expand the abilities of Project Austin and ask the committee to advance LB1076 in your budget recommendations. I'm happy to answer any questions.

HILKEMANN: Are there questions? Senator Kolterman.

KOLTERMAN: Thank you. First off, thanks for being here today. I understand you started this project.

TIFFANY SIMON: Yes.

KOLTERMAN: Would you care to tell us some of the history behind it?

TIFFANY SIMON: Sure. You want the short version or long?

KOLTERMAN: What brought you-- and obviously you've done a lot of work on this.

TIFFANY SIMON: Yes.

KOLTERMAN: And there's a need.

TIFFANY SIMON: Yes. So Austin was my son. He had a tracheostomy as well as a critical airway and some cardiac issues. And I was at home with my husband and Austin and it was a perfect day, the day after Christmas actually. And his tracheostomy plugged and we did everything that we were trained to do, but we're not able to fix the issue on our own, so we called 9-1-1 for assistance. And I do want to make note that we live in a large-- one of the two largest cities in the state of Nebraska. I don't want to say the name of it because I want to protect those first responders, but when the first responders came, they did not know how to care for my son. There was ten firefighters and first responders in our living room and they looked at us with the deer in the headlights fear in their eyes and had no idea how to help us. And so I rode in the ambulance with Austin to the hospital and watched my son die because nobody was able to help him. And from there-- sorry-- from there, I became a nurse and I worked in-- I worked in the pediatric intensive care unit for 15 years and realized very quickly that-- I'm sorry-- that Austin's story isn't just our story, but the story of tens of thousands of other children. So I worked at a facility that was gracious enough to allow me and one of my colleagues the opportunity to create a program to help children just like Austin. And right now, I can proudly say that we've helped 1,400 children, and I really want to make it known that I do not blame anybody for the situation with Austin. Even if those first responders had known exactly how to care for him, he still would have died. I know that. My husband knows that. What would have been different is on nights that I can't sleep, I think of those first responders and how terrifying and helpless they felt taking care of a young child and watching him die and watching his mother watch her son die. And I never want another first responder to have to feel like that again. So even if I would have known that those first responders would have known my child and they would have known how to help us help him, even if he would have died, it would have made the situation at least a little bit easier to get through for everybody.

KOLTERMAN: Thank you for that.

TIFFANY SIMON: And I'm sorry. I did the one thing I didn't want to do.

HILKEMANN: Senator Dorn.

DORN: I guess a question. Part of this, your conversation or in the bill there, there was been about that you're wondering-- wanting to develop an app that now a child will have basically a bracelet that-- I think a lot of us are familiar with apps. When you go to a--

TIFFANY SIMON: Right.

DORN: --restaurant, you point it over there and then it gets the menu up. Are there other programs around that you, I call it, created this off of? Or are there other types of things that those apps will be able to be used for or why just this?

TIFFANY SIMON: So no, there are no other programs in the nation that are similar to Project Austin. The American Academy of Pediatrics actually created the emergency information form that we have used and modified to what has been best for our patient population. There are some other apps out there that have accessibility to scan a QR code, but those are very limited to the amount of information. The patient actually puts the information in and the first responders will see the patient's information. What stands different with our app is that our app is entered by medical professionals and we give guidelines for those first responders in how to care for that child in particular. Every emergency plan is based on that individual patient and not just a bucket list.

DORN: That's the-- thank you. That's the difference because I mean, if-- I belong to a rescue squad and if we, you know, pulled that up, it's still-- there's still a question in my mind, are we doing the right thing, I guess, you know? And but this app would really help clarify it or make you feel more comfortable when you're there.

TIFFANY SIMON: Yes. So it will be the very particulars to that child, as well as tips and tidbits on how to best care for that child, not only their medical, but also their behavioral. So if it's a child with autism, maybe you don't turn on your lights and sirens because-- unless we absolutely have to because that would maybe overstimulate them or do not give this child oxygen because of their heart defect. It could be very devastation-- devastating to them. It would have that type of information in it, which it does right now. If you look at the emergency information form, it will give you a guideline for that.

DORN: Can you get this someday for all of us, I guess?

TIFFANY SIMON: [LAUGHTER] So Natalie and I are very passionate about taking care of all medically complex kids, as well as ensuring that we are giving first responders and emergency department healthcare workers with the know-how in how to care for these patients and not having-- the worst thing is wanting to help somebody and not knowing how. And our goal would be to broadcast this across the nation at some point.

DORN: Thank you.

HILKEMANN: Additional questions? Do you see this app then down the line, maybe it's-- that it's not going to be specific for Children's. It may start off that way, but it could be--

TIFFANY SIMON: Yes, Senator. It will start off as Children's as we-- kind of like the pilot and then we will distribute it out to other hospitals.

HILKEMANN: Just don't let it go to Iowa.

[LAUGHTER]

HILKEMANN: No, thank you very much for being here.

TIFFANY SIMON: I apologize for being emotional.

KOLTERMAN: No apology necessary.

ANDY HALE: Senator Hilkemann, members of the Appropriations Committee, my name is Andy Hale, A-n-d-y H-a-l-e, and I am here in support of LB1076 and I'll be brief, as Ms. Simon did a very good job. Just knowing several of the members here, Senator McDonnell and Senator Dorn, in your backgrounds with firefighters and EMS, the important job that you do in going into situations that are such as, as what they experience is, is got to be terrifying. But to your point, Senator Hilkemann, this is something that all of our healthcare individuals could potentially use when you think of we either have medically complex children in our families or have friends that know them and they come and they get superior and excellent treatment, but then they have to go home. And so then how do you care for them? The parents and guardians are provided great care, but what happens if they have to pick up that phone and call 9-1-1 and go from there? And so this is a fantastic idea and I know I've been in front of this committee and I know several others have been in front of this committee with astronomical asks because of the money that is out there. And when you look at what is able to do for $600,000, it is really a no brainer to

me. I'm not the ones that sit on this committee, but the work that it will do and potentially will do could be really life-changing. And to have somebody like Austin in your-- your home that-- that could be, you know, saved by this someday, that's worth a lot more than anything else. So with that, I want to thank Senator Stinner and his-- and his staff for bringing this and really want to thank Ms. Simon's testimony. It's very powerful, impactful, and it's something that being a lobbyist, we don't always hear those sides of stories. And I know that was very difficult, but I appreciated her telling that side of the story and I ask that you guys, you senators, advance this bill. So I'll take any questions.

HILKEMANN: Are there additional questions? Thank you.

ANDY HALE: Thank you, senators.

HILKEMANN: Are there additional proponents for LB1076? Seeing none, are there any opponents to LB1076? Is there anyone who would like to speak in the neutral position on LB1076?. Seeing none, Senator Stinner.

STINNER: It's getting late and--

HILKEMANN: He waives closing, so.

McDONNELL: Perfect.

HILKEMANN: So-- we, LB1076-- got to get-- I got a little list here. LB1076 has two letters in support and one in the neutral position of LB1076. And with that, we close the hearing on LB1076 and we begin the hearing on LB1254.

STINNER: Senator Hansen, it's good to see you.

B. HANSEN: It's good to see you as well. My first time in front of Appropriations.

STINNER: I was going to ask if--

B. HANSEN: Exciting.

STINNER: --it's your maiden voyage here.

B. HANSEN: Yeah, hopefully won't go four hours like my hearing did yesterday, so. I'm assuming it won't.

DORN: You might be the only one in the room then.

B. HANSEN: I saw I was last today on the schedule and the two of them after Senator Stinner. I thought I was going to be here, like, eight o'clock p.m., so this is kind of nice. OK, ready?

STINNER: Yeah.

B. HANSEN: OK. Good afternoon, Chairman Stinner and members of the Appropriations Committee. My name is Ben Hansen. That's B-e-n H-a-n-s-e-n. I represent Legislative District 16 and today I'm bringing LB1254 that would provide funds to certain eligible programs in Nebraska to assist in preparing youth who have aged out of the foster care system to enter the workforce. The numbers show that Nebraska, 168 youth, at the age of 19, aged out of the foster care system and found themselves on their own last year. That number is up 29.2 percent from the previous year. These young adults need the same support other teens have coming from their families, but instead they often have to face the world alone. Nebraska's Foster Care Review Office 2021 annual report states that nationally, there is concern for the number of young adults who have aged out of the foster care system without achieving permanency and find themselves ill-prepared for the adult life. Research shows that these youth are more likely than their peers to drop out of school, be unemployed or homeless, experience health and mental health problems, and not have health insurance, become teen parents, use-- use illegal drugs and have encounters with the criminal justice system. Whether able to return to their families or not, older youth need to begin the process of gaining skills needed as a young adult. They also need a supportive environment that provides activities similar to their peers. Twenty percent of children who were previously in foster care immediately become homeless when they age out-- when they age out and only half of them will find gainful employment by the age of 24. Unfortunately, some of this is due to the fact that 25 percent still suffer from the direct effects of PTSD from trauma in their childhood. The statistics show that there is only a 3 percent chance for them to earn a college degree at any point in their life and for-- and for young ladies who have aged out the foster care system, seven out of ten will become pregnant before the age of 21. These young people of our communities should have the same opportunities and the same potential to become influential individuals in our state as every other 19-year-old. They are capable, intelligent and have strengths that would benefit Nebraska. We need them, but first, they need us. In supporting them, we are advocating for their future, for our future neighborhoods, families, business owners, leaders and more. LB1254 would appropriate $2 million of federal funding received by the state of Nebraska from the American Rescue Plan Act of 2021 to the Department of Health and Human Services

for-- for Program 354. Beginning July 1, 2012, child welfare-related programs were moved from DHHS Program 374 to Program 354 to fund things like child welfare, assisting children who have experienced domestic violence, support for adoption or guardianship, and funding educational assistance to state wards. This includes youth who have aged out of the foster care system. These funds appropriated to DHHS with LB1254 would be used by organizations that provide low-income housing in a campus environment with like-minded peers for these young adults who prefer to work blue-collar jobs but don't want to attend college. The funds would help with facility upgrades, building maintenance, transportation and industry training. As a way to ensure responsibility and a focused purpose, using these programs are required to find employment, attend school or both. This, along with the combination of housing, set goals and a healthy learning environment, will prepare them to enter the workforce in Nebraska. It will be properly equipped for success and the state of Nebraska will be better. Ed Shada from Angels Share will be sharing with you in more detail how programs like this will thrive. As someone who works closely with the youth who have aged out of foster care system, he might be able to-- he might be able to provide you better expert opinion. With that, I will answer any questions to the best of my ability and I appreciate your time and ask that your support-- you support LB1254. Thank you very much.

STINNER: Questions? Senator Clements.

CLEMENTS: Thank you, Mr. Chairman. Thank you, Mr. Hansen. Senator Hansen, on line 11, page 2, I see it will be used for construction training. Why would you restrict it to just construction training other than just job training in general?

B. HANSEN: You know, that's a great question. You know what, somebody behind me might be better to answer that--

CLEMENTS: All right.

B. HANSEN: --an expert in this field.

CLEMENTS: We'll ask for that. Thank you.

B. HANSEN: Yep.

STINNER: Senator Erdman.

ERDMAN: Thank you, Senator Stinner. Thank you, Senator Hansen. So the fiscal note, they made a comment about the bill does not specify what

facilities would receive funding or upgrades and maintenance. Have you an opinion what will-- that will be used for, what buildings you're going to improve or facilities you're going to upgrade?

B. HANSEN: It probably depends on the organization. Like, we're not-- you know, we can't just limit to one organization, so some other organizations might use it for something different.

ERDMAN: OK, so $2 million and then it will be an ongoing program? What happens when the $2 million runs out?

B. HANSEN: From my understanding, then it's done. I believe it's a one-time appropriation.

ERDMAN: Have you ever seen a program in the state of Nebraska be started and it doesn't get funded going forward?

B. HANSEN: It's funny, we were just having this conversation at HHS. It should be.

ERDMAN: You know, the situation is this: these are one-time asks, most of these bills, and then they say, well, when the funding is gone, then the program will stop.

B. HANSEN: Um-hum.

ERDMAN: That's not necessarily true. And so when we begin to make decisions about what to fund, we need to understand what that is going forward because we could be raising the base.

B. HANSEN: Sure.

ERDMAN: And when we raise the base, then there's going to be an obligation to meet that with future funding. And so we need to be able to consciously say this is a one-time ask from ARPA, but going forward, this is going to be how much we're going to have to put in it because our budget may be $5 billion now, but if we do all these one-time asks and all those things continue after the funding runs out, we could be $5.5 billion or whatever the number is. So we need to be aware of that. So that's just the reason for my question.

B. HANSEN: That makes sense. Thank you.

STINNER: Senator McDonnell.

McDONNELL: Senator Hansen, thanks for bringing this legislation. So to follow up on Senator Erdman, you're receiving-- these programs are receiving private money that are running them. Right now it's being funded by private dollars, correct?

B. HANSEN: Yes, there might be some grant money also involved.

McDONNELL: OK, but right now you're asking for this based on construction, on capital.

B. HANSEN: Yes, we try to limit to certain things like maintenance and repair and--

McDONNELL: So it would be a one-time spend.

B. HANSEN: It should be, yes.

McDONNELL: All right. Thank you.

STINNER: Senator Vargas.

VARGAS: Thank you for being here, Senator Hansen. Can you tell me a little bit more about Program 354?

B. HANSEN: Yes. I feel like someone asked me that. I have a specific handout that lays that in much more detail, but Program 354, which is set up earlier by DHHS as Program 374, provides services that work to ensure that abused, neglected, dependent and/or delinquent children are safe from harm and maltreatment. And then with that, making sure that people who are aged out of foster care, then we're trying to help make sure that they kind of thrive when they kind of leave and we're not just going to leave them hanging.

VARGAS: Yeah.

B. HANSEN: Based on certain categories that they have in Program 354 that I can give you a handout on if you want more information--

VARGAS: Yeah, yeah.

B. HANSEN: --on specifically what it is, instead of reading the whole thing.

VARGAS: Yeah, that would be helpful. And part of the reason I bring it up, too, is-- and maybe a little disagree with-- it doesn't seem like it seems like capital construction. It seems like supporting the youth in programming as well. So maybe that's the reason why Senator Erdman

was-- well, he's been asking everybody that question. So he's been an equal opportunity question-asker on that. But no, that makes a lot of sense. I'll look to some more information for the--

B. HANSEN: Sure. And for what it's worth, I believe in-- let's see. In the bill in Section 1, subsection 2(a)(i), or 1, "The Department of Health and Human Services shall use the funds appropriated in this section for the following purposes: facility upgrades, building maintenance, transportation, and construction training for youth who have aged out of foster care system." So that maybe specifies what-- what the use of the funds were for.

VARGAS: As one of the uses that they could be used for?

B. HANSEN: Yeah.

VARGAS: OK.

STINNER: Additional questions? Seeing none, thank you.

B. HANSEN: Thank you.

ED SHADA: Senator Stinner and Appropriation Committee. Thank you, senators, for entertaining this bill. I'll answer your two questions first, if you don't-- oh, my name is Ed Shada.

STINNER: That's OK.

ED SHADA: Sorry about that, and it's E-d S-h-a-d-a. And I sort of let-- the bill should have had an "and" between construction and training, so there should have been an "and" in there, OK? And with regards to sustainability, we're looking at the funding that's going-- we have the floor of our Dana College campus and we're converting it into this place for youth aging out of foster care. So we have a gymnasium, we have a library, we have a student center, so that money will go into building so it continues to be self-sustaining. As a banker in Nebraska, my goal is that five years from now, we don't have to ask for any more money. This-- this stands on its own with the rent that we're collecting from the youth that are on the campus. One-- in my estimation, my humble opinion, 1.9 percent unemployment is unhealthy and that's what we have here in the state of Nebraska. And what we're looking at doing is taking a group that is at risk and giving them an opportunity to work and live in low-income housing. Basically, they're paying $425 a month in rent and we're going to continue on with this rent to give them the ability to work and train and start and get into jobs. We have, at this point, 14 youth up on

campus. We've been in a proof-of-concept kind of stage. We have-- we're converting the dormitories into apartments. We've got 62 more that should be coming online in the next year and a half. We have 24 currently and we have another 120 that are in the works after that. The issue of finding youth is immense. There's no issue. They're-- these youth are coming out of the foster care system and we're seeing applications of three to four a week to get into the program with us. And if we don't move rapidly, there are cities-- I've been called by the city of St. Louis and they're looking at starting a program. Minneapolis is talking about how they can use foster youth and how they can help the foster youth and get them into positions. So out of these youth that we have up there on campus right now, the 14, we have some success stories and we had some failures. We've had four leave-- had to leave the program because they just weren't compatible with the program. But what we're doing is we've got one that's a welder. He's up at 4:30 every morning and out the door at 5:00. I know because we have cameras up there and we can see when he's leaving. We have another who's had two promotions at Woodhouse. He's now moved out. He's got a bigger, more expensive apartment. He's bought a new car and we have 14 of the youth that are working. So the program basically is to take these youth, get them-- youth who are not interested in going to college and giving them an opportunity to experience a campus background where there's a gymnasium. We have youth that are going to gymnasium after their shift, their late-night shift at midnight, to get activities to play in the gym. We've got basketball for them and so they're playing, but we need heating and air conditioning for them. We've got a library that has 35,000 books and we're taking the library and it needs heating and air conditioning. We have a student union that'll feed 700 people. So if you look at what we're doing up on the campus with 84 youth and giving them an opportunity to work in the trades to develop skills that they'd prefer rather than going to college-- most of these kids can't go to college, they won't go to college, and so we're giving them an opportunity to continue to move forward. I'll end it there.

STINNER: Senator McDonnell.

McDONNELL: Yeah, thanks for being here. I mean, your-- your passion for this and the work, you-- we first had this discussion in 2019.

ED SHADA: Yes, sir.

McDONNELL: And this was your vision and you said you were going to build it out to the private sector and get this kind of investment. And I'm just so impressed with the work you've done. Also, I know

during-- before the hearing, you offered for us to do tours this Sunday, also Monday, I believe Friday, the fourth, Friday, March 4.

ED SHADA: Yes, Senator.

McDONNELL: So thank you for the invite to all of us and other senators, but I have been so impressed with the work and time you put in. Is this your goal is to have a-- for this money and working with Senator Hansen, it's a one-time spend. Is that your goal not to set up a situation where you come back and ask for programming money?

ED SHADA: No, again, as-- as a banker, I'm looking at how we could set this up so it's self-sustaining so that people can come in here, step into the role that I'm filling at this point in time and continue to operate this for years to come and not acquiring debt is one of the ways. Being able to live off of the rent that is being paid by these youth by a church-- by-- we've got a church that's up on campus. By taking and renting out the buildings, it makes us sustainable into the future, such as with the student union. If you get someone to operate the diner or a convenience store or the kitchen, there's opportunities for them to pay rent, which continues to make the facility self-sustaining.

McDONNELL: Thank you for being here.

STINNER: Senator Clements.

CLEMENTS: Thank you. Thank you, Mr. Shada. The question I had, what's the name of the organization that's doing this project?

ED SHADA: Angels Share.

CLEMENTS: Angels Share?

ED SHADA: Yes, sir.

CLEMENTS: All right. And how long has this been in existence?

ED SHADA: Well, it's kind of a long story. I founded Project Homeless Connect, where I partnered with Creighton University and sent buses out to collect the homeless and bring them back to Creighton. And we reduced the time that they'd get into housing from 30 days down to within a week of the event and we'd get 12 percent of the people into housing. What we're doing-- so it started out as Project Homeless Connect Omaha. We did it for 14 years, again partnering with Creighton. And it wasn't really-- the numbers kept growing. We started

with 238 homeless and we grew to 640 at our last year prior to the pandemic. And even though we'd add psychiatry, we'd add jobs, we'd add a number of different things, we weren't hitting-- we weren't reducing homelessness. And so I thought maybe what we should be doing is taking the McDonald's approach. And every time your kids wake up on Saturday morning, they go down, flip on the TV, there's cartoons, and the first thing they see is a McDonald's commercial so that by the end of the day, when you're asking them where they want to go to dinner, they say McDonald's. So I thought, let's focus on the youth. You've got Boys Town, who's taking these youth and they're moving them through the system. And then all of a sudden they reach 18, 19, and as soon as they graduate, they have to leave. Well, what happens to them at that point in time? We need workers. And if we can't figure out how to take these youth that can form a base and give them an opportunity to succeed and put them into a program where they literally are filling jobs that-- that people don't want to take, but they pay substantially more money-- I mean, we've got kids that are making $23 an hour and they could work all over the world if they wanted to.

CLEMENTS: Do they pay you rent to live in your facility?

ED SHADA: Yes, sir. They pay $425 a month in rent.

CLEMENTS: OK, thank you.

ED SHADA: Yes, sir.

STINNER: Senator Hilkemann.

HILKEMANN: So do you have-- now you mentioned the Dana campus. Do you have the whole campus then now?

ED SHADA: Yes, sir.

HILKEMANN: OK. And--

ED SHADA: You need some space?

HILKEMANN: Pardon?

ED SHADA: You need the space?

HILKEMANN: There's a lot of space up there.

ED SHADA: Yes.

HILKEMANN: The last time I was-- a few broken windows too, but.

ED SHADA: Yeah, we've been replacing all those.

HILKEMANN: Yeah, the-- so-- so how-- what's the-- this is exciting to hear about. So what's you-- what-- what do you see as the potential number of people you get, you said 84?

ED SHADA: Yeah, we've got 84 in the works right now. We were just approached by someone to put 120 more in so that would give us 200. Now, if you look at Cargill, Nature Works, Ebonics, CW Services, there's over 500 jobs that are available and that's not even counting Dollar General that's going to come in with 400 more jobs. So you've got-- just alone in Blair, you've got 900 open positions that are going to be coming up. You've also got the ancillary businesses that are coming in to support them. There's a welder who's a teacher in the union who's opening a shop up there in Blair across from Dollar General and that's going to be what he's going to focus on is Dollar General and the work there and he can train the youth that we have up there. So you look at those programs. We've got a gentleman who-- who founded, oh, what's it, two-wheel cart? I just met him and he's interested in coming in and teaching the youth how to work on electric vehicles. He bought an electric engine company and he's now running them in the Formula One-- to serve as Formula One races. And he's interested in coming up because he said this program, for the next 50 years, there's going to be job openings in the electric vehicle field. So if we can implement a program like that or a training program, we get these kids pushed through there. Another gentleman-- I was out fly-fishing in Montana-- has a company where he's come up with the software that basically will reduce the cost and time of construction. And he's teaching the kids in Puerto Rico to do this. And he said, I'd love to move this up here to the states. And so he's out in California and we've already started to talk about how we could maybe bring some of his programs in. We've got a library that's got 43,000 square feet with 35,000 books. You know, you just move the books aside and you've got an MCC basically that you could set up an entrepreneurial space and training space.

HILKEMANN: Good. That's great. Thank you.

STINNER: Any additional questions? Seeing none, thank you.

ED SHADA: Thank you. I appreciate your time.

STINNER: You bet.

CHRIS TONNIGES: Senator Stinner and members of the Appropriations Committee, my name is Chris Tonniges, C-h-r-i-s T-o-n-n-i-g-e-s, appearing before you today as president and CEO of Lutheran Family Services in support of LB1254. Lutheran Family Services is grateful for Senator Ben Hansen's commitment to young adults aging out of the foster care system, as evidenced by the introduction of this bill. As the parent of several young adults, I have a lot more gray hair than I used to, and I also know well the planning and logistical, not to mention emotional and academic support young adults need as they navigate high school and prepare for adulthood, whether that means entering the workforce, entering a trade school or attending college. Youth aging out of the foster care system have the same needs as they prepare for adulthood, yet they face greater challenges as many navigate a complex system on their own. According to Voices for Children in Nebraska's annual report in 2019, 90 youth aged out of the foster care system in Nebraska without a permanent home on their 19th birthday. We know that youth who age out without a permanent home are more likely to experience homelessness, joblessness, substance abuse and early parenthood. Lutheran Family Services, or LFS, provides wraparound services for teenage youth who are aging out of the foster care system. Beginning at age 14, youth receive yearly assessments to identify youth needs in areas such as financial planning, college planning, housing, parenting classes if the youth is parent-- is a parent, assessment for developmental disability services and job skills. LFS staff serve as connectors for these youth as they make progress on their goals in the areas identified in the yearly assessments, as well as ensuring that youth understand the various benefits, including educational benefits to which they are entitled. LFS also works with foster parents to ensure that FAFSA and other documents are completed on the foster youth's behalf. Programs like Angels Share ensure that young adults exiting foster care without a permanent home are provided additional support as they pursue higher education and job opportunities in a safe, nurturing environment. LB1254 represents a small investment in the future of these youth as they prepare and plan for their future. We encourage the Appropriations Committee to invest in the young adults by including LB1254 in the final-- final ARPA package. With that, I'll answer any questions.

STINNER: Very good. Questions? Seeing none, thank you.

CHRIS TONNIGES: Yeah, thank you.

STINNER: Any more proponents? Any opponents? Anyone in the neutral capacity? Senator, would you like to close?

B. HANSEN: I'm kind of torn actually. It's nice to be in front of this committee, but that means I'm spending money. It goes against my philosophy, so I'll do my best to not be in this committee if I can. So I think-- I think I did a great job of explaining what Angels Share is and where this money could best be used to help our youth aging out of the foster care system because there does seem to be a growing problem, according to the annual report that I just listed earlier. And so the more I've seen of this facility, the more impressed that I am. And so I think this would be a wise use of some of these funds to help make sure we take care of these kids. So with that, I'll answer any final questions if anybody has any.

STINNER: Any questions? Seeing none, thank you.

B. HANSEN: Thank you.

STINNER: We have three letters of support, one in opposition, and that concludes our hearing on LB1254 and our hearing for today. Have a great weekend, everybody.