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ARCH: Welcome to the Health and Human Services Committee. My name is John Arch. I represent the 14th Legislative District in Sarpy County and I serve as Chair of the HHS Committee. I'd like to invite the members of the committee to introduce themselves, starting on my right with Senator Murman.

MURMAN: Hello, I'm Senator Dave Murman from District 38: seven counties to the west, south, and east of Grant-- or excuse me, Kearney and Hastings.

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

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

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

ARCH: Also assisting the committee is one of our legal counsels, T.J. O'Neill, our committee clerk, Geri Williams, and our committee pages, Peyton and Izabel. A few notes about our policies and procedures. First, please turn off or silence your cell phones. This morning we'll be hearing four bills. We'll be taking them in the order listed on the agenda outside the room. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters of the bill, then from those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given the opportunity to make closing statements if they wish to do so. For those of you who are planning to testify, you will find green testifier sheets on the table near the entrance of the hearing room. Please fill one out and hand it to one of the pages when you come up to testify. This will keep us-- this will help us keep an accurate record of the hearing. We use a light system for testifying. Each testifier will have five minutes to testify. When you begin, the light will be green. When the light turns yellow, that means you have one minute left. When the light turns red, it is time to end your testimony. We will ask you to wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone, and then please spell both your first and last name. If you are not testifying at the microphone today, but want to

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go on record as having a position on a bill being heard today, we have implemented a uniform set of rules for public input, some old and some new, across the committees of the Legislature. For the details on those policies, including submitting written testimony and position letters for the record, please see the new public hearing protocols on the HHS Committee's Web site on nebraskalegislature.gov. For the safety of our committee members, staff, pages, and the public, we ask those attending our hearings to abide by the following. Due to social distancing requirements, seating in the room is limited. We ask that you only enter the hearing room when it is necessary for you to attend the bill hearing in progress. The bills will be taken up in the order posted outside the hearing room. We request that everyone utilize the identified entrance and exit doors, and we request that you wear a face covering while in the hearing room. Testifiers may remove their face covering during testimony to assist committee members and transcribers in clearly hearing and understanding the testimony. And pages will sanitize the front table and chair between testifiers. With that, we will begin today's hearing with LB401, which happens to be my bill. And I will turn this over to Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and you are welcome to begin your opening on LB401.

ARCH: Thank you. Good morning, Senator Williams. Members of the Health and Human Services Committee, for the record, my name is John Arch, J-o-h-n A-r-c-h, and I represent the 14th Legislative District in Sarpy County. I'm here today to introduce LB401. I consider this a cleanup of some of our statutes. Last fall, a group of senators requested an Attorney General's Opinion regarding the potential need for legislation to address planned changes to the use of the Hastings Regional Center campus. As many of you know, that campus was recently-- most recently was the site of a residential substance abuse treatment center for adolescent males. The Department of Health and Human Services moved that program in October, 2020, to the Whitehall campus in Lincoln and has announced its intention to relocate the girls' YRTC program to the Hastings campus. In part, the request for AG Opinion asked if this could be done administratively without legislation. In September, 2020, the AG released Opinion 20-010, which essentially said legislation wasn't necessary, but did point out a section of statute that was obsolete with respect to the Hastings Regional Center. And that's what we're attempting to address in LB401. LB401 would address this by eliminating the designation of the

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Hastings Regional Center as a state hospital in 83-305, which is in Section 1 of the bill. Hastings has not been licensed as a hospital since 2008, with the residential and outpatient programs for mentally ill adults ending in 2007 due to declining admissions. Given the condition of many of its buildings, it is doubtful it will ever be licensed as a hospital again. It is currently licensed as a mental health substance abuse treatment center, as well as a psychiatric residential treatment facility. Section 2 of the bill was added by Bill Drafters and is intended to harmonize language. It clarifies that while the Hastings Regional Center is no longer a state hospital, it does remain a state institution. Upon further consideration of this section, I think it'd be cleaner to eliminate the reference to Hastings altogether in 83-363, as another section of statute, 83-107.0, already identifies the Hastings Regional Center as an institution under the supervision of DHHS, along with the Lincoln and Norfolk Regional Centers, Beatrice State Development Center, and the YRTCs. So I'll be bringing an amendment-- amendment to the first bill to strike that reference to line 14. And that's all there is to LB401. Like I said, it's simply a cleanup bill that amends obsolete language. And I'll answer any questions. So long way of saying, it-- it references Hastings as a hospital. It's not a hospital, so we want to clarify that language as recommended by the Attorney General.

WILLIAMS: Thank you, Senator Arch. Are there questions?

MURMAN: I've got one.

WILLIAMS: Senator Murman.

MURMAN: Yeah, thank you, Senator Williams. And thank you for bringing it in, John.

ARCH: Sure.

MURMAN: Or Senator Arch. I've got a question about-- I think it's Building 2-- I'm not sure. But there's a building on the campus that did house the chemical dependency.

ARCH: Building 3, yeah.

MURMAN: OK, 3.

ARCH: Yeah.

MURMAN: Just to the north of the buildings that are going to be used for--

ARCH: Correct.

MURMAN: --the girls' YRTC.

ARCH: Correct.

MURMAN: Do you-- what's the most recent plans for that building?

ARCH: The most recent that I've heard is that Building 3 was scheduled for demolition, but that's being held off. And-- and-- and so it-- it's being held off in the event that we might need to reinstitute that. But at the present time, I don't think that need is there. That's not been communicated to me. So at the present time it's just on hold for the-- for the actual demolition of the building.

MURMAN: OK, thank you very much. Yeah, that's the latest I had heard, too.

ARCH: Yeah.

MURMAN: I just wanted to verify that. Of course, that is a very historic building also.

ARCH: Yeah.

MURMAN: But that-- that-- I just wanted to know what the latest was. So thank you.

ARCH: Um-hum, yeah.

WILLIAMS: Senator Walz.

WALZ: Thank you, Senator Williams. Thank you, Senator Arch. OK, I just want to make sure I'm clear. So it-- it's changing the reference from a hospital to a--

ARCH: Regional center.

WALZ: OK.

ARCH: Yeah, as-- as it is.

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WALZ: All right. Just wanted to make sure.

ARCH: Yeah.

WALZ: Thanks.

ARCH: Right.

WILLIAMS: Any additional questions? Seeing none, thank you for your testimony. We would invite the first proponent. Seeing none, is there anyone here to testify in opposition? Seeing none, is there anyone here to testify in a neutral capacity? Seeing none, Senator Arch, if you would like-- he-- Senator Arch waives closing. Geri, do we have any letters?

GERI WILLIAMS: No.

WILLIAMS: OK. Thank you. That will close the public hearing on LB401.

ARCH: Thank you, Senator Williams. And we will now open the hearing on LB296, Senator Hansen. Welcome, Senator Hansen.

B. HANSEN: Thank you.

ARCH: You may proceed.

B. HANSEN: Good morning, Chairman Arch and the rest of the Health and Human Services Committee. My name is Senator Ben Hansen, B-e-n H-a-n-s-e-n, and I represent District 16, which includes Washington, Burt, and Cuming Counties. LB296 focuses on the current overwhelmed environment of patient treatment centers across the state of Nebraska. We are seeing too many situations where patients are being overlooked and forced to stay in healthcare institutions much longer than they should. Sometimes the situations are so erroneous that patients stay in a healthcare institution six months to one year longer than necessary. As you may know, a complete record of every patient or resident of every institution is kept from the date of their entrance to the date of their discharge. These records are only currently accessible to certain entities, such as: DHHS, the Governor, the federal government, the HHS Committee, or to a judge for the purposes of assigning a person to a proper facility. This bill will add a mental health board to that list. This allows the institution to share records in a similar manner to what is allowable by HIPAA and

practiced in private facilities. Right now, these institutions are subject to restrictions more burdensome than those required by HIPAA. This change will allow DHHS to work with community providers to determine the appropriate treatment for a patient and discharge patients in a timely manner. In situations where the department is unable to obtain a release from the patient, this would allow for the records released under HIPAA to have the individual referred to a more locally-based community center, or at least to a family member, only after DHHS has fully evaluated the resident's physical or mental status and needs related to discharge or transfer and, if applicable, request release from a governing mental health board. That concludes my opening statement. And I believe I do have Sheri Dawson, director of the Division of Behavioral Health, testifying after me, and she may be more able to answer more specific questions if you have any. Thank you for your attention, and I am open to any questions, if I can.

ARCH: Any questions from the committee members? Seeing none, thank you.

B. HANSEN: Thank you.

ARCH: We will take a first proponent. Good morning.

SHERI DAWSON: Good morning. Good morning, Chairman Arch and members of the Health and Human Services Committee. My name is Sheri Dawson, S-h-e-r-i D-a-w-s-o-n, and I'm the director of the Division of Behavioral Health at the Department of Health and Human Services. I'm here to testify in support of LB296, which would amend provisions regarding the release of patient records for residents at our state facilities. DHHS would like to thank Senator Hansen for sponsoring this legislation. Currently, DHHS may release patient records only with written authorization from the patient or the patient's legally authorized representative, and under specific circumstances in Statute 83-109. These restrictions can keep DHHS from effectively coordinating care with other treatment providers when patients are ready for discharge from the facility. The bill would permit DHHS to seek and obtain an order permitting the release of records from a mental health board. Currently, only judges or courts can order the release. Second, the legislation would allow DHHS to release records to treatment providers for purposes of coordination of care. The federal Health Insurance Portability and Accountability Act, HIPAA, permits private providers to release otherwise protected patient records for this

purpose. However, Nebraska law is more restrictive for state institutions than HIPAA and does not currently permit release without written consent for this purpose. When authorizations have not been provided or have been delayed, individuals residing at state institutions have experienced delayed discharges, even up to an additional 12 months. By facilitating care coordination in accordance with HIPAA, patients can be served in the most integrated setting, with reduced length of stay and improved timeliness of admissions. LB296 will benefit patients by ensuring a timely and coordinated transition as they leave our state facility, and allow DHHS to admit persons awaiting needed care. We respectfully request the committee support this legislation and move it to a floor full debate. And I thank you for the opportunity, and happy to answer any questions.

ARCH: Are there questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here. Just kind of out of curiosity, how did this happen that we-- do you-- do you know how we became more restrictive than HIPAA?

SHERI DAWSON: You know, I don't know the history to that, Senator Cavanaugh.

M. CAVANAUGH: That's fine. I was just curious.

SHERI DAWSON: Yeah.

M. CAVANAUGH: Thank you.

ARCH: Other questions? Senator Walz.

WALZ: Thank you, Senator Arch. Thank you. And I-- I was just kind of struck by something that Senator Hansen said regarding the-- people are staying six months to one year longer. How does that happen, and who's making that determination?

SHERI DAWSON: Um-hum. So primarily the-- the issue we see at the Lincoln Regional Center, where there may be a patient that does not want to sign a release of records, they may, you know, like the care at the Lincoln Regional Center and are not signing the release for information to other providers. And then the second circumstance is when there would be guardians of patients. And it may be that the

guardian doesn't want the individual to move as well. So those are the two primary situations.

WALZ: And in those situations, how much weight is given to the person who's receiving care and their guardians? Because obviously, the person receiving care knows themselves and the guardians know them in most cases. How much weight is given in making that decision on whether or not they are truly ready to leave?

SHERI DAWSON: Sure. So there certainly is a treatment review process. And patient choice, to your-- to your question, as well as working with the guardian, is very important. And so there is significant effort put to talking with the patient and, you know, sharing the opportunities, as well as the guardian. So currently what happens is if there is a recommendation and, again, there's not a signed release, then the treatment team reviews that. And then, along with the administrator and our medical director, they look at what are the opportunities here to, you know, try and get some movement. And so in the guardian's case, it's not just going to be a one and done. There is significant effort, documentation of the attempts to try and explain and-- and provide options for the guardian before that happens. And so what this bill is asking is, at a point when there still isn't that consent for release, that there is the ability, either under HIPAA or if those individuals are mental health board-committed and those folks are committed to the department, to have the mental health board then have that information and release the record and make that determination for discharge.

WALZ: Um-hum. All right. Thank you.

ARCH: Other questions? I have-- I have one, and that is could you-- could you give us a brief overview of the mental health board system in Nebraska?

SHERI DAWSON: Um-hum, sure. So in Nebraska-- and I can't give you the statute, but I certainly can provide that to you-- when individuals are found mentally ill due to-- or dangerous-- due to their mental illness, an individual can be put under emergency protective custody first, and those individuals are evaluated. And if that recommendation would be for inpatient care, they go before a mental health board. The mental health boards are organized by judicial district. And in some districts, because of the size, there's more than one mental health

board. The presiding judge in that district appoints, and also can remove, individuals from the mental health board. So there's always an attorney that serves as chair of the mental health board, and there's two other members. And those members are either from the category of physician, psychiatrist, psychologist, advanced practice registered nurse, licensed clinical social workers, LIMHP. And then there's also laypeople that have experience or knowledge of mental illness. So they-- they go before the mental health board, those three individuals. The person is represented, has the right to be represented by an attorney, and then the county attorney, and then sometimes there's other people that may have additional clinical information. And the mental health board will decide if the person needs to be committed. There are times where the person will stipulate voluntary treatment. And then there's also an outpatient mental health board committed-- or commitment-- that can take place, so both inpatient and outpatient. I don't know if that gets at your questions, but--

ARCH: It does. And so this bill then would allow a mental health board to decide to release-- to release the information, to release the records, but still always in accordance with HIPAA.

SHERI DAWSON: Yes, yes. HIPAA is sort of the floor.

ARCH: Right.

SHERI DAWSON: We've just had that higher, higher standard, if you will. And in the current mental health ward process, there is notification that goes to the mental health board when a treatment team decides about discharge and-- and ready. So there's already a process in place for that to happen.

ARCH: Thank you. Other questions? Senator Walz.

WALZ: Thank you. I have one more question. Thank you, Senator. Arch. So I'm sure that prior to the mental health board determining whether or not this person can leave or be discharged, I would imagine that they also have access to the plan that will be in place for that person once they are discharged?

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SHERI DAWSON: Yes, the treatment plan is part of what is submitted to the mental health board, and there's regular updates and then, again, a notice of potential discharge to the-- to the board.

WALZ: OK.

SHERI DAWSON: Um-hum.

WALZ: Thank you.

SHERI DAWSON: Um-hum.

ARCH: Other questions? Seeing none, thank you very much.

SHERI DAWSON: Thank you.

ARCH: Thank you for your testimony. Other proponents? Seeing none, any opponents? Anyone who wishes to testify in a neutral capacity? OK. We did have two letters of support that were provided: Stephanie Olson, on behalf of the National Association of Social Workers; and Joseph Kohout, on behalf of the Nebraska Association of Regional Administrators. No letters of opposition, no-- no letters in the neutral capacity. Senator Hansen, you're welcome to close.

B. HANSEN: I just want to say thanks again to Ms. Dawson for answering all your questions, that-- she's a lot more specific at it than I probably would be. But I'll be up here again, answering any questions as best I can. But if not, thank you for listening.

ARCH: OK, any other questions for Senator Hansen? Seeing none, thank you very much.

B. HANSEN: Thank you.

ARCH: And this will close the hearing on LB296, and we will open the hearing on LB374. Welcome, Senator DeBoer.

DeBOER: Good morning, Senator Arch-- Chairman Arch-- and members of the Health and Human Services Committee. This is my first time before your committee, so be gentle. So thank you very much for having me. My name is Wendy DeBoer, W-e-n-d-y D-e-B-o-e-r, and I represent Legislative District 10, which includes Bennington and northwest Omaha. Today I'm introducing LB374, a bill to adopt the Alzheimer's

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Disease and Other Dementia Support Act. The act would establish the Nebraska Alzheimer's Disease and Other Dementia Advisory Council and require the council to publish a state Alzheimer's plan and provide annual reports to monitor the plan's implementation. First, I want to provide some legislative history on this topic. In 2014, former Senator Kate Bolz passed LB690, which created the Aging Nebraskans Task Force, a statewide task force on aging. As part of the task force strategic plan, they recommended that the state should develop an Alzheimer's state plan to coordinate and strengthen the existing resources used to support individuals living with Alzheimer's and dementia, and their caregivers. LB320, passed the following year, implemented some of the recommendations and required the task force to develop a state plan regarding persons with Alzheimer's or related disorders. While the state plan that was created as a result in 2015 did lead to positive implementations, public health has changed and developed over the last six years, particularly in this area. The needs of, and resources available to, individuals affected by Alzheimer's and other dementia is constantly evolving, and an updated plan is needed to reflect these changes. LB374 establishes the Nebraska Alzheimer's Disease and Other Dementia Advisory Council that would create an updated state plan that would act as a continuation of the 2015 state plan. The council would present that plan to the Legislature and to the Governor, provide an annual report on the status and implementation of the plan, and update the plan every four years. While creating the-- the plan, the council will consider and make findings on a variety of topics related to Alzheimer's. These items are listed in Section 6 of the bill and include topics such as: the state's role in providing or facilitating long-term care; the fiscal impact of Alzheimer's disease and other dementia on publicly funded healthcare programs; existing resources for individuals living with Alzheimer's. Through the creation of a comprehensive statewide plan, Nebraska can collectively address issues related to Alzheimer's and other dementia. A statewide plan will assist Nebraska in increasing public awareness of Alzheimer's, encouraging early detection and diagnosis-- and that's key-- and evaluating the capacity of the healthcare system in meeting the growing number and needs of those with Alzheimer's disease and other related dementias. The council would update the state plan every four years to ensure it is relevant and adaptive to the changing needs of this population. At this point, I have an amendment to hand out. Thank you very much. In the original draft of the bill, both DHS-- DHHS and the LRO would

provide staff and support to the council as necessary to assist the council in the performance of its duty. There were concerns which were communicated to me by the Speaker's office, surrounding the inclusion of an office housed under different branches of government to assist the council. So AM38 would remove the Legislative Research Office from the bill. The Speaker also suggested to me this morning an additional amendment which is needed to make sure that the legislator-- Legislature confirms the members of the council, and I will prepare an amendment to make that happen and submit it to you all as soon as I can. In Nebraska, there are currently over 35,000 individuals who have been diagnosed with Alzheimer's disease-- 35,000. And over 83,000 Nebraskans provide unpaid care for people living with Alzheimer's disease and other dementias. These numbers will continue to grow in coming years due to longer average lifespans and the expected growth in the population of older Nebraskans. We need to be proactive in planning and implementing policies to care for these Nebraskas-- Nebraskans. A letter of support from the Alzheimer's Association was submitted to the committee and should be part of the official record, as they have a policy during COVID not to come and testify in person. I will add one-- since I'm not going to have any testifiers behind me, I will add one personal note, which is that Alzheimer's has, I think, affected almost everyone in the state in some way or another. They know-- someone knows someone who has Alzheimer's or related dementias. For me, it was my grandmother. And my grandmother lived until I was in sixth grade, but I only heard her speak once. So this is a devastating disease that affects a lot of people. And as we see our population in Nebraska get older, it's clear that this is going to be something that we need to have at least knowledge of what's coming at us and some ability to address. So with that, I thank you for consideration of this legislation. I'm happy to answer any questions you have. And as I said, because the position of the Alzheimer's Council is to not attend these hearings in person, I will not have any testifiers today, I don't believe.

ARCH: Thank you. Questions for Senator DeBoer? Senator Hansen.

B. HANSEN: Just a quick question. Do you expect the fiscal note to be about $100,000 every year or will that change? Do you see it going up or down?

DeBOER: Yeah, so we're working on the fiscal note. There are a couple of things we've already talked about that are going to bring that

down. And I'll continue to work and apprise the committee of how that's going, because we think that that shouldn't, in fact, be that high at all. So I think we're going to be able to take care of most of that.

B. HANSEN: Thank you.

DeBOER: Um-hum.

ARCH: Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for bringing this. Just-- and you might not know the answer. The previous committee that was formed under Senator Bolz's legislation, did that require confirmation from the Legislature?

DeBOER: You know, I don't know that because that is an issue that was just brought to me this morning about the confirmation, but--

M. CAVANAUGH: I can find that out. But--

DeBOER: Yeah, I'll let you know.

M. CAVANAUGH: --just curious.

DeBOER: Yeah.

ARCH: Other questions for Senator DeBoer? OK, seeing none, you'll stay in touch with the committee--

DeBOER: Yeah.

ARCH: --on the number-- on the future amendment and the fiscal note and all of that-- and keep us informed?

DeBOER: Yeah, absolutely. I will-- I will probably send the-- the amendment up today. We'll get that back and then, as far as the fiscal note, that'll be in the next week or so, I would say.

ARCH: All right.

DeBOER: Thank you very much.

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ARCH: OK, thank you. Thanks very much. We will take now any proponents for the bill, if you'd like to speak. Seeing none, any opponents for the bill? Seeing none, any neutral testimony? OK. Seeing none, we did have two written testimonies that were submitted this morning that will be part of the committee-- committee statement: Jina Ragland from AARP and Tim Gay, Catalyst Public affairs for Home Instead are written-- is written testimony in support.

***JINA RAGLAND:** Chair Arch and members of the Health and Human Services Committee: AARP is a non-profit, non-partisan organization-that works across Nebraska to strengthen communities and advocates for the issues that matter most to families and those 50+ such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse. AARP supports LB374, a bill to create the Alzheimer's Disease and Other Dementia Advisory Council. According to the Alzheimer's Association, we know that currendy 35,000 Nebraskans over the age of 65 are living with Alzheimer's disease. According to current estimates, more than five million people in the US have Alzheimer's Disease, the most common form of dementia. Under the current trajectory, more than 13.8 million additional baby boomers are expected to develop dementia by 2050. Despite considerable effort by researchers, there are currently no drugs or medical procedures for preventing or curing dementia. A 2015 AARP policy survey revealed that virtually all members recognize dementia is a serious problem, and that 85% know someone who has or had dementia. While members want to know about their mental functioning and health care providers are the first in line of defense for individuals who notice a decline in cognitive health, few health care providers are discussing dementia with their patients or assessing mental functioning during the Medicare Annual Wellness visit. Nearly half of members mistakenly believe that dementia is a mental illness, and 41% think dementia is a normal process of aging. The human societal, and financial costs of dementia are all very high, including health care costs, impacts on individuals, their family and friends and on the workforce. Currently, it is estimated that the average per-person Medicare spending for people 65 and older with dementia is three times higher than for seniors without dementia. Medicaid payments are nineteen times higher. And research projects that the cost of caring for those with Alzheimer's will make up 24.2% of Medicare's spending by 2040. Dementia not only impacts the patient, but also theiJ: family and friends. In 2015, the direct annual cost of

caring for those with dementia is estimated to be $226 billion, with expectations that it will reach over $1.1 trillion by 2050. People caring for family or friends with dementia had $9.7 billion in additional health care costs of their own due to the physical and emotional toll of caregiving. It is the policy of AARP that policymakers should expand and bring to scale demonstrations that are cost-effective, person-centered and proven to improve quality of life for individuals across all stages of the diseases that cause dementia. The goal would be to delay the progression of dementia and increase independence through person-centered care while lowering overall health care costs. Dementia "centers for excellence," which educate, conduct research, and expedite the adoption of cost-effective best practices should be established and replicated. LB374 will provide the opportunity to continue the discussions and decipher where and what resources, education, etc. are lacking and put into place an effective plan to address the needs of some of Nebraska's most vulnerable and their families moving forward. Thank you to Senators DeBoer and Wishart for introducing this important legislation and for the opportunity to comment. We appreciate your support and encourage the advancement of LB374 to general file.

***TIM GAY:** Chairman Arch and Members of the Health and Human Services Committee, Thank you for the opportunity to offer testimony for LB374, which was introduced by Sen. Wendy DeBoer and would create the Alzheimer's Disease and Other Dementia Advisory Council. On behalf of Home Instead, Inc., I offer the following testimony and ask that this position be recorded and reflected on the committee statement for the bill. With its global headquarters in Omaha, Home Instead is the franchisor of a network of over 1200 independently owned and operated agencies that provide personalized in-home senior care services and empower seniors across Nebraska, the United States, and in 13 other countries to age in place. At any given moment, more than 100,000 Home Instead caregivers are providing essential and life-sustaining care to elders around the world, more than half of whom have some form of Alzheimer's or other dementia. Along with providing high-quality care for those with Alzheimer's and Dementia, Home Instead has had opportunity to be a driving force and a leading voice on this topic through our involvement with varied organizations like the Alzheimer's Association, World Dementia Council, CEOi, Alzheimer's Disease International, US Against Alzheimer's, Women's Brain Health, the Alzheimer's Disparities Symposium, the Global Coalition on Aging, and

the World Economic Forum's Alzheimer's Collaborative. You are all well-aware of the statistics showing the prevalence of Alzheimer's disease and other dementia and the impact on Nebraskans and their families. You know both the visible and the more hidden costs of these diseases, including the tremendous costs of informal care and the hardships exacerbated by the COVID-19 pandemic. None of us can quantify the human suffering of the 50 million individuals who have this disease, or the hundreds of millions of family members and loved ones who are caring for those who have this disease. We do know, however, that until there is a CURE, there is CARE. And we very much appreciate Sen. DeBoer's introduction of this important bill and its goal of a more coordinated approach to addressing Alzheimer's disease and other dementia. Nebraskans living with dementia and their families would benefit from an increased focus on the policies and strategies outlined in Section 6. This focus will lead to more and better care options in our state. We cannot afford to delay.

ARCH: We also had five letters in support: Randall Jones on behalf of the Nebraska Association of Area Agencies on Aging; Sharon Stephens on behalf of the Alzheimer's Association, Nebraska Chapter; the Nebraska Hospital Association; Dr. Michelle Walsh on behalf of the Nebraska Medical Association; Stephanie Olson on behalf of the National Association of Social Workers. We had-- we had no letters in opposition and no letters in the neutral capacity. With that, Senator DeBoer, would you like to close? Senator DeBoer waives close, and that will conclude our hearing for LB374. Thank you. Our next bill to be heard is LB476. Senator Blood is to introduce that. I don't see Senator Blood in the room.

T.J. O'NEILL: I think she told me that she had a bill--

ARCH: Oh, there she is. OK.

T.J. O'NEILL: She had a bill in another committee, too, I think, or something.

WALZ: Probably didn't expect to be done in-- 30 minutes in.

ARCH: Welcome, Senator Blood. You may begin on LB476.

BLOOD: Well, thank you and good morning to you, Chair Arch and to the entire Health and Human Services Committee. My name is Senator Carol

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Blood, spelled C-a-r-o-l B as in boy-l-o-o-d as in dog, and I represent District 3, which is western Bellevue and southeastern Papillion, Nebraska. And I thank you for the opportunity to-- opportunity to bring forward LB476 this morning. LB476 is the next natural step after the Nebraska Legislature passed and implemented the Stroke System of Care Act in 2016. This act established the stroke system of care to provide Nebraska patients with the highest quality of care and to ensure a seamless transition with all medical personnel involved in the care of those patients. As you likely know, strokes are the fourth leading cause of death in our state, and it is the leading cause of disability in the United States. These disabilities can lead to an increase in your insurance premiums because, as patients require more assistance, the cost must be spread among the members. It can cause concerns with family dynamics when you must care for your loved ones, a decrease in the workforce, quality-of-life concerns for those affected, and other issues that we can avoid by being prepared. The current act allows DHHS to designate hospitals as Nebraska stroke centers. They are-- there are comprehensive stroke centers such as Nebraska Medicine in Omaha, thrombectomy stroke centers such as CHI Immanuel in Omaha and primary stroke centers in Norfolk, Lincoln, Grand Island, Bellevue, Scottsbluff, and North Platte. Also, acute stroke-ready hospitals are located in Elkhorn and Papillion. Stroke designation applications are available to Nebraska hospitals should they like to renew their designation or apply to become a stroke-designated hospital on the Nebraska Stroke Systems of Care Web site, so the list remains fluid and updated. This effort to help Nebraska live better lives also offers stroke education for EMS services and continuing education credit for its Mission: Lifeline training. Now we know that science and research continue to change how we handle medical emergencies, and it is important that we update our protocols to keep up with those changes. This is where LB476 comes into play. LB476, expands this act and requests that DHHS, in conjunction with the stroke system of care task force, establish and implement an improvement plan for a comprehensive stroke system for stroke response and treatment. As part of this expanded plan, they will maintain a statewide stroke data registry that utilizes the American Heart Association's Get With The Guidelines-Stroke data set, or a data tool with an equivalent data measure and appropriate confidentiality standards that are consistent with the federal and state laws and other health information and data collection, storage, and sharing requirements of this department. The bill will require

comprehensive stroke centers, thrombectomy-capable stroke centers, and primary stroke centers, acute stroke-ready hospitals, and emergency medical services to report data that is consistent with nationally recognized guidelines on the treatment of individuals with a suspected stroke or transient ischemic attack with the state. The bill encourages the sharing of information and data among healthcare providers on ways to improve the quality of care for stroke patients here in Nebraska. The department will facilitate the communication and analysis of health information and data among healthcare professionals who care for those stroke patients. Lastly, the department will establish a data oversight process for stroke response and treatment. They will provide for the analysis of data generated by the stroke registry on stroke response and treatment, and the identification of potential interventions to improve stroke care here in Nebraska or specific to geographic areas within our boundaries. All of this data and information developed or collected, and the release of this data will comply with Sections 81-663 to 81-675 of state statute. Data may be released as Class I data, Class II data, Class III data, or Class IV data, as is found in Section 81-667 of state statute, of which I've supplied you each copy of. Medical records and health information registries are not new to Nebraska. We are already performing this function for brain injury and Parkinson's disease. In closing, having a healthy Nebraska is good for all involved. We all know the power of data in garnering federal funds, grants, private donations and more, as Nebraska's medical community strives to keep up with research, data, and science, and they look for creative ways to fund those efforts. Preventing strokes, responding quickly to prevent long-term issues caused by strokes, and providing an excellent level of care is something we can all get behind because everyone deserves good health. Thank you for your time today. And I will stay, should you have any questions, but would like to remind you that we do, I believe, have qualified testifiers, and you will likely receive those answers during their testimonies. I'll also add that, in addition to the information in your packets that I handed out, I've included letters of support from CHI Health and Tamsen Butler. With the changes to the hearing procedures this week, I understand why there might be some confusion over when and how the letters needed to be submitted. And I'm hoping you'll accept them into the record now. With that, I thank you for your time, and I'm available to answer any questions, should you have any and not want to wait for the experts.

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ARCH: Any questions for Senator Blood? Senator Walz.

WALZ: I do. Thank you, Senator Blood. You talked a little bit about qualified stroke centers.

BLOOD: Um-hum.

WALZ: What does that entail?

BLOOD: You mean what does each stroke center do? And-- and--

WALZ: How do you--

BLOOD: --or the services that they--

WALZ: --determine a qualified stroke center, I guess?

BLOOD: I would actually refer you to that--

WALZ: OK.

BLOOD: --particular Web site. There's a very comprehensive explanation for each type of stroke center and what they're able to offer, which is actually the benefit of that Web site. If indeed you had a parent who had had-- had had a stroke, or a loved one, you would be able to utilize that Web site as a resource to know which facility would-- would help your family member the best.

WALZ: Um-hum. And I'm just trying to make this easy for myself.

BLOOD: Sure.

WALZ: So basically this bill would provide facilities, fire departments more information on how to help someone who's having a stroke.

BLOOD: It's more that they're revisiting what already exists, because that information already does exist because, as you know, our protocol for pretty much every health issue has changed year after year after year, how we handle heart attacks, how we handle strokes, how we handle traumatic brain injuries. And so we're asking that it be revisited and updated. And then the-- the thing that's very different from what already exists is the fact that now we're going to be

collecting data. So those are really the two changes in the bill. Everything else already exists.

WALZ: And just to be clear, the data that you're collecting is what? Like what type of data will be collected?

BLOOD: I would encourage you to ask that question of the person who comes behind me, because I think that you'll get a more comprehensive answer.

WALZ: OK. All right.

BLOOD: And if not, I'll come back and address it, I promise.

WALZ: OK, thank you, Senator Blood.

ARCH: Other questions for Senator Blood? Seeing none, thank you very much. Will you be staying for closing?

BLOOD: I will.

ARCH: OK, thank you. And we will welcome the next proponent testifier. Welcome.

BETH MALINA: Good morning.

ARCH: Good morning.

BETH MALINA: Good morning, Senator Arch and fellow committee members. And Senator Walz, I could answer that question about who certifies those hospitals, if you want me to real quick, and then I can go into what I was going to share.

WALZ: Oh, thank you.

BETH MALINA: So currently in Nebraska, our cert-- our hospitals are certified. Almost all of them are certified through the Joint Commission. So there's a certifying body that certifies the hospitals. And Joint Commission is what-- of the 15, 14 are certified through Joint Commission. One is certified through DNV, another certifying-- hospital certifying agency. Those hospital certifying agencies have disease-specific certifications. And so with those certifications, they-- there's-- there are specific things that they have to meet. And

then there's a body that comes in and certifies them every two years to say that they're meeting those measures. So that's how the certification works. And instead of the state going in and certifying, the way the original bill was written was that we would just use the certifying bodies that are already certifying these hospitals. Before this bill was written, this is-- the disease specific certifications were occurring. Does that explain that a little bit more?

WALZ: Yeah. Yeah, it-- it does.

BETH MALINA: Yeah, OK. All right. So feel free to ask me questions when you-- when I'm done here.

WALZ: I will.

BETH MALINA: But my name is Beth Malina. I'm a registered nurse, and I am the director of quality and system improvement for the American Heart Association and the Mission: Lifeline director. And we'll talk about what Mission: Lifeline is here in just a moment. Thank you, Senator Blood, for introducing this bill and for all of the other senators that are supporting it. So prior to coming to the American Heart Association, I was the stroke coordinator at a Lincoln Hospital. Oh--

ARCH: Can I ask you to please spell your name?

BETH MALINA: Oh, I'm sorry.

ARCH: Thank you.

BETH MALINA: You know, this is all new to me. Beth, B-e-t-h, and last name is Malina, M-a-l-i-n-a.

ARCH: Thank you.

BETH MALINA: Uh-huh. All right. So prior to coming to the American Heart Association, I was a stroke coordinator at one of the Lincoln hospitals. And then five years ago, I went to work for the American Heart Association and worked with their quality programs in Kansas and Nebraska. And then in 2018, I took over as the Mission: Lifeline director for Nebraska through the American Heart Association, working on our stroke systems of care. So what does Mission: Lifeline mean? To the American Heart Association, Mission: Lifeline is our system of

care work. We've done it with STEMI, and we're doing it with stroke now. So it's really just-- what does the system look like, from EMS to rehab, for our stroke patients? With that, I've become pretty passionate about stroke care. I've been all over the state and I've been in many of our hospitals throughout the state of Nebraska. We have made steps to improve our stroke care in Nebraska, with the-- with the passing of LB722 in 2016. But with that bill, we did not have a registry part of it. And the American Heart Association and the Helmsley Charitable Trust said, OK, here's a state that's working on things; we want to support this. And so they, through a grant-- through the Helmsley Charitable Trust-- we have been working on systems of care, which I've been directing since 2018. A major component of that grant is quality improvement for hospitals. And so we have been providing our-- providing the hospitals across the state with Get With The Guidelines, which is the American Heart Association's quality program, and providing them with some financial support to work on their education and their stroke systems of care. Just to share with you some of the gains that we've had since 2016, I just wanted to share with you some of the data that we've been able to collect now over the last couple of years on what's been happening with that. So the biggest thing with stroke is that time is brain. The quicker a patient is treated, the better the outcomes. So obviously we have areas in our state that that happens really well and areas, because of the geographical areas, that that doesn't happen as well. But since 2000-- so we're going to look-- I'm going to share with you some data from 2016 through 2019. Part of that is we don't have all of 2020's data in, and so 2019 was the last time we have complete data for the year. So over those three years, these are the improvements we've seen. The door to CAT scan in less than twenty five minutes has improved by 13 percent. IV thrombolytic therapy.-- it's the only drug on the market that is used for stroke to treat acute stroke. And the sooner it's given, the studies show, the better the outcomes. So those gains that we've seen in that have increased, so the patients that are receiving it have increased from 8.7 to 11.3. The median time from when the patient arrives at the door to when the drug is given has-- has decreased from 54 to 42 minutes, and those patients receiving it in less than 60 minutes from the-- from the door has increased from 67 to 80 percent. Another guideline that was reached-- in 2007, it became a standard of care-- was thrombectomy. And so that allows us to evaluate our stroke patients up to 24 hours. And so in 2017, we, in the state of Nebraska, performed 17 thrombectomy cases-- sorry, 77

thrombectomy cases. And in 2019, we performed 138, so almost double what we did over those two years. It's critical to sustain the work that we have been doing, especially with this Mission: Lifeline grant, that we approve some type of statewide system for data collection. Due to the data collection, we'll be able to provide feedback to our EMS partners and, with our EMS partners, we can report on the time spent in that field, whether they prenotified the hospital, they were door in-door-out, and for treatment activation of the team. And then for the hospitals-- and those are just a few of the things-- for our hospitals, we can look at the door to treatment, how they activated their teams, how quickly they gave the thrombectomy, their door-in and door-out measures, any kind of secondary prevention that they did for those patients, and then being assessed for rehab, because that's also a huge part of it. Those are just a few of the measures that are out there. The American Heart Association has guidelines, according to the measures that we look at, but these are just some of the key things that we look at. There are many more things that we can look at. COVID-19, as we all know, has created a little havoc in our lives. And a recent study that was published in the Stroke Journal [SIC] in-- in January of this year confirms that patients with COVID-19 have more severe strokes and poorer outcomes.

ARCH: Excuse me for just a second.

BETH MALINA: Sure.

ARCH: The red light has come on. However, I'd like to ask you a question--

BETH MALINA: Sure.

ARCH: --so we can be consistent. Do you have more that you'd like to share with us?

BETH MALINA: You know, I'm pretty darn close.

ARCH: OK, feel free-- feel free to continue.

BETH MALINA: OK. So with that, especially what we're seeing, what's happening with COVID-19 is-- is-- just reiterates the importance of us having system-of-care work. We're working on providing hospitals with tools so that they can be successful. Education has been a huge part of what we're doing with the Mission: Lifeline grant. We have an

incredible team of volunteers that I've been able to work with across the state. And I just feel very strongly that data gives us knowledge, and knowledge gives us power. And so the fact that we are not-- we-- we don't have something in place to be able to collect that data, I think it's really important for us to be able to continue to work on our system-of-care work for Nebraska. So I'm in favor of support of LB476. So thank you very much.

ARCH: OK, thank you.

BETH MALINA: Yeah.

ARCH: Senator Hansen.

B. HANSEN: Thank you. Thanks for coming and testifying.

BETH MALINA: Sure.

B. HANSEN: So what kind of information are you hoping to learn-- new information more than what we have, more than what you already learned from previous legislation that we've done with the-- with the-- with the stroke information, from a registry to help change or improve upon patient care? So all the information that because of this new legislation we're going to make, how is this going to improve patient care? You know, it might give you more data, or is it more just a registry? Because you're-- it seems like you already get the data about how we take care of stroke victims. Is this just more to just keep it collected in a certain area?

BETH MALINA: Well, I think to continue to collect the data, so we right now are collecting that data through the American Heart Association, and really, the hospitals voluntarily participate in giving us that data. So if there is nothing that says they have to give us that data, we wouldn't have that data. Right now, we are volun-- those hospitals are voluntarily participating in a data registry. So I think the thing that it makes a difference in is that we're-- with data we can provide feedback and hopefully be able to continue to improve that system of care. I mean, I can tell you many a story of where we need to continue to improve that. We're working on it, but there's definitely more areas. And so to have that ongoing, particularly after this grant is done, that that will be ongoing through some type of legislation to continue to get data.

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B. HANSEN: So do you expect hospitals to stop providing data? Or to make--

BETH MALINA: I think that they-- that they will to some degree, because most of them are certified. And so they have to collect some form of data, but they don't necessarily have to share that with-- I mean, they share it internally, but they wouldn't have to share it with anyone else to look at the whole system-of-care piece of it.

B. HANSEN: OK. And so this would pretty much just require them to do it now.

BETH MALINA: Right. It just requires them to do it.

B. HANSEN: OK. Do-- do you-- do you have an unforeseen burden on hospitals having to do this all the time or even people like in the field having to always--

BETH MALINA: I-- I don't because most of them are collecting-- that, I mean, as certified centers, they have to collect data and report it back to their agency that certifies them.

B. HANSEN: Yeah.

BETH MALINA: So they're collecting data. That's just part of how you run a stroke program. EMS, they are collecting data. And one of the things that we've really been working with, with our Department of Health and Human Services-- and EMS leads there-- is that we get that feedback back to our EMS. So there's been this vast amount of data going in through their-- their EMR, or their electronic medical record.

B. HANSEN: Um-hum.

BETH MALINA: And they haven't been able to-- they haven't been giving them a lot of feedback to that. And so this-- we've just really encouraged. Let's make sure that they know exactly what's going on so that they can work on-- on their times, too. So--

B. HANSEN: OK, good. Thank you. Appreciate it.

BETH MALINA: Uh-huh.

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ARCH: Other questions? Senator Williams.

WILLIAMS: Thank you, Chairman. And thank you, Ms. Malina, for being here. I want to be sure I'm understanding something. There are certain hospitals in our state that have gone through stroke certification. So they are listed as that.

BETH MALINA: Right.

WILLIAMS: The bill mandates for those hospitals to participate in this program. What about the many other hospitals that we have in our state that still treat stroke--

BETH MALINA: Right.

WILLIAMS: --victims? Where-- where do they fall, under--

BETH MALINA: So--

WILLIAMS: --this legislation?

BETH MALINA: --under this legislation, they are not required to give us-- to-- to submit data. And so-- but one of-- I guess one of the ways those patients-- those patients are captured. So if a patient goes to a critical access hospital, most of those patients are transferred to one of our primary stroke centers. If they have an acute stroke that requires them to get thrombolytic therapy, it's-- it's a drug that requires intensive management. And most of them, they may give the drug, but they'll transfer that patient on to another facility. So we're hoping to capture that on that side of it, that they-- when-- once those patients are at those facilities. Part of the data registry that they look at is, where did those patients come from? So that you're kind of capturing it on the back side of it. They can see where those patients are coming from and how long it took for transfers, those types of things; they can see that. I mean, if we are in an ideal world, I would say, yes, it would be great if all of our hospitals gave us the data. I think for them it-- it-- it does become more of a burden for our small hospitals, even though they have a low volume, it would be for them to feel that they have one more registry they have to submit to. And so I think that's why-- I would say that's why it wasn't put in the bill, was that we didn't want it to be a burden to them, any more of a burden, that we have been working with

the Department of Health and Human Services to find ways to recognize those hospitals, to encourage them to continue to give data. So--

WILLIAMS: And-- and you did list this, I think, but how many, again, certified hospitals are there?

BETH MALINA: I believe it's 15, and I'm taking that off the top of my head.

WILLIAMS: Yeah, yeah. OK.

BETH MALINA: But I'm pretty sure it's 15. Yeah.

WILLIAMS: That's-- that's close. I just wanted a ballpark.

BETH MALINA: Right.

ARCH: Thank you, Senator Williams. Other questions?

WALZ: I--

ARCH: Senator Walz.

WALZ: Thank you, Senator Arch, and thank you so much for your work and your care--

BETH MALINA: Oh, thanks.

WALZ: --regarding this. It's-- it's really important. This is personal for me because my mom passed away from a stroke. So I appreciate your care.

BETH MALINA: Yeah.

WALZ: Is data collected by nursing homes or assisted living facilities, and if not, do you think it should be?

BETH MALINA: Well, that kind of opens up a whole nother thing. So our-- that is really looking more at that post-acute phase, so looking at-- what we've been very focused on is the acute side of it. So EMS, to the hospital, and then-- then determining where they're going to go to rehab. As a side note, I'll just tell you, the American Heart Association is working on some guidelines for-- for our skilled nursing facilities and nursing homes on how they should care for those

stroke patients that go to those facilities. We have several rehab facilities in the state that are rehab hospitals. Most of them go through a similar certifying type of thing. It's called CARF. They go through that and they get certified on how they-- how their rehab services are. As far as an acute situation, that is captured in our data collection, 'cause we do capture where those patients come from. So whether they come from outside of this-- you know, they're at home, they're in a facility, they're in another hospital and they had a stroke. We do capture that piece of it in the data collection, but the post-acute part of it would be more around standards related to rehab, which kind of is a whole different thing, too.

WALZ: Right. I was-- I was just wondering because, you know, you mentioned the-- the fact that the sooner a stroke patient can be--

BETH MALINA: Right. And that is really the key, is that they are identified very quickly and they're treated quickly. What we have done with our Mission: Lifeline grant is try to provide education to those facilities. We're kind of done. We were-- we just did a mass type of education, letting them know, kind of reiterating with them the importance of them realizing their patients might be having a stroke and getting care for them.

WALZ: Um-hum. All right. Thank you.

BETH MALINA: Uh-huh.

ARCH: Other questions? Senator Hansen.

B. HANSEN: Thank you. One more quick question.

BETH MALINA: Sure.

B. HANSEN: But this-- this could be answered maybe by Senator Blood or somebody else following you with testifying. So what do the certified stroke centers think of this? Because obviously it probably requires them to pay somebody to put it together, to collect the data, to-- to send it off-- maybe not so much now electronic health records, but I haven't seen-- I think it's the Nebraska Hospital Association or the certified stroke centers come out and-- with any letters of support. And so I just don't know for sure where they're at because this will be affecting them.

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BETH MALINA: Right.

B. HANSEN: And so like if we're going to make a law that's going to affect somebody else, so I'm kind of curious to know where they're at. And then they--

BETH MALINA: Right.

B. HANSEN: --they could be here testifying, too.

BETH MALINA: And Brian might be able to address where the hospital association-- verbally, they-- they've been in support of this--

B. HANSEN: OK.

BETH MALINA: --with as far as my conversations with them. But it doesn't-- it doesn't increase their burden because they're already doing it, I guess, is where that comes into it. So they're already collecting this data. It would just really be depending on how the state uses it, it may mean that they need to share that with them. Or if the state uses our Get With The Guidelines program as a super user, they wouldn't have to do anything. That data is already in there. And so they would be able to pull it right out.

B. HANSEN: Right, good. Yeah, thank you. Appreciate it.

BETH MALINA: Yeah.

ARCH: Other questions? I-- I have a-- I have one.

BETH MALINA: Sure.

ARCH: So there's a lot of reporting going on.

BETH MALINA: Yes.

ARCH: A lot of reporting. Hospitals report a lot of information. And-- and so, you know, I guess my-- my question is, have you explored whether or not our Health Information Exchange, NEHII-- now Cync-- CyncHealth-- I believe they've changed their name-- have you-- have you explored whether or not this information is already available that you could-- that you could extract this from our Health Information Exchange?

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BETH MALINA: I personally haven't. And I'm not sure what it looks at for disease-specific things as far as to the depth that we have looked at it. And I do agree, we-- there is the burden of data collection.

ARCH: Right.

BETH MALINA: But-- and that's some of the reason the bill was written for us to look at those centers that are already collecting that data, because what they're collecting for their certifications is not in those exchanges. They have to have a much more in-depth look at what they're doing, related to their treatments, related to the whole package of what happens in the emergency room, related to how they discharge those patients and making sure that they're on the secondary prevention. And I-- I can tell you that it's-- that's not in any of those other things, because we-- even as a stroke center that I worked at here in Lincoln, we have to use some type of other data collection to collect that first certification.

ARCH: OK. All right.

BETH MALINA: Yeah.

ARCH: OK, thank you. Other questions? Seeing none, thank you very much for your testimony today.

BETH MALINA: All right. Thank you.

ARCH: Next proponent for LB476.

JAMES BOBENHOUSE: Good morning.

ARCH: They want to wipe down your--

JAMES BOBENHOUSE: Oh, sorry. Oh.

_____: Yeah. It's not a great thing. It's really good.

JAMES BOBENHOUSE: Is it all right if I take off my mask? Or--

ARCH: Yes. Yes, sir.

JAMES BOBENHOUSE: I've been vaccinated, too, so--

ARCH: Yeah.

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JAMES BOBENHOUSE: Good morning, Mr. Chairman and members of the Health and Human Services Committee. My name is James Bobenhouse, spelled B-o-b-e-n-h-o-u-s-e, Bobenhouse, and I am a stroke neurologist in Lincoln, Nebraska. I appreciate the opportunity to speak with you today in support of LB476, the establishment of a Nebraska stroke registry. I would also like to thank Senator Blood for presenting this bill, and please enter my testimony into the permanent record. I'm a board certified neurologist in general and vascular neurology and I've been in clinical practice for 36 years. I'm a member of the Nebraska Medical Association, as well as the American Academy of Neurology, and have served more than 15 years as the stroke center medical director for CHI Health St. Elizabeth and, up until very recently, at Bryan Health Medical Centers in Lincoln, Nebraska. Over the past 25 years, great strides have been made in our understanding and treatment of stroke. In 1995, two groundbreaking studies were published in the New England Journal of Medicine, which confirmed the benefit of IV tPA. It's a clot-busting medicine, so it breaks up the clot when a person has an acute stroke. When given within three hours of a-- of stroke onset, patients have had a greater chance of recovery with fewer complications if the tPA was given early. And this led to renewed efforts at that time to establish stroke centers and educate the public in the rapid identification of stroke, emphasizing the importance seeking-- of seeking medical-- immediate medical attention. Since 2006, the Nebraska Stroke Advisory Council, otherwise known as NSAC, a statewide coalition of stroke experts and stakeholders, began implementing strategies to improve stroke care. Based on a large European study, the use of IV tPA was later-- later extended to four and a half hours. It was three before, and now it became four and a half from-- from the stroke onset. Additional analyses show that there was much greater benefit when IV tPA was given at 90 minutes and, in fact, almost 3 times a better chance of returning to normal, rather than at 4 and a half hours, which is only 1.5-- 1.3 times the chance, so a much greater chance if you take it early. It was also shown that there-- every 15 minutes gained, there was a 4 percent decreased chance of bleeding in the brain, decreased chance of dying and increased chance of being able to walk out of the hospital and a 3 percent increased chance of returning home. In 2015, there were five studies that showed nearly twice the chance of recovery in large strokes when the clot was physically removed-- and what they do is they go up in the groin, go up into the brain and pull out the clot-- within six hours with those studies. And that's called mechanical

thrombectomy. Subsequent studies showed that the mechanical thrombectomy was also beneficial, even up to 24 hours in some selected individuals. And in light of these findings, stroke centers adopted a pit crew approach to further streamline the evaluation process, attempting to give IV tPA as quickly as possible and then determining if a mechanical thrombectomy was warranted. And this confirmed the need to treat stroke quickly and efficiently in order to provide the best stroke care possible, and prompted calls nationally to develop integrated and coordinated stroke systems of care throughout the country. The Nebraska Legislature ratified LB722 in 2016, mandating the establishment of the stroke system of care in Nebraska. In 2018, the American Heart Association and the Helmsley Charitable Trust announced Mission: Lifeline Stroke, a commitment to expand and enhance systems of care in Nebraska. This partnership has enabled many Nebraska hospitals to participate in the Get With The Guidelines that Beth had mentioned earlier. In other words, they were not able to afford to participate this until-- with-- in this program obtaining that data-- until after the grant was given to us. And that's provided site-specific stroke data and led to the launch of numerous stroke related initiatives in the state. Data from Get With The Guidelines-Stroke has enabled examination of the impact of these interventions. In fact, from 2016 to 2019, the participation in Get With The Guidelines-Stroke grew from 7 to 40 hospital sites, including 21 critical access hospitals. There was a 30 percent increase in utilization of IV tPA and a 22 percent increase in the door-to-treatment-- or improvement in the door-to-treatment time. In other words, more patients were getting the medication earlier, which means that there was a greater chance of getting back to normal if they obtained-- received this medicine. The number of patients treated by mechanical thrombectomy nearly doubled. These improvements in the Nebraska stroke system of care will be highlighted in a poster presentation at an upcoming international stroke conference in March of this year. Establishing a stroke registry will greatly enhance the continued development of the Nebraska stroke system of care. Data collected with the grant-- with Guidelines-Stroke has been essential in providing necessary feedback for ongoing stroke quality improvement, and has provided a much clearer picture of the true stroke care needs within the state. Just as an aside, before we had Get With The Guidelines-Stroke, which is right now through the American Heart Association in this grant, really the only data that we received was from hospital records, discharge records. And so I-- as a

neurologist, I couldn't even say how many strokes occurred in the state. I couldn't tell how many actually died from stroke in the state, other than what was in the hospital records. So-- so that's the purpose of this-- this registry. A registry will enable us to identify the incidence, frequency, and types of stroke, and recognize changing geographic trends, and identify factors affecting stroke in our state. This information will improve efficiency and treatment of stroke, assist in education and awareness of stroke, particularly in the rural communities, because we have very little data from the-- from the rural communities, or we have had up until this recent grant, and guide coordination and allocation of resources, as well as planning for future needs. Many Nebraskans have already benefited from the continued development of the stroke system of care and improved access to stroke expertise. However, there are still large areas that are neurologically underserved. Establishing a stroke registry of site-specific, detailed information will enable the most efficient current and future allocation of resources, with the goal that all Nebraskans have access to the best care possible. Thank you for listening.

ARCH: Thank you, Doctor. Questions from the committee? Seeing none, thank you very much for coming and testifying today. Other proponents? Welcome.

BRIAN KRANNAWITTER: Thank you. Mr. Chairman, members of the committee, good morning. My name is Brian Krannawitter; that's spelled K-r-a-n-n-a-w-i-t-t-e-r, and I'm the government relations director for the American Heart Association in Nebraska. And on behalf of the Heart Association, I want to express our support for LB40-- LB476, which would establish a statewide stroke registry. And I also very much want to thank Senator Blood for introducing this bill. Stroke is the fifth leading cause of death in the United States and a leading cause of disability. And as my colleague has pointed out, the pandemic has only added to the challenges; COVID-19 patients have experienced severe strokes. As with Senator Walz and, literally, thousands of other families across our country, this is a very personal issue for me, as well. Nearly three years ago, my mother-in-law suffered a severe ischemic stroke, which left her disabled until she passed away a few months ago. I saw firsthand the toll it took on her physically, mentally, and emotionally. I also witnessed the toll it took on my wife, who could no longer have a conversation with her mom, who would see her mom confined to a wheelchair and struggle to move, to talk

and, at times, struggling to remember the name of her own daughter, her other kids and grandchildren. The burden of our stroke on our society is very real. The experience of my mother-in-law and-- and the impact on her family is not unique, unfortunately; it happens to thousands of families every year. And as my colleagues have stated, data can help drive and improve outcomes. To improve performance, you must first measure where you are and then use that data to plan for how the gaps and outcomes can be closed. Seeing what my mother-in-law went through, as well as my wife, the issue of stroke and data to help drive and improve outcomes is very dear to my heart. I respectfully urge the committee to advance LB476. Thank you for the opportunity to testify on this important matter. And before I forget, Senator Hansen, to your question, I have been in contact with the Nebraska Hospital Association, actually starting several months ago. At that time, I did not receive any pushback with respect to the concept of this. And-- and we actually communicated last week, as well. I believe earlier this week their association was having a policy committee meeting. I don't know, you know, if they've issued a letter to the committee or not. But at least as-- from previous conversations, I did not receive any pushback. And I should say, as well as with respect to LB722, back in 2000-- I think '16 it was-- I believe they did submit a letter of support for the System of Care Act-- Stroke System of Care Act. So I don't know if that answers your question, but that's the information I have with respect to the Hospital Association.

B. HANSEN: Thank you.

ARCH: Thank you. Questions? I have-- I have one.

BRIAN KRANNAWITTER: Sure.

ARCH: And I-- again, I'm just trying to simplify this. We have-- we have a registry that exists, but it's voluntary. It's being funded by the American Heart Association. And so what this bill does is it makes it required to report--

BRIAN KRANNAWITTER: Um-hum.

ARCH: --to the department to put into permanency the-- this registry, and-- and-- and done to-- and done-- and-- and the ones reporting are the ones that are certified.

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BRIAN KRANNAWITTER: That's correct. Yeah. It'd be that they-- the-- certified by the Joint Commission--

ARCH: Right.

BRIAN KRANNAWITTER: --which was part of the bill back at-- LB722 back in 2016, to be the comprehensive, the primary care stroke centers and the thrombectomy-capable, which I believe, as mentioned previously, it was 15-- 15 hospitals. Yes.

ARCH: All right.

BRIAN KRANNAWITTER: Yeah.

ARCH: Thank you.

BRIAN KRANNAWITTER: Yeah, you bet.

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

BRIAN KRANNAWITTER: Thank you.

ARCH: Are there other proponents for LB476? Welcome to the Health and Human Services Committee.

TIMOREE KLINGLER: Good morning. This is weird. Good afternoon-- or good morning, Senator Arch and members of the Health and Human Services Committee. My name is Timoree Klingler, T-i-m-o-r-e-e K-l-i-n-g-l-e-r, and I am here today in my capacity as the registered lobbyist on behalf of CyncHealth in support of LB476. In 2020, LB1183, passed by Senator Arch, designated CyncHealth as the state-designated health information exchange and, through the Population Health Information Act, authorized our organization to collect and report data on behalf of facilities we serve for registry submission, immunization reporting, and syndromic surveillance from an electronic health record. Section 2(a) of LB476 creates a statewide stroke data registry. This legislation encourages sharing of information and data among healthcare providers on ways to improve the quality of care for stroke patients within the state. As a health data organization, CyncHealth facilitates the exchange of data to enrich patients longitudinal health records, thereby improving patient care through a single access point. Having a health registry as a longitudinal record

of an illness or disease is similarly helpful in providing a more complete picture of how a disease or illness affects the population of our state and, furthermore, offers suggestions on how to increase the quality of care and perhaps additional treatment options. The ability of CyncHealth to collect and report data on behalf of facilities who participate and share data in our HIE reduces time, cost, and burden on those facilities for their reporting responsibilities. It is important to note that all registries and their data are owned and operated by the Department of Health and Human Services. CyncHealth assists their facilities, who participate by sharing data in our HIE and the extraction and reporting from their electronic health records to DHHS. Health information is an effective tool to provide background, assist in research, and improve the delivery of care to patients. We ask that the committee support LB476 and advance to the full Legislature for consideration. We thank you for your time and consideration of this important matter, and I would be happy to answer any questions

ARCH: Questions? Thanks for coming. I do have some questions.

TIMOREE KLINGLER: Excellent.

ARCH: So-- so CyncHealth is the conduit for--

TIMOREE KLINGLER: Correct.

ARCH: So you're-- so you are-- you are gathering the information from these certified-- I don't know if you were in the room earlier, but I asked the question about, you know, what role does CyncHealth play. You're-- you're already gathering it. You are-- you are sending that information to the registry.

TIMOREE KLINGLER: Correct.

ARCH: Right.

TIMOREE KLINGLER: If the-- if the organization we're working with has a partition agree-- participation agreement with us that we are-- they are sharing data and we are sharing data back with them. It's part of their agreement.

ARCH: OK. So it isn't-- it isn't one more thing for the hospitals to report?

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TIMOREE KLINGLER: No.

ARCH: They are reporting it, and you are then providing that information to the registry. That registry then sits with DHHS, and-- and the questions then, the extraction of information-- then it comes out of that registry specific to stroke, how we're doing, what the numbers are and so forth.

TIMOREE KLINGLER: Right. But again, it's important to note that not all organizations have a participation agreement with us--

ARCH: Right.

TIMOREE KLINGLER: --that goes both ways. So there-- there may be organizations who are, you know, the registered organizations, but we are not providing that service for them. That burden would still fall upon them.

ARCH: They would have to report directly.

TIMOREE KLINGLER: Correct.

ARCH: But again, I know-- I happen to know that participation numbers for CyncHealth and they're--

TIMOREE KLINGLER: Yes.

ARCH: --they're pretty high.

TIMOREE KLINGLER: Yes.

ARCH: So it's, you know-- we may have a couple that aren't, but-- but most of them would be.

TIMOREE KLINGLER: Right.

ARCH: Right.

TIMOREE KLINGLER: Yeah.

ARCH: OK, thank you. Other questions? All right. Thanks for coming.

TIMOREE KLINGLER: Thank you.

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ARCH: Any other proponents for LB476? Any-- seeing none, any opponents for LB476? Anyone testifying in a neutral capacity?

***JERRY STILMOCK:** Chairman Arch, members of the Health and Human Services Committee, my name is Jerry Stilmock and I appear before you today on behalf of the Nebraska State Volunteer Firefighters Association (NSVFA) and Nebraska Fire Chiefs Association (NFCA), in a neutral position for LB476. Volunteer emergency medical providers are a critical component in responding to injuries and illnesses to all Nebraskans and visitors of our state. In performing this critical role, a tremendous sacrifice of time is dedicated by volunteer emergency medical providers in responding to calls, but additionally, in completing required documentation after the rescue call, and submitting it to the Nebraska Department of Health and Human Services. It is believed that the information concerning strokes is already being submitted to the Nebraska Department of Health and Human Services by emergency medical personnel upon completion of a rescue call. We recognize that the legislation does not require emergency medical services to report the data as described in the bill, but rather it only encourages emergency medical services to report data on the treatment of individuals with a suspected stroke and transient ischemic attack within the state. We appreciate the fact that the legislation recognizes that emergency medical services are encouraged, rather than required to report the data. It is our request that this language be contained with any action the Committee may take on LB476. Thank you for receiving these comments on behalf of the NSVFA and NFCA in this neutral position concerning LB476.

ARCH: Senator Blood, if you'd like to close. I-- I do have some letters and some testimony that I want to note for the record, written testimony delivered this morning in a neutral capacity, Jerry-- Jerry Stilmock from Nebraska State Volunteer Firefighters Association and Nebraska Fire Chiefs Association. We've also had letters of support, ten letters of support: Corrie Kielty; Dayna Kran-- Krannawitter; Haley Haymart; Jill Duis; Katie Neujahr; John Woodrich, on behalf of Bryan Health; Dr. Michelle Walsh, on behalf of the Nebraska Medical Association; Raegan Anderson; Shelby Vesely; and Todd Stubbendieck, on behalf of AR-- AARP of Nebraska. And there were no opposition letters and no neutral letters. Senator Blood, you are free to close.

BLOOD: Thank you, Chairperson Arch. And to Senator Hansen's concern, when I have any bill, the first thing we do is we reach out to every

organization we feel that this would touch, including the NHA. It was my understanding that they had a meeting this week about bills and so it was more of a window of time thing than an opposition thing. So we-- we just started about six months out and let people know what kind of bills that we're thinking of doing and ask them for their input and ask them if they have concerns about that legislation. So we never try and sneak anything through; and I didn't think you were implying that, by the way. But I want you to know that we always do our due diligence when it comes especially to the health of Nebraskans. And with that said, I'd like to say that because we have constantly been revisiting and updating procedures that pertain to strokes, many of you remember that three years ago while we were in session, my mother had a stroke. And my mother is alive because of CHI-- CHI Immanuel Center getting to her in time, thanks to our-- our EMS in that area in north Omaha. And it is a matter of time that it makes a difference between life or death, long-time disability or some normalcy. And thank God, in her case, it went back to normalcy. And then we know that the data is being collected, but there's power with shared data. And the American Heart Association-- and I wear my hearts today in honor of the American Heart Association, I'd like to point out-- is-- is that they have saved so many Nebraskans with their ongoing advocacy on the behalf of their health. And the fact that we can team up with them and make Nebraskans healthier and have longer, more productive lives is a good thing. And so with that, I'm glad the experts came because I knew they would answer the vast majority of your questions, if not all of the questions. And I sincerely appreciate your time today. And it is my hope that you do vote this out of committee for full debate to the floor.

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

BLOOD: Thank you for your time.

ARCH: This closes the hearing on LB476 and closes the hearing for the morning. We will-- we gather at 1:30.

ARCH: Well, good afternoon and welcome to the Health and Human Services Committee. My name is John Arch, I represent the 14th Legislative District in Sarpy County, and I serve as Chair of the HHS Committee. I'd like to invite the members of the committee to introduce themselves, starting on my right with Senator Murman.

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MURMAN: Hello, I'm Senator Dave Murman from District 38. I represent seven counties in southeastern Nebraska, kind of to the west, south and east of Kearney and Hastings.

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

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

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

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

ARCH: Also assisting the committee is one of our legal counsels, T.J. O'Neill, and our committee clerk, Geri Williams, and our committee pages, Kate and Rebecca. A few notes about our policies and procedures. First, please turn off or silence your cell phones. This afternoon, we'll be hearing three bills and we'll be taking them in the order listed on the agenda outside the room. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters of the bill and then from those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given the opportunity to make closing statements if they wish to do so. For those of you who are planning to testify, you'll find green testifier sheets on the table near the entrance of the hearing room. Please fill one out and hand it to one of the pages when you come up to testify. This will help us keep an accurate record of the hearing. We use a light system for testifying. Each testifier will have five minutes to testify. When you begin, the light will be green. When the light turns yellow, that means you have one minute left. And when the light turns red, it means it is time to end your testimony. We'll ask you to wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone and then please both your first and last name. Please also note that materials are provided to the committees electronically, so you may see committee members referencing their laptops and tablets during your testimony. If you are not testifying at the microphone today, but want to go on record as having a position on a bill being heard today, we've implemented a

uniform set of rules for public input. And please see the new public hearing protocols on the HHS Committee's website on-- at nebraskalegislature.gov. And there is a white sign-in sheet at the entrance where you may leave your name and position on the bills before us today as well. For the safety of our committee members, staves, pages-- staff, pages and the public, we ask those attending our hearings to abide by the following procedures. Due to social distancing requirements seating in the hearing room is, is limited. We ask that you only enter the hearing room when it is necessary for you to attend the bill hearing in progress. The bills will be taken up in the order posted outside the hearing room. We request that everyone utilize the identified entrance and exit doors to the hearing rooms, and we request that you wear a face covering during-- while in the hearing room. Testifiers may remove their face covering during testimony to assist committee members and transcribers in clearly hearing and understanding the testimony. And pages are going to sanitize the table and the chair between testifiers. So if we could just pause in between people that come up to the-- just to the table. And with that, we will begin this afternoon's hearing with LB325, and welcome, Senator Albrecht. Good afternoon.

ALBRECHT: Good afternoon. It's that same one with all the lights.

ARCH: Yes.

ALBRECHT: Alrighty. Good afternoon, Chairman Arch, members of the Health and Human Services Committee. For the record, my name is Joni Albrecht, J-o-n-i A-l-b-r-e-c-h-t, I res-- I represent the 17th District, which includes Wayne, Thurston and Dakota counties in northeast Nebraska. I'd like to begin by thanking you for your time on this critical consideration of LB325. I'm here today joined by two advocates who have worked with me on this bill to share the background, support of, and amendments to this bill. If the amendment passes, LB325 would amend all relevant sections of the Uniform Credentialing Act, Mental Health Practice Act to provide the qualified art therapist the title of licensed mental health practition-- practitioner or licensed independent mental health practitioner with a credential as a certified art therapist. The amendment you have before you today, which is AM22, I made a copy, I think it was electronic to you as well, which serves as a substitute to the bill. So LB325 would go away, the amendment would become the bill, is the result of a two-year advocacy and review process. The 407 credentialing review

process for the art therapy began on October 9 of 2018, with the director's acceptance of the Nebraska Art Therapy Licensure Coalition letter of intent. The coalition compromised [sic] of Nebraskans for the Arts, Concordia University, the Brain Injury Alliance of Nebraska, Heartland Counseling and the Arts-- The Nebraska Arts Council, and the individual art therapist proposed providing for credentialing of professional art therapists as licensed mental health practitioners under the Mental Health Practice Act, excuse me, with associated certification as a professional art therapist. This decision was a pivot from the coalition's original intent to create an independent licensure in art therapy and was adjusted in response to the feedback from the Platte Institute and lawmakers. In September of 2019, the coalition submitted a full 150 page 407 credentialing and review application for art therapy. The following submission the dep-- the Department of Health and Human Services established the Art Therapist Technical Review Committee, which held six meetings between October 19 and March 20-- March 2020, excuse me, including a public hearing. Final reports in support of the proposal were issued by Technical Review Committee, the Board of Health and the director. The director's report stated, quote, The Technical Review Committee members recommend in favor of the art therapy proposal. The Board of Health recommended in favor of the art therapy proposal. I concur with these recommendations, end of quote. The report shares comments particular to four criteria of the 407 process and concludes, quote, The only way to address the shortcomings of the current practice situation of art therapy services in Nebraska is by passing the applicant's proposal, end of quote. So while the 407 process was underway, the coalition's original sponsor, former state Senator Sara Howard, introduced LB422 as a shell bill in 2019 to familiarize the Legislature of the process while the 407 review was underway. During this time, the coalition also worked with the American Art Therapy Association and the Department of Health and Human Services to ensure that the amendment that you have before you today incorporated not only feedback from the 407 process, but the feedback from other important stakeholders. So per the recommendation of the Department of Health and Human Services and other parties, this bill utilizes the legal framework that currently extends title protection to clinical social workers, professional counselors and marriage and family therapists. For these professions, title protection has ensured that Nebraska practitioners are held to the highest standard of care and that the public have a clear understanding of what services their practitioner can provide

for them. Accordingly, I hope that you'll agree that offering this title protection to art therapists would be of value not only for the art therapist but also to the members of the public seeking mental health care. So, again, I've handed out the, the new amendment, AM22. And I also asked if we could hand out Jennifer Jackson, she is one of my residents that-- constituents, if you will, up in South Sioux City. She's the executive director of the Heartland Counseling Services. And I hope you'll take some time. I'm not going to read that to you, but please take time to read that. I would like it to be on the record. I know that she planned to be here today, but due to the weather, she's not able to get down here. So let's see. So then I'll have a few folks behind me, an art therapist and care coord-- coordinator at the Open Door Mission, Jenelle Hallaert. And then she's also brought Jeanne Triplett to, to visit with you. And Skyler Dykes is the interim executive director of the Nebraskans for the Arts. Doug Zbylut is someone I was working with before, and Doug is retired. And I wish him well. And but I do thank you for your time and I look forward to working with the committee on this particular bill.

ARCH: Questions for Senator Albrecht? OK, I don't see any, so--

ALBRECHT: I might have to run next door and introduce, but I'll be back.

ARCH: OK, thank you. Thank you. All right, if we could have the first proponent for the bill. We have a, we have a no props policy.

JENELLE HALLAERT: OK.

ARCH: I'm, I'm afraid to tell you that, but--

JENELLE HALLAERT: OK.

ARCH: All right.

JENELLE HALLAERT: Thank you for letting me know.

ARCH: Thank you.

JENELLE HALLAERT: And it was OK, if I remove this to enunciate?

ARCH: You can, you can feel free.

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JENELLE HALLAERT: [INAUDIBLE] more clearly. OK.

ARCH: Welcome to the HHS Committee.

JENELLE HALLAERT: Thank you. All right. Jenelle Hallaert, and I will spell that, J-e-n-e-l-l-e H-a-l-l-a-e-r-t. Good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Jenelle Hallaert and I am a founding member of the Nebraska Art Therapy Coalition, a grassroots team that's advocated for art therapy legislation since May of 2018. I'm also a full-time art therapist at the Open Door Mission, a homeless shelter in Omaha, Nebraska, and an adjunct professor for undergraduate art therapy at Concordia University Nebraska. I'm here today in support of LB325, which will be amend-- the amendments of AM22 will come into place, adopt the Art Therapy Practice Act. So at this time, no legislation protects Nebraskans by assuring their choice of art therapist is regulated using sound criteria, putting our consumers and businesses at risk for potential harm. LB325 safeguards consumers from harm by requiring the state to regulate the practice of professional art therapy through title protection and requiring industry standard educational supervision and examination requirements. So LB325 is asking for a couple of things, and I passed out an example of the testimony that I'm reading. And then on the second page, I wanted to give you a look at the document that we're asking to be included. So it's the certification, marriage and family professional counselor master, social work, and underneath we would hope to have our therapist certification. So the regulation-- so we're asking for regulation of the profession of art therapists through the certification process, something that's already been done before. We've seen it three or four times on that page, so that's what we're intention, is just to have a certification that mimics what's written for marriage and family, social work, professional counselors and the LMHP and LMI-- and the LIMHP application. So that's in order to distinguish the specialty of the professions. So art therapists would be required to get their licensed mental health practitioner license and then they could get the certif-- their certification. So there's two things there, OK? So this does not take away the use of art materials for other professions whatsoever. We actually encourage other professions like counselors and social workers and so on to use art materials within their competence. I know that can be something that's unclear for some other professions, but we just want to make sure it's very clear that other professions, please use art materials that's, that's important in

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healing. So art therapists are trained to use art media and the creative process specifically for appraisal and assessment of emotional, developmental, cognitive processing. And our training helps our clients utilize the art materials and the processes to increase awareness, practice self-regulation, process trauma, increase self-esteem. And the list goes on and on and on. And I was going to show you an art example of what that looks like. But if you're interested, it's here. So we'll hold off on that. I did want to say that the 407 process that we went through last year, I do have that if you're interested in reading more details about what our therapists do, our education, every single detail you would want to know, right here, we've got that. And then also the director's report did through the 407, I have that as well. And he did give us a recommendation to have this regulation. So this is a conversation that we've had and we're hoping that it will, will go well. I did want to clarify one more thing. In our levels of state regulation of health professionals, this is a document we can find on the 407 website, it does clearly state under state certification that state certification is always voluntary. The scope of practice is not restricted only to certified practitioners. Anyone may practice these acts without regulation of any kind. However, only the state-certified practitioner may use the distinctive title as specified in the act itself that identifies certified practitioners. So just again, another reiteration. Other professionals can use art materials, we just ask that they don't use the title art therapist or allude to art therapy because it's confusing to our consumers. Second is that we're asking for title protection again. Kind of went through that. Really, it is to reduce harm, bring clarity. As art therapists, we have a specialty and that's something that we want to share with the public. So with that, one more comment, just about how important, as we've seen in the 2020 COVID-19 myself as a practitioner, how important it is to have more mental health practitioners. So with that, I will say thank you.

ARCH: Thank you. So are there questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: I know we have a-- thank you, Chairman. I know we have a no-prop policy, but I am dying to know what is your prop that you--

JENELLE HALLAERT: Yes.

M. CAVANAUGH: Just tell us about it.

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JENELLE HALLAERT: Yes, absolutely. So I'll show you the big one because it's kind--

ARCH: You can't show it.

M. CAVANAUGH: You can't show.

ARCH: Just talk.

JENELLE HALLAERT: Oh, I'm sorry.

ARCH: Just talk about it.

M. CAVANAUGH: Just what--

JENELLE HALLAERT: I'll tell you about it. Sorry.

M. CAVANAUGH: Yes.

JENELLE HALLAERT: So what I did, so one of the assessments that we do is art therapist is called the bridge assessment. And so working at a homeless shelter, what I had this mom and daughter do was to create a bridge from one place to another. So what they did together, which was creating unity and working on their transition from homelessness to their home, is create a bridge. And they made a rainbow bridge from their old house to their new house and their dog was included so.

M. CAVANAUGH: Oh, cool.

JENELLE HALLAERT: It was a very, very powerful intervention for them to come together during that traumatic and tough time during homelessness. But now they have a home.

M. CAVANAUGH: Well, thank you for sharing that.

JENELLE HALLAERT: Yes, thank you.

ARCH: Other questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and thank you for being here.

JENELLE HALLAERT: Yeah.

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WILLIAMS: We rely, or at least I certainly rely heavily on the 407 process. In your judgment, is the 407 process matched in the legislation that's before us today, LB325? Does-- are the particulars that were asked for in the 407 included?

JENELLE HALLAERT: Yes, absolutely. Because there were many clarifying questions in that 407 process. And so we went through line by line, and yes, the amendments that we're proposing, same, same language, same things that were in the 407, yes.

WILLIAMS: That's what I wanted to be sure.

JENELLE HALLAERT: Yep.

WILLIAMS: Thank you.

JENELLE HALLAERT: Absolutely. Yep.

ARCH: Other questions? Senator Murman.

MURMAN: Yes, thank you, Senator Arch. And thank you for testifying. If someone, say, an occupational therapist or a psychologist or someone in their practice used art and, and said, well, we're going to use, let's try using some art therapy in our practice, and this person didn't have a license or a credential, what would happen in that case, do you know?

JENELLE HALLAERT: Well, if it was something that, that we knew about as art therapist, there is a process of reporting things like that. But honestly, as a person to person, I would probably go to that, that colleague or that person and say, well, we'd like to have you use the phrase: Let's use art in art therapy or let's use art in art practice. So there are disciplinary actions I know we can take as mental health professionals and within the health field, but really we're hoping it's just more word of mouth and that if this was to be enacted, that other professionals would start to understand, OK, maybe I shouldn't use the term art therapy because it's confusing. Let's just say that we're going to use some art supplies. We're going to use some art materials while we work together, something like that. If it was an ongoing thing, that could probably constitute some disciplinary action, but I don't think we would want conflict like that.

MURMAN: Thank you.

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JENELLE HALLAERT: Yeah.

ARCH: Other questions? Senator Hansen.

B. HANSEN: Thank you, Chairman Arch. Just a couple quick questions.

JENELLE HALLAERT: Sure.

B. HANSEN: Do you perceive that going down, going down this route might curtail maybe some people becoming art therapists, like would it increase the cost to become an art therapist, education, the certification process, the licensure, it will--

JENELLE HALLAERT: I actually think it will increase--

B. HANSEN: OK.

JENELLE HALLAERT: -- the possibility of, of people becoming art therapists. One reason is because we're having brain drain in our state, meaning that students like myself are going out to other graduate programs to, to get the career, and then they're not coming back because there's no certification. People don't know that we're a job that they could actually have. You know? So rather than curtailing, I think it would be a great, like, it would be, it would be great. Just I know my students that I have are interested in learning the process. So I think it would actually increase it and businesses would see, oh, art therapist, I could hire them as a mental health practitioner. That would be great. So I think it would increase it, yeah.

B. HANSEN: I usually just ask that any profession that looks to expand their scope of practice or get into licensure or become registered, because those are some of the unintended consequence, consequences we sometimes see of that.

JENELLE HALLAERT: Yeah.

B. HANSEN: Then all of sudden they, all of a sudden now this-- they have entire control over their organization and now they can kind of control like how much it's going to cost to get certified. So that's one of the reason why I asked that, just out of curiosity. So thank you. Appreciate it.

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JENELLE HALLAERT: Yeah, absolutely. Yes.

ARCH: Other questions? Senator Walz.

WALZ: I-- thank you, Senator Arch. I have a quick question. Thanks for being here.

JENELLE HALLAERT: Yeah.

WALZ: What, what kind of training is required for art therapy or to become an art therapist?

JENELLE HALLAERT: Yeah, so in order to become an art therapist, you have to have a master's degree, according to the American Art Therapy Association and the Art Therapy Credentials Board. So those are those national organizations. Right now in the state of Nebraska, anyone could say they're an art therapist because there's no certification, there's no regulation. But the association and the Art Therapy Credentials Board have created this system where, if you want to get certified at that level, you have to have a master's degree, you have to have at least 60 hours within that program. You have to have two, two or more internships, one with adults, one with children. And so there are also dual programs for states like Nebraska, where we would require art therapists to be licensed mental health practitioners and get their certification. So sometimes those programs are three years to get your master's degree. So it's very, very closely aligned with professional counseling, mental health.

WALZ: Thank you.

JENELLE HALLAERT: Yeah.

ARCH: Other questions? I guess I just, I have, I have one and I just, I just want to clarify.

JENELLE HALLAERT: Yeah.

ARCH: So do you have to, first of all, be an LMHP, LIMHP marriage and family social worker to get certification?

JENELLE HALLAERT: You apply for them both at the same time so--

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ARCH: So if you had an art therapy training program, master's or doctoral level, you would qualify to receive a licensed as what?

JENELLE HALLAERT: If it met the Nebraska standards for licensed mental health practitioner, then you would be able to qualify for that and then you could check mark that little box on the application that says, yes, I took all these additional art therapy courses, so-- and I took the exam. So I can also be a certified art therapist. So that's kind of the whole, the whole thing if that--

ARCH: So what is so what is not being proposed is a license as a, as an art therapist.

JENELLE HALLAERT: Correct.

ARCH: It is the certification that would come with a licensed as, as one of those other categories that you mentioned.

JENELLE HALLAERT: Yes, sir.

ARCH: Correct? But it isn't necessarily, I mean, I suppose you could have an LMHP, a current LMHP who goes out and gets additional training in art therapy and comes back and requests to be certified as well. That would be a possibility.

JENELLE HALLAERT: Yes, sir.

ARCH: OK.

JENELLE HALLAERT: Yeah, that was my route.

ARCH: Oh, was it? OK.

JENELLE HALLAERT: Yeah.

ARCH: OK. All right, thank you. That answers my questions. Any other questions from the committee? Seeing none, thank you very much for your testimony today.

JENELLE HALLAERT: Thank you.

ARCH: We would ask the next proponent for LB325, if they'd be willing to come forward.

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JEANNE TRIPLETT: Thank you for letting me be here.

ARCH: Welcome to the Health and Human Services Committee. And you can feel free to remove your mask if you'd like to. Or if you want to leave it on, that's fine too.

JEANNE TRIPLETT: Trying to slide up the chair.

ARCH: Yeah.

JEANNE TRIPLETT: My name is Jeanne Triplett, J-e-a-n-n-e T-r-i-p-l-e-t-t. Art therapy has been so helpful to me, and it was something that I had never knew that it had existed before. I had tried top therapy for over 30 years and it did not help me at all. But with the art therapy to help me face my real life issues, my PTSD and trauma, I've finally seen a breakthrough to healing. With ADHD, I have to hear, I had to see and I have to do to comprehend the whole picture. This artwork is like a-- the picture I wanted to show you, it's a representation of my spiritual journey through chaos, trauma and lies. Here I have been given a visual to see my life from childhood that led me to my bondage. But God was with me all my life and led me to art therapy, so that I could understand my past and be set free with the truth. I also did an art piece of weaving by using ribbon and yarn and embellishments, and that art therapy helped me to face losses from my childhood and rebuild my life as seeing it, as seeing it with my eyes, not just by words on a page. I'm able to process as I'm creating the artwork a visual symbol that opens doors to healing, taking off my rose-colored glasses a layer at a time, revealing reality where I had buried my life under a fantasy world. And that also helped carry me into an abusive relationship. So art therapy has given me new life where I had no hope before. Thank you.

ARCH: Thank you. Please wait just a second. We'll see if the committee has any questions, but thank you very much for coming today. Are there any questions from the committee? Senator Williams.

WILLIAMS: Thank you, Chairman Arch. And thank you for being with us today and appreciate having you tell your story. Were you helped in this journey that you talked about by a licensed person that had training in art therapy like we're talking about in this legislation?

JEANNE TRIPLETT: Yes, yes.

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WILLIAMS: Is that person here today?

JEANNE TRIPLETT: Yes.

WILLIAMS: Had that person testified already today?

JEANNE TRIPLETT: Yes.

WILLIAMS: Thank you.

ARCH: Great. Any other questions? Well, thank you very much for coming today.

JEANNE TRIPLETT: Thank you.

ARCH: The next proponent for LB325. Welcome to the Health and Human Services Committee.

SKYLER DYKES: Thank you. Good afternoon, Chairman Arch and members of the Health and Human Services Committee. Ms. Jeanne, you are a tough act to follow. My name is Skyler Dykes, spelled for the public record S-k-y-l-e-r D-y-k-e-s, I am interim executive director of Nebraskans for the Arts, a statewide nonprofit organization that has played an active role in the Nebraska Art Therapy Coalition since the group's creation in 2018. On behalf of NFTA, I would like to express our organization's support for LB325, the adopt the Art Therapy Practice Act. Two years ago, my predecessor, Doug Zbylut, came before this committee to testify in support of LB422, the original shell bill introduced by Senator Sara Howard. In his testimony, he shared anecdotes, including a story about the time he partnered with art therapists while serving as executive director of the Ronald McDonald House to address the trauma experienced by sick children and their families. This story and the others he shared underlying the fact that there is a growing need for art therapy statewide and nationally, and the unique positioning of art therapy to evaluate emotional, cognitive and developmental conditions. Recently, the United States Department of Defense recognized these facts by incorporating creative arts therapies into the FY 2020 and FY 2021 defense appropriations bills, specifically the William M. Thornberry Defense Authorization Act supported the use of creative arts therapies to treat service members with traumatic brain injuries and psychological health conditions, and direct-- directed the Secretary of Defense to submit a report to the health-- to the House and Senate Armed Services Committees detailing

the feasibility of expanding the creative arts therapies program. Currently, there are 30 art therapists engaged in similar work in our state. These mental health practitioners work in over 10 Nebraskan communities, including Grand Island, Wayne and Scottsbluff, just to name a few. Their practices range from working in prisons to cancer treatment, treatment centers and community health centers, as was previously stated by Senator Albrecht and Jenelle Hallaert, establishing a credential in art therapy in Nebraska would ensure that these practitioners are held to the highest standard of care, a change that would benefit all consumers of mental health services in Nebraska. Lastly, as Jenelle did, I would like to acknowledge that during the 407 review process, it was brought to our attention that certain language in the art therapy credential proposal might be interpreted to preclude mental health professionals from incorporating art materials into their practice, an implication that was absolutely not intended by our group. In response to this, Section 19, subsection (2) of the amendment you have before you today, AM22 was added. We continue to work with the Department of Health and Human Services, most recently meeting this morning with a DHHS program manager, legislative coordinator and attorney to reiterate that our intent is not to limit, restrict or exclude other professionals from using art or art materials as a part of their professional practice and to ensure that the language in LB325 cannot be construed as such. Our efforts are simply focused on assisting Nebraska patients and their families to identify credentialed art therapists that can aid in the clinical psychotherapeutic practice of utilizing art in mental health capacities. So with that, thank you so much for your time and I would be happy to answer any questions.

ARCH: Thank you. Thank you. Questions? Well, I have a couple.

SKYLER DYKES: Great, OK.

ARCH: OK, so how many training programs are there in Nebraska for art therapy?

SKYLER DYKES: I believe that there are two, Concordia University, and then I know-- is one of them. And through this process, we've learned of other programs that might be interested in implementing graduate programs in art therapy, and establishing a credential for art therapy would definitely inspire them, you know, encourage them to follow through with that graduate program.

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ARCH: And if, and if someone is not certified, if this bill were to pass and someone didn't have the qualifications work, you know, again, they use, they use art in their in their counseling or whatever their, whatever the therapy is they're doing it. They could still do that. They just, it's, it's that, it's the identification of an art therapist, right? Certified art therapist. Can they call themselves an art therapist without calling themselves a certified art therapist? Would that be allowed?

SKYLER DYKES: The language is specified in that Section 19, subsection (2). I think that we're trying to limit, trying to limit individuals from calling themselves art therapists generally, just to ensure, again, that the public is not confused, any consumers of mental health services are not confused as to the services that they're receiving.

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

SKYLER DYKES: Thank you so much.

ARCH: Are there other proponents for LB425-- LB325, excuse me? Seeing none, are there any opponents to LB325? Welcome to the Health and Human Services Committee.

SUSAN REAY: Thank you so much. Thank you for having me here today. Hello, my name is Dr. Susan Reay, I've been a social worker for over 25 years. My doctorate is an education and I'm a licensed independent clinical social worker. I'm an assistant professor at the University of Nebraska at Omaha, at the Grace Abbott School of Social Work. In addition, I have served on the Board of Mental Health Practice for the last 12 or 13 years or so, and I'm here as an opponent to LB325. I should say that my views that I'm sharing today are not-- are my own and do not represent the official position of the University of Nebraska. Additionally, the views I'm sharing today do not represent an official position of the Mental Health Practice Board. However, I can say in good faith that I believe that they would all agree with my testimony. I just didn't have time to gather everybody together. So I thought I could talk maybe a little bit about clarifying some statements about licensure and certification and title protection that might be helpful for the board and then talk about my specific points. So in Nebraska, we have a license for mental health practice, LMHP, and then we have a licensed independent mental health practice

license, which provides additional ability to diagnose and treat major mental illness. So we have that piece, then we have certifications. And those certifications are certified master social worker, marriage and family therapist and counseling. Of those certifications, only one actually has title protection, and that's social work. So the other disciplines do not have title protection as part of the certification process. Additionally, I wanted to clarify before I got started too, I think the senator had to ask about the alignment with the 407 process. I think there are a few differences with that, one of them being that the 407 excluded psychology and psychiatry from the, from their position. And I don't believe that this bill did do that. And I think there's some other things in there that aren't quite aligned. But I wanted to move on and talk a little bit about our role on the board and my role. We draft regulation, we assist the-- we review complaints against mental health practitioners, we provide recommendations to the Attorney General and Health and Human Services on discipline, and we advise on best practices. So my understanding of the revised bill today is it's about title protection. And currently, mental health practitioners can participate and use art therapy because art is generally seen as a modality, it's not necessarily seeing traditionally as a specific credentialed profession. If we're talking about this bill doing anything about reducing malfeasance or bad practice, that process is already established to address that through our complaint process through licensure. In my tenure on the board of 12 to 13 years, I've read every single case and we have not had any complaints about there being problems related to the use of art in therapy. There has been no complaints about that. So I want to put that aside and make sure that we're putting public protection at the forefront and not necessarily title protection as our main point of making more regulation and more statute. So while I really respect title protection, I just want to make sure that we're keeping focused on what the role of mental health practice is. And I'm going to summarize in three points essentially what I mean by that. So first of all, this legislation, legislation would eliminate mental health practitioners to call themselves art therapists. In my understanding and my work with the art therapists and the people championing this, I don't believe there's been a study that's been established to determine how many mental health practitioners that would impact, how many would not be able to call themselves art therapists when they're doing it now. And since we haven't seen any complaints about art therapists, I'm assuming unless, you know, there's people not

reporting bad things, that things are moving along fine and people that are calling themselves art therapists are doing, are doing good work. And so I think we need to establish that to make sure that we're not limiting practice of mental health practitioners. Secondly, this would allow for an appointment on our board, and our board is 10 members. And this is a very encompassing and also a very voluntary job where you do not get paid. We've discussed this bill at our board meetings for over a year. We've worked with-- I've talked to Senator Howard many times about it. I served as the liaison with the art therapists on this. Additionally, we've been following the 407 process and really thoughtfully in those meetings trying to tease out like, what does this look like? How does this impact people? Yet no art therapists have come to any of our meetings to discuss this with us, and I personally invited them to come and talk to the process about it. So to me, I would assume that if you're, if you're asking and requesting a position on our board that you would want to be a part of that process of seeing what the scope of that work might be. Our board is really struggling right now with trying to figure out how we're going to get these new regulations out, which we're so excited, we've been working on them for almost 15 years. Our 172 NAC 94 regs, which are going to make sweeping changes in some ways with mental health practice. And I want to make sure that we have that really focused and we have people on our board that are going to be participatory in that process. And thirdly, I think we need to look at some of the larger implications of what this will mean for mental health practice. So right behind art therapists, we have music therapists going through a 407 now. We have behavior analysts that have tried for several years to establish their own credential and title protection in the state. And honestly, I think the behavior analysts probably make the best case for it in terms of the specificity and the efficacy of their work, the research that supports their work with autism. Yet we do not have, you know, I think that we're going down this slippery slope of title protection for all, all these little subsets. It's adding more regulation onto an already, I think, regulated appropriately mental health practice. So while I appreciate the attention toward mental health conditions, I really do, I think we need some more time to collaboratively work together on the inte-- integration of what this will look like for all the interested parties and look at the larger implications of how we can meet everybody's needs here and do this efficiently and best for the community and public protection. Thank you.

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ARCH: Thank you. Thank you. Questions? Senator Murman.

MURMAN: Thank you, Senator Arch, and thank you for coming in. I do have a daughter that's got Rett Syndrome, that's on the autism spectrum. You mentioned that. We used, or we wanted to use music therapy when she was young. You know, we've had experience with a lot of these therapies. But I'm wondering, like, the difference between, like, say, music therapy and art therapy, you mentioned music therapy is not on the list here. You know, what, what do you look at as credential-- or the credentialing or the the reasons, I guess, that particular modality would be listed on this list?

SUSAN REAY: Yeah, thank you for the question. You know, I think there are so many specialty areas of mental health practice. And in Nebraska, we have a composite board. So it's not social work has their own board and marriage and everybody doesn't have their own, we're all together. I think that there are certain modalities, like as a mental health practitioner, I'm really good at treating people with eating disorders, but I'm not really good at treating sex offenders. So I think that we need to-- every mental health practitioner needs to determine what their scope of practice is and they need to stay in their lane with that. And then if you don't, then you get into a complaint or you're getting into areas where you shouldn't be practicing. So as a professional, practicing within your scope and making sure that you are trained in the best way to do it is, is the way that I think best practice is. So regardless if, you know, we have title protection for one and not the other doesn't necessarily mean one is more important than the other. It just means that, you know, these people want to be called this. And I think it's more of a guilt thing than it really is about public protection.

MURMAN: Thank you. Back at that time, we were looking for a music therapist and we couldn't find one in Nebraska, so that's part of my reason for asking. I mean, that would be a way of, you know, identifying a particular therapy that people might be looking for.

SUSAN REAY: I think there's so much new innovation coming around. And, you know, you, you and your family were at the forefront of determining, trying to try things out. You know, and now we have more information, we have more research to support it. Now we just do need, like some of the previous testifiers said, we need to get those practitioners in our state to make sure that everyone has that, which

is a separate issue than title protection. It's about making sure we have an adequate behavioral health workforce.

MURMAN: Thank you.

ARCH: Thank you. Other questions? Senator Walz.

WALZ: Thank you, Senator Arch. Thanks for being here today.

SUSAN REAY: Thank you.

WALZ: You mentioned in your testimony that you would look forward to more collaboration. Can you kind of talk about what that would look like or if you have ideas on how you could collaborate?

SUSAN REAY: Sure. Thank you. Yes, I, I've had a lot of contact with, with Skylar and I've had contact with our other testifiers as well. I think-- but I have personally. But I think the collaboration needs to be with more about understanding about mental health practice. So coming to our meetings is, is incredibly important because those are public meetings. You know, we want people to be involved. No one ever comes to the basement of the state office building and wants to sit with us for the day. We want more community collaboration. We love to have discussions about what this looks like. What are the implications for mental health practitioners? How many are there in the state? How can we figure that out? How do we determine what the need is? How many music therapists do we need? How many art therapists do we need? We need to know what those numbers are so that we can help to drive that and also to do education about what regulation is, what is mental health practice? What is a certification? People don't know this, consumers don't know this information and we are not doing enough, and my board included, to make sure that the community knows what that is.

WALZ: I would totally agree with that. So, and I'm sorry if I'm asking a question that, you know, I should know, but you sit on the State Board of Mental Health?

SUSAN REAY: Yes.

WALZ: OK.

SUSAN REAY: Practice.

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WALZ: OK, and when are those meetings held?

SUSAN REAY: They are every other month, I want to say on the first Friday of the month, I think. Sorry, I'd have to get my calendar out. And but they're public meetings and anyone can get on a list to have those agendas emailed them-- to them directly by emailing Kris Chiles. And those meeting agendas can go out. We are, they're sending out postcards to mental health practitioners right now, a lot about COVID. But we would love to have participation. We would love to have people there, and we'd love to collaborate with all of you on what we can do to make things better for the public.

WALZ: So if we just email you, you could get us [INAUDIBLE]?

SUSAN REAY: I will get you that for sure.

WALZ: OK, thank you. Thank you.

ARCH: Thank you. Senator Hansen.

B. HANSEN: Sorry, I probably should have asked this earlier. I don't know if you know it or not, maybe Senator Albrecht might. But how many other states and the United States do this? How many of them have title protection--

SUSAN REAY: For?

B. HANSEN: -- for art therapy?

SUSAN REAY: That I don't know.

B. HANSEN: I'm just curious.

SUSAN REAY: Yeah.

B. HANSEN: I should have said earlier. I may have missed that or something. So I was just kind of curious of how we would be falling in line with the rest of the states.

SUSAN REAY: I don't know the answer to that. But I can tell you, it's really interesting about specific, like school social workers. There are probably 18 states that have title protection for school social workers. There are different states that, it's kind of all over the

board. And I think it's so important on a national perspective that we start doing a lot more about reciprocity and about standardization and making sure that things are consistent across states for licensure because it's so complicated for licensees to understand, and even more so for consumers. So I couldn't speak to this specific with art therapists though.

B. HANSEN: Just curious.

SUSAN REAY: Yeah.

B. HANSEN: Thank you. Appreciate it.

ARCH: Thank you. Other questions? Seeing none, thank you very much.

SUSAN REAY: Thank you.

ARCH: Thanks for your testimony. Other opponents to LB325? Seeing none, is there anyone that would like to testify in a neutral capacity? Seeing none, we received one letter in opposition from Sarah Hanify on behalf of the National Association of Social Workers, the Nebraska Chapter; and two neutral Letters: Douglas Vander Broek on behalf of the Nebraska State Board of Health and Laura Ebke on behalf of the Platte Institute. So that will conclude the hearing for LB325.

WILLIAMS: [INAUDIBLE] close.

ARCH: I'm sorry. I'm sorry. I'm sorry, Senator, please. Thank you.

WILLIAMS: [INAUDIBLE].

ARCH: I just rolling here--

ALBRECHT: You did.

ARCH: -- and onto the next.

ALBRECHT: Well again, thank you for taking the time to listen to everyone. I was not around for these, for the history that I'd given you about this particular bill. So maybe some of you can enlighten one another. I'm not so sure if they obviously didn't include the state board in this decision making process. So if they didn't, my apologies to the doctor that was in opposition. And I understand with your

question, it's 30 states that do recognize the art therapy. And with that, if you have any other questions, I'd be happy to work with the committee and see what we can do to get this to the floor.

ARCH: Thank you. Other questions for Senator Albrecht? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here and bringing this. I think it was Jenelle Hallaert who mentioned copies of the 407. If she or someone else could get us copies, I think that would be helpful.

ALBRECHT: OK.

M. CAVANAUGH: Thank you.

ALBRECHT: Work on that.

ARCH: Other questions? I just have one, the amendment, that AM22, is that a, is that a major rewrite? I haven't had a chance to review the amendment versus the green copy.

ALBRECHT: I would say it is a major rewrite. There's lots of technical--

ARCH: OK.

ALBRECHT: -- issues that we had to talk with Health and Human Services about to make certain that everything was where it needed to be.

ARCH: OK, all right. All right, thank you. Any other questions? All right, thank you, Senator Albrecht. That will conclude the hearing for LB325. The next bill we'll hear will be LB211 and will be introduced by Senator Murman.

MURMAN: Good afternoon, Chairman Arch and members of Health and Human Services Committee. For the record, my name is Dave Murman, that's spelled D-a-v-e M-u-r-m-a-n. I represent District 38, which includes the counties of Clay, Nuckolls, Webster, Franklin, Kearney, Phelps and southwest Buffalo County. I come before you today to introduce LB211, which amends the Uniform Credentialing Act to to include the Reflexologist Registry Act. The purpose of this act is to ensure the health, safety and welfare of the public by providing for the accurate, cost-efficient and safe utilization of registered

reflexologists in the state of Nebraska. This act would create a reflexologist registry to be operational by September 16, 2021, and no person that's not a massage therapist shall engage in the practice of reflexology for remuneration in Nebraska unless such person is listed in the reflexologist registry. The practice of reflexology is different and distinct from the practice of massage therapy. As defined in Section 7 of LB211, reflexology means: services which are limited to the application of specific, specific pressure by the use of the practitioner's hands, thumbs and fingers to the soft tissue of the hands, feet and outer ears, and which are not designed or implied to be massage or massage therapy. Currently, those that wish to practice reflexology are required to obtain a credential to practice massage therapy. To do so requires an individual to pay around $20,000 for approximately one thousand hours of education in the massage therapy school, which unfortunately doesn't focus on reflexology. It's a major, unnecessary and expensive barrier to those who only wish to practice reflexology. LB211 requires successful completion of an examination given by one of the two national groups, the American Reflexology Certification Board or the Reflexology Certification Board, and document-- documentation of such certification. In comparison, 200 to 300 hours rather than a thousand hours are required, and the curriculum is reflexology specific. Furthermore, to maintain certification, evidence of good standing with the applicable board will need to be provided annually. Reflexologists completed the 407 credentialing process in 2018 for licensing, and the director of the Division of Public Health saw no reason for separate licensing. He stated, and I quote, The creation of a licensed reflexology profession in Nebraska is not necessary. However, I see no reason why reflexology should not become an independent profession separate from massage therapy. Most states recognize reflexology as a separate and distinct profession in its own right. I see no reason why Nebraska needs to be different in this regard, given that reflexology is arguably safe, safely, unregulated in most states, no physical harm or insurance claims ever reported, for example, it is difficult to justify Nebraska holding possibly the most arduous reflexologist licensure requirement in the United States and requiring training and licensure for massage therapy, in addition to training befitting reflexology. It is difficult to conceive of any treatment or approach more medically risk-free than reflexology, I end quote. Thereafter, I introduced LB347 in 2019 to exempt reflexologists from licensure under Massage Therapy Practice Act. The bill was advanced out of this committee.

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After floor debate, I proposed an amendment to provide for a registration process as a compromise position. Then COVID-19 hit. This bill, LB211 reflects that attempt at compromise. Rather than fully exempting reflex-- reflexologists from licensure, it provides for a registry. Please note that most of the country does not regulate reflexology at all. Rather than subjecting reflexologists to unnecessary, burdensome and irrelevant educational requirements, it focuses on reflexology-specific courses. Currently, Nebraska's require, requirements for reflexologists are the highest in the nation. Rather than creating barriers to employment, it helps people pursue their practice of choice and gets people back to work in this time of COVID. I thank you for your consideration of LB211, and I'd be open to question now. But I would defer to those behind me, and I'll answer questions again at the end.

ARCH: OK. Thank you, Senator Murman. Are there questions? Seeing none, thank you very much. At this time, we'll take the first proponent for LB211.

NICOLE FOX: Good afternoon.

ARCH: Welcome.

NICOLE FOX: Chairman Arch, members of the HHS Committee, I'm Nicole Fox, N-i-c-o-l-e F-o-x, and I'm director of Government Relations at the Platte Institute here in support of LB211, sponsored by Senator Murman. And so, as I've said multiple times, the state of Nebraska has the most burdensome licensing requirements for massage therapy in the country, one thousand hours at a cost of nearly $20,000. And in the state, if all you want to do is practice reflexology, not massage therapy, you must go through this training. And in this training, the curriculum provides very little, if any, instruction on reflexology. A much less burdensome path exists to practice reflexology. There are two very well-known national private certification courses that exist at only 200 to 300 hours, and the training is at a fraction of the cost. And 100 percent of that training is geared towards reflexology. Reflexology, as Senator Murman mentioned, is different than massage. They, the practitioner is only touching the ears, the hands, the feet. Nobody is disrobing. People have left Nebraska because they wanted to practice reflexology, but our laws were too burdensome. So they went elsewhere. They went to another state to live and work. We do have some providers in our state that provide services in secret. They

can't grow their business. They're very limited, out of fear of receiving a cease and desist order, out of fear of being charged with a felony. So LB211 provides a pathway so that people can practice openly, they can grow their client base, they can grow their business, and they can provide for themselves and for their families. Now, as far as how Nebraska compares nationally, you'll see the flip side of your handout, I've got a map with the states that do and don't regulate reflexology. And in a nutshell, 36 states don't regulate reflexology at all. Now, there are five states that have reflexology-specific laws and LB211 is mirrored after a couple of those states, Tennessee and Washington, where they have essentially a certification, registration type process. And that is what LB211 proposes. Now, if you look regionally, Nebraska is not competitive. Pretty much all of our neighbors, Iowa, South Dakota, Colorado, they don't they don't regulate reflexology. And also, as Senator Murman pointed out, in 2018, reflexology went through the 407 process. And the medical director did state that he did not feel that reflexology needed to be regulated. And this bill, as Senator Murman has pointed out, it has evolved. We had proposed LB347 as a result of the 407 proposal or the process. And just so you know, the Platte Institute did apply specifically for licensure, hoping to be turned down because people interpret the 407 results differently. They say that our application was denied or, you know, our request was denied, but we did that on purpose because we were trying to prove that it doesn't need licensure. So anyway, in the last legislative session we introduced LB347 and LB347 was to completely deregulate reflexology. The bill made it out of committee, as Senator Murman indicated. During floor debate there were some concerns raised and some ideas proposed, and that's why we have LB211 now. Senators felt that it did not need full-on licensure, as currently Nebraska law requires, but they felt that at least some minimal training and education would be good and maybe to establish a registry so we know who is here in the state and who is practicing. And that's what you see before you. You know, the other thing. So, you know, basically, this is a, this is a bill to try and allow a pathway for people to practice reflexology in the state and to earn a living, because as we all know, people are hurting right now with COVID. Lots of small businesses have closed, lots of people have lost their jobs. And I think it's really important that here in Nebraska we work to make sure that we're getting people, you know, getting people working, keeping people working so they can provide for themselves and their families. Now, before I close, I do want to talk

about a few things. It, you know, it has come to my attention that there are some concerns with this bill. And what I want to point out is our goal, really, I guess first and foremost is, is, is this committee OK with the idea of saying, hey, reflexologists, if all you want to do is solely practice reflexology, can we find a different pathway? Do you, you know, do we feel like it's reasonable to say we're going to decrease the education requirements and unless-- and at least let them pursue some private certification? It is not our intent to tell people that currently hold a license in massage therapy to say you can't practice reflexology. And so we know that the bill as far from a language standpoint, needs some work. That we're going to have to probably spell it out that this would be like an either/or-type situation. You either, you know, you want to do both massage therapy to reflexology and that pathway has already been established or you want to solely do reflexology, no massage therapy, so here's an alternative way to be able to do that. And so you can work in and establish your business. So we're happy to work with people on that. I also know there's concern that on the registry that we in the bill didn't spell out that the business name had to be included. I mean, our big thing was we wanted to say, you know, who the person was. This is how you, you know, you contact them. So adding a business name, we're OK with that. We're open to those, those types of tweaks. So with that, again, I just want to say this is a jobs bill. This is a bill that, that lowers the requirements, that makes it less burdensome to earn a living. And I, I urge the committee to consider this new proposed idea and to move this bill forward. And with that, I will conclude my testimony. And if anybody has any questions, I'm happy to answer them.

ARCH: Questions from the committee? Any questions? Senator Walz.

WALZ: Thank you, Senator Arch. Thanks, Nicole, for being here.

NICOLE FOX: Yeah.

WALZ: Who, who seeks out a reflexologist? Like what-- who who does it? Like, what are they trying to gain?

NICOLE FOX: Accomplish?

WALZ: Yes.

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NICOLE FOX: Or what benefits?

WALZ: Yes, thank you.

NICOLE FOX: Well, I can't speak for everybody, but as I understand in conversations I have had, either with, you know, people that want to practice or people that have pursued it, I mean, I think it's just kind of a general well-being. You know, they're not feeling well for whatever reason. You know, maybe it's fatigue or, you know, they're stressed. For some people I know, they have an ailment and they're kind of like, well, you know, conventional therapies have not helped. And so I'm going to do this because other things haven't helped or they're doing it as complementary medicine. I mean, I would say in all honesty, it's just like any complementary type therapy. They're doing it either in conjunction with something else to improve their health and wellness, or they're just doing it just to see if it, you know, to see how they feel afterwards that there's a benefit of, again, reflex-- relaxation or stress reduction.

WALZ: OK.

NICOLE FOX: So--

WALZ: And then how many reflexologists-- do you know how many we have in Nebraska or what the demand is for that?

NICOLE FOX: OK, unfortunately, I do not. And I think a lot of that has to do with the fact that they're concerned about getting a cease and desist order and those types of things. What I will say is that we really never know if a business is needed or a service is needed until we allow it to proceed, you know, whether it's reflexology or a, you know, a restaurant or some sort of establishment or some sort of service. You know, the market consumer demand is going to drive that. So, yeah, I wish, I wish I could give you a specific number. I know we get asked that every year, but we don't know.

WALZ: All right, thank you.

NICOLE FOX: Um-hum.

ARCH: Other questions? Seeing none.

NICOLE FOX: All right, thank you.

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ARCH: Thank you very much. Other proponents for LB211. Seeing none, are there any opponents for LB211? Welcome to the HHS Committee.

BECKY OHLSON: Thank you. Good afternoon, my name is Becky Ohlson, B-e-c-k-y O-h-l-s-o-n, I'm an LMT, a reflexologist and the current president of the AMTA Nebraska Chapter. We as a chapter have concerns regarding this bill. We are not fully opposed to the idea of a reflexology registration, but as written, we cannot support it. So the following are our reasons. The first is with scope of practice. As we read Sections 4, 5 and 8 on page 7, it seemed to remove reflexology from massage therapy scope of practice. Reflexology is a modality taught in massage schools, and many LMTs receive their certification through continuing ed to practice it. LMTs in good standing and certified to practice reflexology should not have to register separately or be required to pay to be on another registry when it's already within their scope of practice. In 2017, the Platte Institute initiated a 407 credentialing review program proposing reflexology to be removed from our law and scope of practice. All committees voted and recommended against approval of this proposal. Regarding Section 10, page 8, lines 6 through 9, lists specific certification avenues, which are the ARCB and the RCB to be able to register as a reflexologist. However, we believe this should be prescribed by the governing board, as it is with many other professions. It is especially important in emerging professions gaining recognition because the industry-accepted certification can change quickly. It would be beneficial to reflexologists for their governing board to have the ability to update acceptable certification options rather than going through the process to change statutes. In Section 10, also, it states the required information for registry application. We would like to see a business address and contact information be included within the application form. This is a simple precaution that can be added to assist in public safety to help the public know they are going to a registered facility, aids and preventing bad actors and eases the process for the board to follow up if issues arise. And our last concern is the absence of framework for students and schools. This lack of guidance leaves in question how a student can gain their education and if schools are allowed. Potentially a student can go out of state, but some certifications allow a mentorship or online learning at their own pace. This leaves a gaping hole for bad actors. If a school does open and no parameters are set, human traffickers can use this as an opportunity to open a reflexology school as a front.

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There is nothing in statute saying the state needs to know about the school or the unregistered practicing students who are working with the general public. We would like to see this either covered in the statute or for statute to allow the state governing board to provide the framework. If these issues are addressed, we could support this bill. But as written, we are in opposition. Thank you for your time and I'm happy to answer any questions.

ARCH: Thank you. Are there any questions from the senators? Senator Williams.

WILLIAMS: Thank you, Chairman Arch. And thank you for being here. If my memory serves me right when we started this process a few years ago, or maybe even longer than that, there was a significant gap between the proposals and where the massage therapists were coming in on this.

BECKY OHLSON: Correct.

WILLIAMS: It seems to me that gap has, has narrowed significantly. And would you say that, if given the opportunity, you could come to an agreement with the reflexologists to something you could support?

BECKY OHLSON: Yeah, we can. We can come to something. We just wanted to make sure, though, that it is within our scope. So all current massage therapists need to still have that ability to use it. I mean, I already do. So I don't want to have to worry about filling out another form and all that.

WILLIAMS: I understand that. The other side of that that I would ask, does, does that mean that the massage industry would be willing to recognize that a person that was only going to be performing reflexology could be licensed or registered, whatever term is--

BECKY OHLSON: Sure.

WILLIAMS: -- falls here with a different level of education and hours than a licensed massage therapist?

BECKY OHLSON: Yeah, yes. We would be--

WILLIAMS: So the 200 to 300 hours, in your judgment, because you, you do this, is that enough to protect public safety?

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BECKY OHLSON: I think they should be able to cover the, the subjects needed, the topics as far as human anatomy and kinesiology and pathology. I mean, all of that is kind of crammed together. I think, you know, as far as for me, you know, learning it more at my own pace, maybe you're at, you know, more of a yearlong program would be better. But, but yeah, giving the opportunity for these reflexologists would be good because it's another body work modality. So it's not like it's a whole new modality out there that we don't know about, but we want to know who they would be and if they would be licensed or registered. That helps us to know.

WILLIAMS: Thank you.

BECKY OHLSON: Um-hum.

ARCH: Thank you. Other questions? Senator Walz.

WALZ: I'm asking a lot of questions today. I'm sorry, Senator Arch.

ARCH: Quite all right.

WALZ: What was I going to ask? Oh, I'm curious about the hands-on training for reflexology as compared to massage therapy and the oversight or supervision of actual hands-on training.

BECKY OHLSON: Right. We have no idea how that happens.

WALZ: Does it happen for massage therapy?

BECKY OHLSON: Oh, yeah. With massage therapy, it would. When you're at a massage school or you do your continuing ed, then we have that hands-on work and it's supervised by either the instructor, you know, who came in to teach it or the instructors at the school.

WALZ: OK, but not that you know of for reflexology?

BECKY OHLSON: Not how it's proposed here.

WALZ: OK.

BECKY OHLSON: We don't know how they gain any of their education or who would be the supervisor. [INAUDIBLE].

WALZ: All right, thank you.

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BECKY OHLSON: So it's a good question.

ARCH: Other questions? Senator Hansen.

B. HANSEN: So there's got to be a reflexology school, right?

BECKY OHLSON: There are several around and-- but not in Nebraska. There's more like on Florida and North Carolina, more on the East Coast area.

B. HANSEN: OK, so, so they go to the school, they learn about reflexology,--

BECKY OHLSON: They can.

B. HANSEN: -- they get certified and they take the prerequisite courses that they need to, right?

BECKY OHLSON: Sure.

B. HANSEN: OK.

BECKY OHLSON: Yep.

B. HANSEN: So that just seems like the answer that-- Senator Walz's question, right?

BECKY OHLSON: Yeah.

B. HANSEN: Like, you don't know who-- like how do they get their training or--

BECKY OHLSON: Well they, so yeah, they could go out of state to get their training, if they want.

B. HANSEN: OK, yeah. OK. And I should maybe know this but you say you believe this should be prescribed by the governing board. Who makes up the governing board?

BECKY OHLSON: The massage therapy board they state in there would be their governing board.

B. HANSEN: So the massage therapists would be the governing board for the reflexologists?

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BECKY OHLSON: Um-hum. Yep.

B. HANSEN: Don't see the potential for maybe some ill will there for issues that they might want to control them quite a bit or--

BECKY OHLSON: I don't think so. I mean, I think if they're a true body worker, they're going to have the right ethical code of conduct, I guess you could say so. And maybe because I already do reflexology, so I, I don't think people are just going to use it for recreation or, you know?

B. HANSEN: Yeah.

BECKY OHLSON: Like, there's specific reasons that people would want to have a reflexology session. So if they have that true intent--

B. HANSEN: OK.

BECKY OHLSON: -- it would be fine.

B. HANSEN: I love both. I love reflexology and massage therapy so much that I just--

BECKY OHLSON: Yeah, me too.

B. HANSEN: And where did the human trafficking part come from? Is-- has there been a history of reflexology school opening up and there's human traffickers there?

BECKY OHLSON: Not so much with schools that we know of, but like the state of Washington and Nevada, both of them, they had reflexology unregulated for a while and it was used as fronts.

B. HANSEN: OK.

BECKY OHLSON: So that's why they are now regulated again.

B. HANSEN: That's what I was wondering. I'm kind of trying to see the tie there so.

BECKY OHLSON: Yeah.

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B. HANSEN: So here in Nebraska, they were trying to follow the same model, some regulation, some certification, at least just not having a free-for-all?

BECKY OHLSON: Correct.

B. HANSEN: OK, cool. OK, thank you.

BECKY OHLSON: Yep. Thank you.

ARCH: Other questions? Seeing none, thank you very much.

BECKY OHLSON: Thank you.

ARCH: Thank you for your testimony. Other opponents for LB211? Welcome to the Health and Human Services Committee.

STEVE CARPER: Thank you. Excuse me. Thank you, I haven't been talking, so now I've got a frog in my throat here. My name is Steve Carper, S-t-e-v-e C-a-r-p-e-r, and I represent the Massage Therapy Board. I gave out or submitted a copy of my statement. You know, some of the things have already been addressed, some concerns that we've heard addressed by Ms. Fox. With massage therapy, the-- our point of view with reflexology, you know, we look at the definition of massage therapy: the physical, mechanical or electric, electrical manipulation of soft tissue in a therapeutic purpose for enhancing muscle relaxation, reduce stress, improving circulation and instilling a greater well-being. You know, we heard the definition of reflexology, a lot of similarities. Manipulation of soft tissue, isolated or specifically for the hands, the feet, the earlobe for well-being. Some of the-- why, why do they go in for reflexology? For relaxation, you know, stress. You know, a lot of similarities to massage. You know, with the-- and I'm kind of going away from my statement just because it would be a lot of repetition here. So, you know, some of, you know, eliminating it from scope of practice has been addressed that they're, you know, looking at changing that, which is good. One thing, the arguments about reflexology of, you know, the somebody that wants to do reflexology has to go through massage school. You know, that, that is currently the way it is, $20,000 is a little exaggerated. You know, taking off my board hat, I'm also a school owner. We charge $9,000. So a big difference. Still a thousand-hour program and such. With the 401 [SIC], yes, the director did make the comment that Senator Murman

stated. But it went through the technical committee, it went through the human-- Health and Services Committee and then went to the director and he agreed that, you know, licensure was-- or exempting and then licensure is not the case. You know, that it's not what's needed. It's already regulated. Some of the other things, you know, it is offered right now. The way that we see reflexology is that it is a continuing education certification. Any massage therapist, you know, they get training on reflexology, lymph drainage, neuromuscular therapy, a variety of different modalities in massage school. It's an introduction to those different avenues that students can go down once they get their license, their initial credential to be a massage therapist. Many of those are the same way. Neuromuscular therapy, 200 hours. You go take these 200 hours of education, you pay a fee, now you can call yourself a certified neuromuscular therapist. Same thing with neuralreset therapy, lymphatic drainage. You know, if we open the door for reflexology then we're opening the door for all these other modalities of massage to do the same thing. You know, as a board, we see reflexology as a modality. It's a type of massage. It's a tool in your toolbox. You get that training, you have somebody come in. Maybe some of the other therapies that you're doing are not working, the person is not responding well. Or maybe there's issues why you can't work on somebody's back or legs, but they will allow you to work on their feet, their hands, so you can work those reflex points to, in-- or to have an effect on those other body parts without having to touch that area. You know, it could be trauma-related or what have you, you know? So reflexology is needed and but it's, it's already in there. You know, massage therapists, you go to school and then you get that added certification, just like I mentioned with neuromuscular therapy, lymphatic drainage, myofascial release, cranial sacral. Any one of those, Reiki. It's, you know, we're giving base education, the foundation of education, which covers the anatomy, not just the anatomy of the feet, the hands, the earlobes, because reflexology affects the whole body. It affects circulation, the nervous system. So they need to have that comprehensive education, that foundation, in order to provide reflexology in a safe way. So I apologize for kind of going off my statement here and things, but I just wanted, you know, since a lot of these issues have already been addressed, I wanted to just kind of hit some of the questions that were answered here, too. So for those reasons, the board does not support LB211 as written here. And I'm going to cut time a little short here to answer any questions.

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ARCH: Thank you. Are there questions?

WALZ: I have one more, just one more. I'm just curious of the cost to the consumer when-- the difference between the cost to the consumer regarding a massage therapy session and a reflexology session.

STEVE CARPER: Cost to the consumer, you know, that's up-- most therapists, therapists that I know, it's very similar. You know, they charge, you know, it's $60 for an hour massage. If they do an hour of reflexology, you know, a lot of times it's half-hour reflexology treatments, so it might be $30. So it would be kind of comparable to whatever they're charging. There are some that do-- that may charge extra, but I don't know of any offhand.

WALZ: All right. Thank you.

ARCH: Other questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch. And thank you, Mr. Carper, for being here. I want to go down the line of questioning that I had with the previous witness a little bit about trying to find a middle ground that has moved. And I'm sensing from the Massage Therapy Board there is, appears to maybe be less room to move. But if, if the legislation was clear that reflexology could still be a modality performed by massage, licensed massage therapists, would you still be opposed to a registry that required licensing or credentialing or education of some type for a reflexology license that would only limit them to that area? I want to try to get specific with that.

STEVE CARPER: OK, if, if this bill goes through and passes, then, you know, we would have to as a board, we would have to implement the procedures there to be able to set up that registry. So we would follow that, the bill, you know, as passed. As a board, we don't think that there's a need for the bill because it's already part of massage therapy. But if it does pass, then we would, you know, we would have to, you know, set that up, the registry, and, and, you know, enforce, you know, any rules that are along with that.

WILLIAMS: OK, thank you.

STEVE CARPER: Um-hum.

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ARCH: Other questions? Seeing none, thank you very much for your testimony.

STEVE CARPER: All right. Thank you.

ARCH: Are there other opponents to LB211? Seeing none, is there anyone that like to testify in a neutral capacity? Seeing none, Senator Murman, while you come up to close, I just want to mention that we received 23 letters in support from indiv-- primarily from individuals and one neutral letter, which was from Douglas Vander Broek on behalf of the Nebraska State Board of Health.

MURMAN: Thank you for considering this bill and conscientiously listening. As I previously stated, this bill, LB211, reflects a compromise from last year's LB347, which is-- which this committee advanced. Rather than fully exempting reflexologists from licensure, it provides for a registry. Rather than subjecting reflexologists to unnecessary, burdensome and irrelevant educational requirements, it focuses on reflexology-specific courses. And rather than creating barriers to employment, it helps people pursue their practice of choice and gets people back to working in this time of COVID. With regard to the concern about massage therapists wanting to practice reflexology, my primary intent with this bill is to create a pathway to allow reflexologists who solely want to practice reflexology a less burdensome avenue. If it's necessary, I'm agreeable to amending the bill to provide for two pathways for practicing reflexology, the first being the certification and registry process that LB211 proposes and the second being the current path where one must complete licensure requirements for massage therapy, for massage therapy. I'm also willing to work on some of the technical changes if needed so this bill can move forward, forward. Just to answer a few of the questions that were kind of brought up there, or concerns, you know, a person can, I assume, get their certification for to be a reflexologist online. You know, there's no-- it doesn't, this bill doesn't address that. You know, more and more things are being done online now in the time of COVID. So they could certainly do that. The only thing they have to do is be certified by the two boards that I mentioned, and that's the American Reflexology Certification Board or the Reflexology Certification Board. It's a job development bill. My daughter lives down in Fort Worth, Texas, and just driving around there, there's strip malls all over the place there. And just about every one of them has a reflexologist sign out in front of one of the stores in the

mall. And I'd just like to say that reflexology is an ancient art that's been around for thousands of years, unlike some of the other modalities that might have been mentioned under massage therapy. So I appreciate your attention. And I'll take any questions if anybody has any more.

ARCH: Any questions for Doctor-- Doctor-- for Senator Murman.

MURMAN: There are Dr. Murmans, but it's not me.

ARCH: The [INAUDIBLE] there. All right, seeing none, thank you. Thank you very much.

MURMAN: Thank you.

ARCH: And this will close the hearing for LB211. And the committee is going to take a 10-minute break. And we will resume at 3:10.

[BREAK]

ARCH: OK, we are-- we will now be hearing LB14. Senator Blood, you are presenting the bill. You may proceed.

BLOOD: Thank you. And good afternoon again, Chairperson Arch and to the entire Health and Human Services Committee. My name is Senator Carol Blood, spelled C-a-r-o-l B- as in boy, l-o-o-d as in dog, and I represent District 3, which is composed of western Bellevue and southeastern Papillion, Nebraska. Thank you for yet another opportunity today to share LB14 with all of you and to those listening in on today's hearing. So when it comes to licensure, navigating the various state licensing requirements, the regulations, rules and fee structure can be very challenging, especially to our military spouses who move approximately every two years from base to base. Unlike universal reciprocity, that only allows for someone to enter our state and get to work, interstate compacts allow for, excuse me, these same military spouses to move from state to state and practice across state lines unencumbered. These compacts create reciprocal professional licensing practices between states and ensure the quality and safety of services and safeguards each safe-- and safeguards each state's sovereignty. There are over 40 states and territories who adopted at least one of the nine available occupational licensure compacts, and there are more to come because of their high level of success. It is something each individual industry has enthusiastically supported and

helped to create. I've included an updated map that shows where Nebraska and other states stand in this process. It's in your handouts. I'd also like to point out that this is not an interstate compact versus universal reciprocity issue. States have both because they serve different purposes. And I'll walk you through some of that when I present tomorrow's LB15. All regulatory interstate compacts are certainly not alike. However, the professions of medicine, nursing, psychology and physical therapy are great examples of effective compacts that Nebraska has chosen to support. Medicine constructed its compacts to address expedited licensure, while nursing, psychology and physical therapy compacts create a multistate license. Nebraska reaps the benefits as a member of these and other interstate compacts. Now I'm hoping to have another compact move forward here in Nebraska for audiologists and speech language pathologists. In Nebraska, we have nearly 200 licensed audiologists, which equates to about 9 audiologists for every 100,000 people. We have 1,285 licensed speech language pathologists, which is about 67 for every 100,000 Nebraskans. An audiologist is the one who diagnosis and treats a patient's hearing and balance problems using advanced technology and procedures. The majority of audiologists work in health care facilities such as hospitals, physicians' offices and audiology clinics, and some work in schools. Speech-language pathologists, you may know them as speech therapists, assess, diagnose, treat and help to prevent communication and swallowing disorders in children and adults. Speech, language and swallowing disorders result from a variety of causes such as stroke, brain injury, hearing loss, developmental delay, Parkinson's disease, cleft palate or autism. As you read in the bill, the purpose of the Audiology and Speech Language Pathology Compact is to increase public access to audiology and speech-language pathology services by providing for the mutual recognition of other members' state licenses to enhance the state's ability to protect the public's health and safety, encourage cooperation of member states in regulating multistate audiology and speech-language pathology practice, supports spouses of relocating active duty military personnel, enhance the exchange of licensure, investigative and disciplinary information between member states, allow a remote state to hold a provider of services with a compact privilege in that state accountable to that state's practice standards, and allow for the use of telehealth technology to facilitate increased access to audiology and speech-language pathology services. Long list. Each state participating in the compact will not cede any regulatory autonomy.

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Nebraska will continue to regulate the actual practice of audiology and speech-language pathology and maintain their individual scopes of practice. Upon review of the state participation section, you should note that the requirements must be met by states to join the compact are very clear and state the professional must hold a home state license in a compact state, participate in FBI fingerprint-based criminal background check, and meet the licensure requirements noted in the compact. This has been a standard in all of our compacts here in Nebraska. When a participant gains a privilege to practice, they may only have one home state license at a time, for that is all they will need as a member. The privilege to practice is renewable upon the renewal of the home state license and they must function within the laws and regulations of the remote state. If the home state license is encumbered, the licensee shall lose the compact privilege in all remote states until the home state license is no longer encumbered and two years have passed since the adverse action. Active duty military personnel or spouses may designate a home state where the individual has a current license in good standing. The individual may retain the home state designation during the period the service member is on active duty. Now, I want to be clear that nothing in the compact will override a compact state's decision that an audiologist or speech-language pathologist participation in an alternative program may be used in lieu of an adverse action, and that such participation shall remain nonpublic if required by the compact state law. The home state may take adverse actions against an audiologist or speech-language pathologist's license. A remote state may take adverse action on audiologists or speech-language pathologist's privilege to practice within that remote state. Compacts create an extra layer of protection where the participating states can share a provider disciplinary actions to protect consumers and those organizations that may hire a potentially problematic employee. They do this through their shared database. Additionally, the compact clearly addresses the obligations of the home state, obligations of the member states, how adverse actions are resolved, and compact funding and governance. Also, if you are currently licensed in your state to practice, you are not mandated to expand your license beyond that and are not forced to join the compact. The compact is an optional tool for those who choose to partake in the benefits of the compact. So in a nutshell, this compact creates a mechanism that allows the legal, ethical and regulated practice of interstate prac-- and regulated practice of interstate practice by granted qualified audiologists and

speech-language pathologists the privilege to practice in other compact member states. It allows for telehealth to be practiced in member states. It allows for increased access to underserved communities and gives our military personnel and spouses a means to maintain the profession when relocating. I will note that this bill is also on the yearly priority list that we receive from the Department of Defense Military Community and Family Policy Office to help our state continue on the path to becoming the leader in military-friendly policy. On a broader scale, the DOD entered in-- entered into a cooperative agreement with CSG to assist with the funding of the development of interstate compacts on licensed occupations in order to alleviate the burden associated with the relicensing by spouses of members of the armed forces in connection with a permanent change in duty of members to another state. This investment, and it was a large investment, by the department towards what we're trying to do with these compacts is going to continue to remove hurdles and red tape in dozens of professions over the next few years. There's actually a story in this month's issue of CSG that highlights this relationship. I've given you a copy today for your perusal so you can learn more about it. So while this compact is not yet active, many states are rushing to put it into effect. There are currently six states that have enacted this particular compact. They are Wyoming, Utah, Oklahoma, Louisiana, North Carolina and West Virginia. When 10 total states adopt it, the compact will officially go live. With Washington, Oregon, Colorado, New Mexico, Kansas, Minnesota, Iowa, Wisconsin, Indiana, Kentucky, Georgia, Maryland and New Hampshire, all considering similar bills to LB14, it's certainly a possibility that this may be enacted by the end of this year. Had we done this last year when it was first presented, we would have been the first in the compact, so in that short window of time, six states have already passed this compact. That's pretty remarkable. So in other words, things are moving quickly and we should get in on that action while the getting is good. I'll also point out that because this is far from the first compact bill that I've brought, I know some of the questions that might arise. Chief among those is whether or not states that border us are interested in participating. And that's usually Senator Williams' question and now he's not here for me to tell him, so. I'll again point to Kansas, Iowa and Colorado, who are all considering joining up, and Wyoming having already adopted it. There's two final quick points I want to make on this bill. The first is that I'm sure you'll all agree that the state is going to be in a bit of a budget

crunch in this biennium and likely a few years beyond. Let me assure you that joining this compact is not a costly endeavor. If you look at something like the physical therapist compact, the fiscal note was approximated at just $2,000 every two years. That is absolutely a small price to pay for legislation that allows workers to hit the ground running when they move to Nebraska or to generate additional revenue by utilizing their skills in other states in person or via telemedicine. This means more money for the state coffers and a better quality, of quality of life for those generating the dollars. Remember as well that during a natural disaster, mass emergencies and other large events that we often need our workers in different medical fields to help and respond in, in other states as well. There's no downside to these compacts and, and one of the many reasons that the Department of Defense has so heavily invested funds in their creation. There are more to come in the future, as I've sat in on many of those meetings. With that, I'll close by saying licensure, licensure is a constitutionally-- is constitutionally a state power. So let's work together and move this voluntarily-- and move this voluntary expedited pathway forward and facilitate multistate practice here in our state, along with what will soon be a total of 10 states to implement this compact. I'd be happy to answer any questions you may have, and I do plan on staying for closing. But I do have folks here to testify, so you may want to allow them to speak, knowing that some of your questions may be answered through their testimony. I also did bring an amendment you should all have in front of you as part of the packet I handed out, that would need to be adopted before LB14 could be moved to the floor. This is mostly just harmonizing language that was approved with the compact people. There's also some immunity language from the trial attorneys that they asked us to insert in the compact. People are good with that language as well. We actually did that with all the other compacts we've brought forward here in Nebraska. And finally, in your handouts, I did offer several letters of support from John Wyvill of Nebraska Commission-- who is a Nebraska Commissioner for the Deaf and Hard of Hearing, and Kirk Peck. As we continue to iron out the process for getting these letters submitted in time for the hearing, these two came after the deadline. But I thought they were important to have included in the record. So I hope we can have that happen. And with that, I will close for now. And thank you all.

ARCH: Questions? Senator Walz.

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WALZ: Thank you, Senator Blood. Very quickly, if Nebraska and Colorado would join the compact--

BLOOD: Um-hum.

WALZ: -- does it also mean that somebody who's practicing in Colorado could provide services to someone in western Nebraska?

BLOOD: If indeed they were part of the compact? Yes, absolutely. One of the things that I always remember from the psychology compact that we did is that psychologists told me that if they had a patient that would go on vacation, perhaps in another state, and they would have-- maybe they were dealing with anxiety issues and needed to speak, they couldn't do it legally over the telephone. But with the interstate compact and with the telehealth part of it, they can now not only communicate with them across state lines, but anything that they do across state lines as part of the compact, if that state belongs to it, is now legal. So you can imagine how the ease that it creates for people who need to practice in multiple states, not to mention the income generation, the extra income they can generate, right?

WALZ: All right. Thank you.

ARCH: Further questions? I do have several questions and I, I'll pose some of them and I'll hold some of them, but--

BLOOD: OK.

ARCH: You mentioned that we did hear this bill last year--

BLOOD: Um-hum.

ARCH: -- or something similar. And, and the Department of Health and Human Services came in in strong opposition. Did you have discussions with the department to resolve some of those issues?

BLOOD: To be very frank, and that person is no longer in that department, there seemed that-- the only opposition they truly had, so I don't know if strong opposition is the right word, last year is they didn't want us to be first in the compact because they felt that it was the unknown. But with all due respect, every single compact is basically the same. And he thought that there might be these outrageous charges as the first in the compact because we would not

know how much it was going to cost the state of Nebraska, and that's what we were told was the biggest issue for them. But if you think about it, if you're in Nebraska, Colorado, Iowa, Kansas, and you join a compact as a person that's representing your state, are you going to say, you know, I know that we usually have it be $2,000, but I think it should be $20,000? I mean, with all due respect, that makes no sense. Why would these states come in and want to charge more than what's been traditionally done across the United States with every single compact?

ARCH: I appreciate that. I went, I went back and retrieved the letter that he provided for testimony last year, Darrell Klein, and there were other, there were other issues. But at any rate, that, that was one of questions.

BLOOD: With all due respect, we have met with HHS and they have, they had a couple of questions, but no issues.

ARCH: OK.

BLOOD: And I think, again, it was a difference between understanding what a compact really did and how it worked--

ARCH: OK.

BLOOD: -- and not meeting with us on those issues prior.

ARCH: OK, do-- another question. The other states that are implementing this--

BLOOD: Um-hum.

ARCH: -- do they, are they required to use the exact same language?

BLOOD: Um-hum.

ARCH: So that's, that's a requirement.

BLOOD: Um-hum.

ARCH: This language is, is the language used in all the other states that are implementing this compact.

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BLOOD: I mean, there are exceptions. For example, when they come to Nebraska, we always have the immunity language that's added. But when it comes to actual working mechanisms, and there are people behind me that can better explain this than I. But when it comes to actual mechanisms that allow the bill to function, those don't change and they don't change because it's something that the states have all gotten together on and agreed upon.

ARCH: OK.

BLOOD: So there's no in-fighting about it.

ARCH: Right. Yeah, it's just whether or not, you know, this, and this, I recall this as a question from last year, state law versus compact, which, which rules. And of course, this would become state law. For, for instance, there's reference to telehealth, one of the things I'm very interested in, obviously, and, and it's, it's fairly broad. Audiology can use telehealth for all services, all services are allowed with audiology. We have in other, in other statutes, other language, we have restrictions as to what can and cannot be used and that type of thing. So what--

BLOOD: You just answered your own question because, because if you look at the compacts you'll see, and Janet is, is better informed on this than I, but whatever your rules are in your state, you still follow the rules in your state when it comes to things like that. Those don't change.

ARCH: OK, so a blanket statement on telehealth doesn't mean--

BLOOD: Right.

ARCH: -- doesn't mean that. OK. All right, very good.

BLOOD: And good question, though.

ARCH: OK, I'll hold my other questions and I'll listen to your testimony, but thank you. Thank you very much.

BLOOD: My pleasure.

ARCH: OK, any other questions? Senator Cavanaugh.

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M. CAVANAUGH: Sorry, and I apologize if this was already asked or answered, but we're making a change from licensing board to commission. And this is so that we can have people practice across state lines if they move here. So for like let's talk about our military personnel. When we've, we've had bills in the past to, I think we had a realtor bill last year to make it easier, how does the military feel about switching to a compact model?

BLOOD: So if I hear you correctly, are you talking about the difference between universal reciprocity?

M. CAVANAUGH: Yes.

BLOOD: OK.

M. CAVANAUGH: Yeah, sorry.

BLOOD: Hang on, I think I have some notes. I just want to make sure I stay concise. I thought some one might ask me that. All right. So let's talk very briefly about the difference between universal reciprocity and interstate compacts. And these notes are from a meeting that I had with the military families office from the Pentagon. So this does come directly from the people who have invested very deeply in these interstate compacts and why they are concerned about states having only universal reciprocity and not both universal reciprocity and interstate compacts, because they can cohabitate and serve different purposes. So both of them require that a practitioner abide by the scope and practices of the state, which we just talked about, in which they're practicing. Both of them allow for exspeedy-- expeditious interstate movement of practitioners during emergencies, and both of them reduce barriers for out-of-state practitioners aiming to practice in our state. However, that's the only time that they're the same. So interstate compacts, unlike universal reciprocity, reduce barriers for in-state practitioners aiming to practice in multiple states. It allows military spouses, Senator Cavanaugh, to maintain a single home state license for the duration of the service member's active duty, regardless of relocations, without submitting a separate application to each state's licensure board. It allows practitioners to work in multiple states, both in person and via telehealth or telework, without submitting a separate application to each state's licensure board, requiring a verification of the current license or obtaining a new background check. It brings together a coalition of

states, of states to establish a uniform and enforceable interstate licensure standards that are narrowly tailored to the public protection requirements of a specific profession. It enhances public protection by creating a multistate database of licensure information to facilitate collaboration on license verification and investigations of potential misconduct. And that one's really important. This shared database, if you're an ne'er, ne'er do well and say that, for instance, that you're a pedophile and you've been busted in your home state, that's going to go into the database. Right now, that database doesn't exist. And what we're seeing with people that are ne'er do wells in that area is that they tend to find ways to go to other states and start practicing again. And so that shared database alone is so valuable and protects the people who are hiring these bad guys, right? Because you don't want to be sued to find out later that this person does the same thing in your state. And then it allows multistate practice without requiring the practitioner to change state of residence, with a few exceptions on that one. So Iowa and Arizona's universal recognition law requires that the practitioner resides in the state, while other states like Colorado and Idaho do not. So that was kind of a sometimes yes and sometimes no. But the previous one, two, three, four or five things that I stated are all only within the interstate compact. So, for instance, if I live in Nebraska and I'm and audiologist and I get my license and I have no desire to practice across state lines, I don't have to join the compact. But if I live, say, in Bellevue and I want to be able to practice in both Council Bluffs and Bellevue in Omaha, I have the ability once Iowa joins that compact to not have to get a second license. So it's really a very wonderful thing. What it does basically is it not only embraces what the Governor has said in his State of the State Address that he wants to do for military families, but it kind of puts it on steroids.

M. CAVANAUGH: Thank you.

BLOOD: Thank you for the question.

ARCH: Other questions? Seeing none, thank you very much and we'll let you close in a little bit.

BLOOD: Thank you.

ARCH: Are there proponents for LB14 that would like to speak? Welcome to the HHS Committee.

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JANET SEELHOFF: Good afternoon, Chairman Arch and members of the Health and Human Services Committee. I'm Janet Seelhoff, J-a-n-e-t S-e-e-l-h-o-f-f, I serve as executive director for the Nebraska Speech-Language-Hearing Association. I am testifying on behalf of our audiologists and speech-language pathologists across the state that are members of our association. And we want to thank Senator Blood for all of her leadership and great work on this important legislation. I have also handed out to you, in addition to a copy of my testimony, a letter from Senator Molly Baumgardner with the Kansas legislature. As Senator Blood mentioned, Kansas is also in the process of working to get their audiology speech-language pathology compact passed. And she wanted to share a letter of support with you as well. And in turn, we are doing the same for the Kansas legislature. I want to make sure to note that the practice of ideology and speech-language pathology occurs in the state where the patient, client or student is located at the time of service. And this does include telepractice, that's the terminology we use for telehealth for our members. It's also important to emphasize that anyone wishing to practice in Nebraska is accountable to the practice standards in our state, as Senator Blood has highlighted. And the same would be true for anyone wanting to practice in other states that join the compact. Our state association has worked very closely with the American Speech-Language-Hearing Association known as ASHA to help ensure that this legislation meets the requirements of an interstate compact. We support this legislation as a measure to make sure it's easier for audiologists and speech-language pathologists to be able to practice in Nebraska. And honestly, top priority is always making sure that there's access to speech-language-hearing services for Nebraskans, and particularly in the rural areas of our state, where we often see the shortages and the challenges. And telehealth is a, is an integral and important part of this compact to help make that happen. I've listed in my testimony the types of services our members provide. I won't read those for you. I know many of you are already familiar with that. As I mentioned in my testimony, we do have a shortage of audiologists and speech language pathologists in our state. And so this compact really does help address that. And it allows an employer to hire a candidate if they're available and they have met the competency requirements. It also helps expedite that hiring process, and speech language pathologists do still have to receive certification and must complete their continuing education requirements every two years in our state to maintain certification. We also have a requirement in our state that some

states don't have that, if you're a speech language pathologist working in the schools, you have to maintain a teaching certificate in Nebraska. So if someone did want to come in as part of our compact and they want to teach in the schools or work in the schools, they do have to have that teaching certificate. I primarily just want to answer questions that we've been asked, Senator Blood has already addressed some of them. So I won't repeat some of those that I've got in my written testimony for you. The first question we've gotten quite a lot is how will our state ensure that audiologists and speech-language pathologists comply with Nebraska's licensure requirements? And the answer is that, that anybody that resides in Nebraska must continue to comply with our state's licensure requirements. They must complete the continuing education requirements every two years to maintain their certification. And as I mentioned, a teaching certificate. How will the compact communicate across state lines with telehealth services? And the answer is that the compact itself only requires that telehealth be allowed. The practitioner needs to be aware of the laws, regulations in the state where they provide services, and the compact commission will compile links to the board's laws, regulations and post them on the website so that states can easily find that information. Another question we've been asked is how will our state be able to verify that an audiologist or speech-language pathologist has-- coming into our state is eligible to practice under the compact? And the answer is that every applicant seeking privilege to practice does need to present proof of authorization from a member state. Senator Blood-- Senator Arch, I know you asked if we did try to meet with DHHS. Our association did reach out to them on numerous occasions, did not receive any response, but we did try to also address past concerns that they had. And Senator Blood also addressed the cost of the compact, so I won't reiterate that for you. But I'll just stop with that and be happy to answer any questions that you might have.

ARCH: Questions from the committee? Seeing none, thank you very much for your testimony.

JANET SEELHOFF: Thank you.

ARCH: Are there other proponents for LB14?

TONI MOREHOUSE: Senator Arch and fellow members of the Health and Human Services Committee, good afternoon. My name is Toni Morehouse,

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T-o-n-i M-o-r-e-h-o-u-s-e, I have been a speech-language pathologist for 47 years. I own Communication Works, a private speech and language clinic here in Lincoln. Over the decades, demand for services has increased and my profession has grown to meet those needs. One significant adaptation is the use of technology. Nebraska has a scarcity of speech therapists and audiologists, and especially in rural areas. The licensure compact would increase access to services across our state via telehealth. I would like to share a few examples of how several therapists at Communication Works have successfully used technology to deliver virtual services. Lindsey Wilson, an early intervention specialist, was serving a preschool client who has autism. When the family moved, interstate collaboration allowed Lindsey to provide this child with two months of therapy, bridging the gap while the child waited for in-person services in her new community. Lindsey had another young client whose family temporarily moved out of state. Due to COVID, the family was not comfortable finding a new therapist. They requested, and their child began receiving online therapy with Lindsey. Without the advantage of interstate telehealth, this child would not have been served in any capacity. Paige Leising began seeing a young professional whose initial job required public speaking. He has congenital malformations of the tongue which affect his swallowing and articulation, resulting in low self-esteem. The client began making progress in therapy, increasing his self-assurance during public speaking. When his job required a move out of state, the young man had concerns about starting over with a new clinician. A licensure compact would allow this client to continue treatment with Paige. Kylie Lureen has an adult client with a severe stutter who lives and works in a small town outside of Lincoln. During the pandemic, he has participated in online church events, family Zoom calls and virtual meetings with a local stuttering group. Telehealth has provided practical application of his therapy goals, been a platform to prepare for online events, facilitated his progress and increased this client's confidence in his communication skills. In today's world, and with technology at our fingertips, state boundaries should not define or confine access to speech, language or hearing services. A licensure compact will increase Nebraskans' ability to connect with professionals across state lines through telehealth. Thank you for your time today and your thoughtful consideration of LB14. I would be happy to answer any questions you might have.

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ARCH: Other questions from senators? Seeing none, thank you very much for your testimony.

TONI MOREHOUSE: Thank you very much.

ARCH: Are there other proponents for LB14? Welcome to HHS.

EDISON McDONALD: I'm so glad to be back. Hello, my name is Edison McDonald, I'm the executive director for the Arc of Nebraska, E-d-i-s-o-n M-c-D-o-n-a-l-d. We are a nonprofit, 1,500 members covering the state representing individuals with intellectual and developmental disabilities. And I want to take a second first to talk about the structure in which we're here today. We were not able to encourage our members to attend this hearing, as we won't from any hearings, because the Legislature is out of compliance with both the Americans with Disabilities Act and Section 504 of the Rehabilitation Act by not providing for proper accommodations. We're addressing this with the Executive Committee and with the Speaker's Office. But as this is a committee that frequently deals with those issues, I wanted to bring it to you all's attention too. We advocate for people to live the most inclusive lives that they can because it is cost-effective, focuses on the best treatment possible and brings the most to us as a society. We strongly support LB14, because we believe that it will help to ensure better access to quality services for those with intellectual and developmental disabilities. We'd like to thank Senator Blood for bringing this legislation and these other compacts because it significantly helps to increase access. We've seen higher rates of conductive hearing loss at approximately 53 to 88 percent for children with Down syndrome who reported and attributed to anatomic differences in the head and neck region of these children. In particular, we see significantly higher need both in the audiology area and a variety of other professional areas to have experts who have expertise not only just in their field of specialty, but in Down syndrome, autism or a variety of other rare conditions, because typically the combination can be significant. We're excited about this movement towards a more streamlined, integrated, comprehensive practice and that this in the long term will help save the state money and allow for better access to services. One issue that I just wanted to, to bring up that we've seen in the past year, we saw significant access to service issues around ABA therapy, where pretty much the only provider in the state of Nebraska, their insurance contracts didn't go through. And so as they were working to renegotiate the

process, there are a lot of families who were kind of left up in the air as to whether they'd be able to get services or not. I think that interstate compacts like these will help to remove those issues in the future and to ensure that individuals with intellectual and developmental disabilities have access to those services, even if they have to go to another state for that service provider. Thank you for your time. And any questions?

ARCH: Questions from the committee? Senator Murman.

MURMAN: Thank you, Senator Arch. And thank you for coming in, Mr. McDonald. I'm just curious how the Capitol is out of compliance with the--

EDISON McDONALD: So the-- in terms of the standards set for testimony, you have to provide a reasonable accommodation. So the current standards basically don't allow for anyone who has an intellectual or developmental disability or who is in a high-risk category, still having to come into the building to provide testimony between 8:30 and 9:30 a.m. doesn't allow them, because still they're putting themselves at increased risk. And I'm still trying to get some guidance because this isn't unique to Nebraska. Other states are navigating this too. In particular, I know Colorado has taken a much more open sort of approach. And so one of the things I'm trying to see about is, in particular, if-- I know we've had a lot of members who have come to this committee and provided within their testimony and said, you know, they need extra time within their testimony process. So one thing that we're looking at and we're talking to some attorneys about is if that time could also be, you know, if we could go and use a similar procedure for written testimony and go and have written comments that ask for that exemption. Because you do have to ask for the exemption, specifically. If we could then go and have those written comments also included in legislative record.

MURMAN: OK, thank you. I do have another question.

ARCH: Yes, please.

MURMAN: You mentioned that this compact would save the state money. I was just curious what that would be or how that would happen.

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EDISON McDONALD: Yeah, I mean, I think that in particular, one of the biggest concerns is making sure that individuals who are receiving services via Medicaid, that they're going to be able to receive those services and get the access to the care that they need when they need it. And from the right specialists, because if you're going to the wrong professional in a wide variety of areas, what we find is that you're going to see increased issues. I know Senator Kolterman has a bill dealing with step therapy. Talking about this similar issue within, within prescriptions, but making sure that folks have the best access to the proper professional at the time when they need it and the person who really has that expertise, not only audiology or any professional practice area, but also having the expertise in how that affects individuals with an intellectual or developmental disability, I believe will help to save us in the long term.

MURMAN: OK, thank you.

ARCH: Thank you, Senator Murman. Are there other questions? Seeing none, thank you very much for your testimony. Are there other proponents for LB14? Are there any opponents for LB14? Is there anybody that would like to testify in a neutral capacity for LB14? Seeing none, Senator Blood, you're welcome to close. While you're coming up, I would mention that we received 25 letters in support for LB14 and one letter in opposition, that particular one from the Academy of Otolaryngology.

BLOOD: Before I close, Senator Arch, I'd like to point out that I think the question that you asked me, you'll find at the top of page 8 of the bill, in reference to practicing in your home state-- or, excuse me, in respecting the home state rules. I think that's where you find the clarity on that.

ARCH: All right. Thank you.

BLOOD: And also, I just want to make sure that I'm firm in the fact that my office did meet with the Department of Health and Human Services within the last seven days, and they do not oppose this bill this time around.

ARCH: Thank you.

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BLOOD: OK. So I did want to point out that you may have received, which you just said you did, letters of opposition to this bill being organized by the American Academy of Otolaryngology. To be clear, this is a group that raised the same issues last year. And CSG, the organization that administers these compacts, has taken a look at these objections before. In short, the objections are either unfounded or, quite frankly, unworkable. I know a few of the letters make mention of working with the American Medical Association on some amendments to the speech pathology compact. But the Nebraska bran-- branch of that organization actually has no problem with this bill and, in fact, support LB14. Furthermore, I know that one of this group's biggest issues has been a claim that those covered in this compact somehow have the ability to override state scope of practice requirements. In fact, we've gone out of our way to make sure that this isn't the case. And they have done this across the United States with every compact and pretty much every state has ignored it because it's unfounded. It's not true. The compact very clearly states that anyone practicing under the rules of these compacts must abide by the practiced laws of the state where the service is located. In the interest of time, I'd be happy to discuss this letter with each of you outside of the hearing, but I want to be clear that, that we're all aware of this opposition, that we're aware of this opposition, and that we've looked into it, as has the Nebraska Medical Association, and we believe their concerns don't have any validity. So I want to leave you something to mull over as I hope you vote to move this bill onto the floor, because I would like to make this my priority bill, this year. Many of you watched Amanda Gorman, the inaugural poet at President Biden's ceremony this month. Amanda's progress is a product of speech therapy support, and she used poetry to overcome her speech impediment. Hearing her interview, where she described that to this day that she avoids certain words in her poetry because she still struggles with her impediment, it really hits home for me because I do the same thing when I write my hearing openings. You know from when we passed my hearing aid bill, for those of you that were around then, that I was deaf as a young child and I took years of speech therapy. But those aren't troublesome things. Those are positive things. She is now a nationally known poet and I'm in Nebraska state senator. We can speak in public in a way that we are understood. But know that this never leaves us, but allows us the ability to still shine thanks to this great sector of our health care community. Let's broaden the opportunities for these professionals to touch the lives of others.

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And I'm guessing we're going to see a lot more stories where others have overcome the same obstacles and had their lives changed forever. With that, I thank you and I appreciate your time.

ARCH: Thank you. Are there any final questions for Senator Blood? Seeing none, thank you very much.

BLOOD: Thank you.

ARCH: And this will close the hearing for LB14, and this will also close the hearings for the day for the committee.