HARDIN: Good afternoon. Welcome to the Health and Human Services Committee. My name is Senator Brian Hardin and I represent the 48th District of the world of Scotts Bluff, Banner and Kimball Counties way out west and I serve as the Vice Chair of Health and Human Services Committee. I'd like to invite the members of the committee to introduce themselves, starting on my right with Senator Ballard.

BALLARD: Beau Ballard, District 21, northwest Lincoln and northern Lancaster County.

DAY: Good afternoon. Senator Jen Day, represent Legislative District 49 in Sarpy County.

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

RIEPE: Merv Riepe, Legislative District 12, which is southwest Omaha and the good folks of Ralston.

HARDIN: Also assisting the committee is our legal counsel, Benson Wallace, research analyst, Bryson Bartels, our committee clerk, Christina Campbell, and our committee pages, Ethan and Delanie. A few notes about our policies and procedures, please turn off or silence, silence your cell phones. We will be hearing four bills and will be taking them in the order listed on the agenda outside the room. On each of the tables near the doors to the hearing room, you will find green testifier sheets. If you are planning to testify today, please fill out one of those and hand it to Christina when you come up to testify. This will help us keep an accurate record of the hearing. If you're not testifying at the microphone but want to go on the record as having a position on a bill being heard today, there are white sign-in sheets at each entrance where you may leave your name and other pertinent information. Also, I would note if you are not testifying, but have an online position comment to submit, the Legislature's policy is that all comments for the record must be received by the committee by noon the prior day of the hearing-- to the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. We would ask if you do have any handouts that you please bring ten copies and give them to the page. We use a light system for testifying. That's the little box up here and 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, we hit the

ejection button and it throws you out. No, no, but I might say, please wrap up your thoughts. When you come up to testify, please begin by stating your name clearly into the microphone. And this is what the rookies forget to do: spell your name and that's so that the people who are writing it all down, typing it all down can get it right. On hearing-- 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 a closing statement if they wish to do so. On a side note, the reading of testimony that is not your own is not allowed unless previously approved. We have a strict no-prop policy in this committee. With that, we will begin today's hearing with LB792 with Senator Wayne. Welcome, Senator Wayne.

WAYNE: Good afternoon, Vice Chair Hardin and members of the Health and Human Services committee. My name is Justin Wayne, J-u-s-t-i-n W-a-y-n-e, and I represent Legislative District 3-- 13, sorry, which is north Omaha and northeast Douglas County. LB792 will create a pilot program within the Nebraska Department of Health and Human Services for assessing and treating those with post-traumatic stress disorder. What you'll see is an amendment that I handed out, AM486. It spells out a little more specific things around post-traumatic stress. And what we're trying to do is target in on, on those-- really children who have, who have dealt with this. So before I go through my written testimony, I just want to give the committee a background on how I got here with this bill. And actually, I wish Senator Hansen was here because it actually started on the mountain of Kilimanjaro. Senator Brewer and I, along with Senator Hansen, were having a conversation about a military combat zone and that how many troops were coming back over with PTSD. And we started talking about what things trigger that in the military. And some of it's sleeping at night and worried about a gunshot because earlier in the day or earlier or a previous night, these soldiers had gunshots flying over their head-- or guns flying-- or ammunition flying over their head. And we just started having a real in-depth conversation for about an hour. And what I left from that conversation was many of the kids that I work with in north Omaha grew up in a very similar environment that they were having in Afghanistan and in other war zones, not from a military occupation or any of those other things, but from simply dealing with trauma of gunshots, trauma of somebody in their family dying from a gunshot unexpectedly. Or I represented a kid who was standing on a street corner and got hit with a stray bullet and all of his basketball

dreams disappeared because he didn't think he could play basketball anymore and actually couldn't play basketball anymore. So as that conversation unfolded last year, obviously LB1024 and ARPA funds was on the forefront so I didn't drop a bill regarding that last year, but this year I did. And there will be some testifiers after me who helped me craft the amendment to deal specifically around violent and shootings because that's where our mindset was when, when I started talking about this bill with Senator Brewer and Senator Hansen, some 15,000 feet in the air. And it just gave me a different perspective of we have all these programs for when people come back from the military, from overseas to deal with post-traumatic stress and the things they see over there and the things they deal with over there. And we expect 18- to 30-year olds to come back and navigate a system and have the support systems in place to deal with their post-traumatic stress. But at the same time, we have nothing to deal with what happens to a eight-year-old who's standing on the street corner or down in the Old Market and a young girl gets killed five feet from them. So while LB1024 may be the legacy that somehow people think is my pride and joy of this Legislature, what I've gone to appreciate from two individuals that I've talked to about this is this may be the most important bill that I've ever done because we've never hit this on head on. We never dealt with this and we never dealt with the true trauma that-- whether it's poverty, whether it's violence, whether it's the foster care system that I think has ran rapid through our community. So this program is centered around the city of a metropolitan class, which is Omaha. And we did so because that's where we see some of the most violent episodes in Nebraska around youth. And in fact, you'll hear statistics about the number of youth who are being charged with felonies and in, and in-- and, and dealing with guns in particular. And I think it all circles around this idea of PTSD and being afraid and having this constant stress and fear of growing up in some neighborhoods. Now, some people will be a little more politically correct than I am, but those who know me on this committee know that I tend to just say what's on my heart and on my mind whether I get in trouble or not. And so I'm not trying to treat north Omaha like a military zone, but when you look statistically at the number of people being shot at every day, we have to look at it differently than what we currently do and just say, well, it's not. No, it is. There are young people, particularly juveniles, who are in and out every day with guns, who are around guns, who are being shot at, being shot or shooting and we got to figure out how to handle the stress that comes from that. And I think this pilot program goes a long way. While most of us experience traumatic experiences in our

lives, only a few-- small percentage actually have PTSD. It's around 20 percent globally. That's one in 13 Americans develop PTSD in their lifetime. But what I would tell you is in north Omaha in particular, east Omaha who are dealing with the violence that they see, that number is significantly higher. I believe there's around 12 million people in this country who are suffering from PTSD. Many of them don't know how to deal with it so you see things like drug use and substance abuse as a coping mechanism. We know that one in two rape victims deal with PTSD. We know that one in three people who are physically assaulted deal with PTSD. We know that there are, like, 17 percent of people who are in serious automobile accidents that deal with PTSD, 15 percent of those who are stabbed as adults deal with PTSD, 14 percent of those who are adults who have a sudden or violent death deal with PTSD. Imagine what those numbers are when we talk about children. There are many people walking around north Omaha with undiagnosed PTSD, no doubt. This isn't just an urban area-- or urban problem. But like with any pilot program, we have to focus in somewhere and that's why this focuses in on Omaha. There will be a lot of people behind me who can talk to you about personal stories who can deal with. There are therapists who are going to come up. I encourage you to ask them questions. I don't mean for this to be a long hearing, but I do mean for this to be an in-depth hearing. So I would encourage you to ask questions, off-the-wall questions and hear what these people are dealing with when you talk about youth and people who have dealt with this crisis. And this is a health crisis. I know in my community as a senator, it's my job to make sure that you are all well informed of the issues facing my community. One who is an expert and works in this industry in Omaha was quoted in an article that I read that says she feels 90 percent of her caseload in dealing with people diagnosed with PTSD fell within the range of 16 to 20 year olds. And what you hear from members who are in law enforcement, that's where we have a lot of problems. So PTSD is significant in our community. I don't feel $25 million is enough. I think this is a great ask to start with and that's why it's a pilot program. I am open to more amendments around the length of this. I think it should be a five-year, but everybody knows this year, a little struggle with the bill drafting. We-- we've been just having some issues and it's not-- it's just good issues. It's growing pains. But this amendment outlines kind of where we're trying to go. But by far, this is probably, after talking to the thousands of families that I've talked to and the few people in this room who came down to testify, you'll hear that this is probably the greatest need facing north Omaha from a community perspective, dealing

with mental health. And that's why this pilot program is definitely needed. And with that, I will answer any questions.

HARDIN: Thank you, Senator Wayne. Questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Senator Wayne. You did answer some of my questions. Timeline, I don't see that in here. With the-- having been through the-- of having a pilot program that had no end, talking through timeline, maybe that's something we can do outside of the hearing process. But how do you envision this? Like, the Department of Health and Human Services, will they contract with, with an entity, a nonprofit or can you just tell me a little bit about your vision?

WAYNE: My vision and what I think we'll have to do as we tighten up this on the floor. I would ask to kick this out as soon as possible and let any amendments we work out on the floor. Because at this point, if this comes out, it will be my priority bill. What I envision is a RFP or a grant process where the department would open up a grant or RFP, RFQ, probably-- request for qualifications-- where they would outline how they would treat, how they would recruit, what partnerships they have. You'll hear from people in the community who are-- already have kids. We-- it's just a matter of linking up some of these organizations and then track those kids and that-- or what I would call youth and some young adults and track those individuals to see the impacts. And in five or ten years-- and the reason I didn't put a deadline in this particular amendment is because I wanted to hear the hearing for somebody to ask some questions around that. Because I'm not an expert in this field so maybe it's a ten-year pilot just to see the data. Maybe it's a three-year pilot. But I wanted those experts because I had conflicting timelines. Some people think it's five years. Some people think it's seven. But I'm open to that on the timelines perspective, but I think it should be a grant process or a RFQ or RFP. People submit their proposals and then we implement those proposals and we come back with true data to figure out what it is.

M. CAVANAUGH: And I-- you, you mentioned in your opening, I see in here it is targeted mostly towards PTSD surrounding gun violence. But you did mention in your opening some of the PTSD that some of our youth might experience through, say, our foster care system. Would those children be eligible to participate in the program?

WAYNE: So foster care is interesting because some of those are already receiving services. What we are trying to attack-- I don't know if

that's the word I'm supposed to use when talking about violence-- are those who are undiagnosed.

M. CAVANAUGH: OK.

WAYNE: Those who are having problems in school, those who are maybe outside the system. I know Lavon is here and, and she has a program that's kind of outside of the system, but inside the system. And there are kids who need to be referred, like, you know your cousin got shot and you know your cousin died early and you are struggling with that. And rather than you react negatively, let's, let's refer you to a, a place that we can figure this out.

M. CAVANAUGH: So kind of building upon services that we currently have to fill a gap?

WAYNE: Correct. And if there are-- I mean, to your point, though, if a-- I don't know. Kevin may testify to this. Sorry, I just know all these people by names because I-- most of them watch me grow up and Lavon lives right down the street from me so she'll, like, burn the house down if I say something wrong. No, no she won't. But, but like, most of them all watched me grow up and are great mentors to me. But, like, you know, Kevin will tell you that kids who go through five or six foster care houses, they also, also suffer a kind of trauma. We are trying to limit it in, in this amendment to just those in violence because of dollars. That's the real reason. If we had more dollars, then I think we can expand it. But we are trying to limit it to those who are dealing with, with violent. Because as, as I think Dan will testify, there, there are more juveniles who are committing violent crimes than ever before and I believe fundamentally it's a result of this cycle of PTSD.

M. CAVANAUGH: Thank you.

HARDIN: Any other questions? Senator Riepe.

RIEPE: Senator Wayne, I appreciate you being here and I appreciate your lead in to give us a little bit more insight from what you can capture on the piece of paper. I guess my question would be, is I know there's active shooter programs for schools, but I assume that that doesn't extend over to community situations. Certainly wouldn't cover over to foster care. But I'm trying to see-- have, have you talked with the people from Region 6 that I would assume have some accountability?

WAYNE: Yes. We've talked to many people. This has been a year in the process. What everybody will say, from my conversations, are those who are in the system, most of them are being referred to some kind of treatment. But what we're finding out is those who are one foot in, one foot out of the system, there's no real treatment or resources out there. Those who are completely out of the system, there's, there's no real-- actually, there's no, no resources out there. So what we're trying to do is be a preventive step, saying you act up in school and maybe the principal finds out that you just had somebody recently shot in your family or close near shooting, then let's, let's refer them to an organization that, that can deal with this trauma that you're dealing with and figure out how to deal with it. Right now, there isn't anybody really focused on this trauma. They're focused on, I would say, overall mental health or overall physical health. The problem is until you get into the system, there's no resources. And so we're trying to be that stopgap saying, before you get into the system, we realize you might have had a couple of fights at school, but what's the underlying issue? That's because your, your brother or your cousin might have got shot and you're trying to figure that out as a eight-year-old. I mean, it's hard as adults to figure that out.

RIEPE: I know we've set up in our court systems some veterans courts and some other DUI courts and different courts to specifically look at issues. Is this what you're saying within mental health, that you want to focus this on, you know, on victims of violence, if you will, specifically within mental health rather than having a counselor that does a little of this and a little of that? That you want them to be focused and concentrated on the violent aspects of it?

WAYNE: I think that's a starting point. I think there will be some, some people behind me who can talk a little bit more, but veterans courts is a prime example of where we decided that because of what you might have been through, there might be some underlying issues. So we're going to, we're going to deviate you from the regular court system to let you figure out your PTSD and some other issues you might deal with that might contribute to your substance abuse. Well, what I'm saying is and what I'm-- what I fundamentally believe is that some of our youth, they may not be drinking and doing drugs. They may be committing more violent crimes because they're dealing with PTSD because they don't have the ability to go to the liquor store and buy a bottle.

RIEPE: Do you think this program would be more effective if not funded through DDH-- you know, Department of Health and Human Services, but be funded through Region 6--

WAYNE: No--

RIEPE: --more responsive to the community?

WAYNE: No, I think we need a direct line right now to make sure we're tracking the data and tracking things to, to a government agency. I wouldn't want to add another layer. To be quite honest, I was trying to figure out a different agency to fund it through. I just couldn't. This is one of the number-one issues facing my community so to streamline that process is the best way that I can figure it out right now through DHHS.

RIEPE: I understand. You can correct me if I'm wrong, but some of the stuff that I've read is that many of the young people do not expect to live to be-- see 30.

WAYNE: I think many is probably the right word. That, that is true that, that, that people joke about-- I had a kid that I mentored forever. He turned-- he had a birthday. I won't say how old he is, but he had a birthday the other day and texted me and was, like, another year. And I think that goes to your point. He made it another year.

RIEPE: Yeah. OK. Well, thank you for bringing the bill. I think it's worthy of discussion.

HARDIN: Any other questions? Senator Ballard.

BALLARD: Thank you, Vice Chairman. Excuse me. I'm trying to figure out how to ask this question so I'll let you respond. There's some talk around the hallways in the Capitol of north and south Omaha got a big chunk of funding last year. Why should we give them more? I'll just let you respond to that. I don't necessarily agree with that sentiment, but I just want you to respond to, to that logic, train.

WAYNE: Well, there's two different reasons. Last year, we focused on economic development. So we believe-- and I say we, Senator McKinney and I, believe that if you create jobs in an area that when our poverty rates go down and it's better for everybody. So the focus last year was on jobs. And that's primarily why I didn't bring this bill last year is because I didn't want to be confused. There shouldn't be a, a number that we could only have for north Omaha, but

unfortunately, that's the reality, right? Like, so we got a little over $300 million for north Omaha. But that is primarily,if you look at the Olssen report, economic development. Now we're talking differently about mental health and youth. So to me, those are two different buckets altogether. And last year, the only reason why I didn't bring this bill is I didn't want them to be confused. So to me, this is-- that's dealing about jobs and economic development. This is dealing about the mental health of our babies.

BALLARD: OK. Thank you.

HARDIN: Any other questions? Seeing none, will you stick around?

WAYNE: I am going to try to. I am in Government. I got two bills in Government. This is the one day that I got, like, four hearings so we are monitoring it. I will try to come back to answer any questions. If I'm not here, consider that to be a waive.

HARDIN: Thank you.

WAYNE: Thank you.

HARDIN: Can we have our first testifier who is a supporter of LB792? Welcome.

LAVON STENNIS-WILLIAMS: Thank you. My name is Lavon Stennis-Williams, L-a-v-o-n S-t-e-n-n-i-s-W-i-l-l-i-a-m-s. Good afternoon, Senator Hardin. Thank you for the opportunity to appear before you and the committee to speak about LB792. I'm, I'm a direct provider of services for the people that Senator Wayne was talking about. On top of that, I've had a chance to experience it in my own family of the violence. And Senator Wayne and I have a unique probably experience from most of you of, you know, living in neighborhoods where the homes are upward of a half a million dollars. But depending on how you approach our neighborhood, we drive through a portion of town that you kind of go through a little bit more slower and you look around you more because you don't know if a stray bullet is going to come. So that's just-- that's the reality of living in north Omaha. The other reality is that I serve kids who oftentimes are misdiagnosed. The problem with the statistics about the number of kids who have PTSD is the fact that it's unreliable. Most of their conditions are being diagnosed as having ADHD. So most of the kids are being treated for a condition through medication when the best response to it would be therapy. So these kids go on and they go on and they go on and after a while,

their behavioral gets so bad. Their behavior gets so bad that it begins to be prosecuted instead of treated. That's the importance of LB792 is that it would allow for this issue to be elevated and for, for the first time, research to be done that would give data to show you the impact of PTSD on our young people. I also have a portion of my program that serves adults who have went to prison and they're coming out with reentry. So I get to see on both ends, what happens when young people are not treated properly with the conditions that they have. And so they come out of prison as adults having never got the treatment that they need and we keep seeing that cycle repeat itself in terms of recidivism. I believe that this pilot program will give the data for us to begin to take this condition very seriously in our community and make sure that it's not misdiagnosed because if it's not diagnosed properly, it could not be treated properly. So what we have is just we keep throwing medication toward the problem or we simply ignore it. And I happen to serve a large majority of children whose symptoms are just ignored. And we talk about being exposed to violence, but a lot of the kids that I serve are young kids who are having to dress the wound of a family member who's been shot because there's nobody else to change the world or to change that vacuum bag from the bullet hole. And for young kids to have to do that, but they do it because they want to help out in the family, that's traumatic. For them to be able to go to class one week and see a kid and next week, not see the kid, that's traumatic. Or the fact that you're walking past a, a boarded-up home in a community and you don't know who's in that home. It could be a shooter after your brother or anybody, but you have to walk past that. So the constant fear that exists in north Omaha, which I'm most familiar with, is one that would say LB792 is long overdue. So I thank you for the opportunity to share my thoughts with you and I hope that this committee will act favorably on the recommendation to get it passed.

HARDIN: Thank you for sharing. Any questions? Senator Riepe.

RIEPE: Thank you for being here. Thank you, Chairman. My question is, is a lot of these young people-- maybe a little bit older, middle school, high school-- are pretty-- because they've been there, they're pretty tough. But my concern gets to be is are they going to self-refer? How are they going to-- how we-- how would referrals come in? Because it's possibly viewed as a weakness among friends, how will they acknowledge that they do, in fact, have this PSD [SIC]?

LAVON STENNIS-WILLIAMS: Well, Senator, these kids are not tough. It's the fact that that's a perception that many people have of these kids.

They tend to over-adult-- as they call it "adultify" poor kids, minority kids. But these kids are just like any other 12-year-old, 13-year-old, 14-year-old. Once you sit down and listen to them and give them a chance to be heard, you're going to be able to see that they also want help. I have no problems with-- I have kids as young as ten in my program and there used to be a time where the only referrals we got was for truancy. And now we're getting for car theft, for shootings, for cuttings. And when we sit down and talk with these kids, they really want help, but because people do not know how to serve them with PTSD, they're diagnosing them with having either ADHD or some other behavioral issue and we're missing the point. So I think it will be easy to assess them once you sit down and give them an ear and let them know that you do care and make the type of therapy accessible. I know you had mentioned earlier Region 6. Region 6 has a waiting list. They're not taking any more kids. And there are kids who need to be properly assessed and this need to be identified so they can be properly treated. They just do not have access, but once you give them access, they're willing, willing participants and service.

RIEPE: I have grandkids that are in the 12, 13, 14 kind of collective group and unless their parents would direct them, they wouldn't know of the community resource. They wouldn't know to self-refer. They would have to have someone that would say, You need to do this and maybe not give them a choice. Says, You need to meet with a counselor because of everything you've been through.

LAVON STENNIS-WILLIAMS: You're correct. So I see your question. That would be schoolteachers. It would be principals. It would be mentors. Anybody with whom they have a relationship would-- it could be just a mentor, a basketball coach. But once we get this data, we're able to educate a larger pool of people to be able to look for the symptoms so they can make the referrals and help the family get the proper service. But right now, we have all of these people in the community. That village we're talking about? Well, they really don't know what the symptoms are to look for, for PTSD. So they misdiagnose them as having behavioral issues through ADHD or opposition defiant disorders or conduct disorders, which is a whole different realm of treatment. So this study, this pilot program will help not only serve the kids, but help educate this community as to the signs and symptoms to look for as well as the professionals to whom refer the families [INAUDIBLE].

RIEPE: A few-- maybe it was a year ago or something. There's an organization, I believe-- correct me where I'm way off here-- that was

100 Black Men. Was that still functioning in the community? I would see that as maybe those 100-- or however exactly number-- they would maybe be in a position to identify some of these situations.

LAVON STENNIS-WILLIAMS: You know, oftentimes groups like that, they're great, but they kind of cherry pick their kids. And oftentimes the kids who really need the help, they're not members. They're not participants in those programs because their behavior is such that those programs won't accept them. And I think these are the type of kids that Senator Wayne is talking about, those kids whose behaviors have caused them to be written off by the larger community. And so I know that every-- each given day, I have between 10 and 15 young men in my program who willingly participate through-- although they're in the system, they're being referred to our program for help. And so I believe they will be just as complicit in participating in a program for PTSD as they will my program for life skills. But there are a lot of programs out here that could be educated to start looking for PTSD and refer those kids to the programs once that kid makes contact with them. So there are a lot of conduits to help get the kids into these treatment facilities.

RIEPE: And bless you for the work that you do.

LAVON STENNIS-WILLIAMS: Thank you.

RIEPE: Thank you, Speaker-- Chairman.

HARDIN: Any other questions? I have one. Forgive me if I missed it. Tell me the name of your organization again.

LAVON STENNIS-WILLIAMS: ReConnect, Inc.

HARDIN: ReConnect, Inc. Very good. Thank you so much. The next testifier, please. Welcome.

KEVIN WILLIAMS: Thank you. Kevin, K-e-v-i-n, Williams, W-i-l-l-i-a-m-s. LMHP, I'm a mental health therapist. I've been in the field over 30 years between the Methodist Richard Young, Omni Behavioral Health, CHI and Carl-- Charles Drew. I'm currently a director of Williams Counseling, PC, and we have youth that we serve, three youths to a home, who have mental health issues, PTSD, anger issues. And I'm honored to be able to discuss this important issue because I've served on many of the gang prevention boards and presentations for mental health conferences. And it's different to be able to talk about the problems versus be able to have a solution,

which you guys have the opportunity to be able to fund a solution. Many of our kids in north Omaha are either living or were born into areas of violence due to gang affiliation or just being in a certain zip code that is very violent. And they've been-- witnessed or been victims of fighting, shootings, murders, witnesses of these type of things. So I have professional stories and personal stories of my own family members who've been-- have had PTSD in this arena due to not having any proper support. I know it-- ma'am, you discussed about foster care. And Senator Wayne and I, you know, we talked about how many kids have been in several different foster care homes, which means also they've been in several different neighborhoods. So they've been moved to different safe neighborhoods. Back in the '80s, when Bob Armstrong implemented the scattered site housing, instead of having all the gang problems centered in one area, it got all across the city. So now you got-- it's harder to deal with because it's not in just one section, but it is higher violence in, you know, north Omaha area. For instance, I was a school liaison in some north Omaha schools where I got to work with kids in schools. And to this day, there's so much violence going on in the schools where-- fighting in the bathrooms to the point they have to lock the bathroom doors, some now to, to limit some of the fighting. Kids getting stabbed, guns being brought to school. So some of our kids are feeling like it's do or die. I need protection. I need to get a gun myself. I don't-- no one can protect me. The school can't. You know, by the time law enforcement is involved, there's already been some type of violence already, you know, done before they were able to report it, if they do report it. So the numbers that Senator Wayne even gave you guys, you notice he didn't give you the numbers for youth because he doesn't know. Most of it's not reported. Kids are just living in fear. My son who played for the Huskers last year for football, you know, he's a licensed carry-- you know, I made him do it the right way. You're going to go take a class, get a concealed carry license. I asked him why he felt he needed it. I still got to go home. So, so when you feel that you have to have protection to stay safe, that's an issue. Volunteer coaches like myself across the north Omaha, we pick up kids to take them to practices and games. We hear these stories all the time. We see the living conditions. We see family members that they scared that their cousin got killed. Somebody is looking for them. Just last year, we took in a youth that the first day we took them to school, he got death threats so we had to take them out of the school because he was cooperating in the case of-- a murder case and was going to be a witness. So they seen him as a snitch and they were going to, you know, get rid of him. So there's just heartbreaking

stories of how our kids are living in fear and we need more support so they have-- they can feel that they are having support and for people to talk to and get the support that they need, whether it be counseling, finding out what they do well to put them in better-- whether they have a gift in cooking and want to be-- you know, that's kind of what we do in our program is we actually go to school with the kids and we give them support in the-- you know, the hallway coaching, find out when it is safe for them because they have their own fears. And so then we can gradually support them and back away from it. And then when Dr. Ray comes and talk to you because we're contracted with Omni Inventive Care. We've been doing this work with these youth. But when we were told that this was a possibility, it was something that was greatly needed and are glad that you guys are even considering it. And it can save lives, it can make productive gun owners in the future. If they do decide to have a gun, they know how to use it correctly and do it the right way.

HARDIN: Sorry, can I have you wrap up your thoughts? And we've got a red light and so--

KEVIN WILLIAMS: Oh, I'm sorry. I didn't see that.

HARDIN: No problem.

KEVIN WILLIAMS: Yeah.

HARDIN: So any-- anything else in conclusion on that?

KEVIN WILLIAMS: No.

HARDIN: We'll ask some questions.

KEVIN WILLIAMS: Yeah.

HARDIN: So thank you for being here.

KEVIN WILLIAMS: Um-hum.

HARDIN: Any questions? I said there would be questions and then--.

KEVIN WILLIAMS: Maybe I covered it all.

HARDIN: --they're letting me down, just like that. Thanks so much--

KEVIN WILLIAMS: Thank you.

HARDIN: --for being here. I appreciate it.

RIEPE: I have a question.

HARDIN: OK, we have a question.

RIEPE: My question is, is this one that's felt by the community, if you will? And if I stumble into any awkward spot, please forgive me. But it's a feeling that your culture, your family, you know, your community needs to do this and be viewed as doing it for ourselves as opposed to have some bigger organization that maybe doesn't understand exactly what's going on in our neighborhood?

KEVIN WILLIAMS: Absolutely. Because I think that our youth need people that they trust, that they--

RIEPE: Yeah.

KEVIN WILLIAMS: --that look like them, that have similar experiences and want to know how they made it through the same situations that they're going through today because--

RIEPE: OK.

KEVIN WILLIAMS: --you know, most of us have been through it. It's just gotten worse. It's hitting these-- our youth at a younger age now.

RIEPE: So in a sense, it's kind of a specialized program.

KEVIN WILLIAMS: Yes.

HARDIN: OK. Thank you very much. Thanks for being here.

KEVIN WILLIAMS: Thank you.

HARDIN: Any other questions? Thank you. The next person who is a proponent of LB792. Welcome.

AARON HANSON: Thank you. Mr. Chairman, members of the committee, my name is Aaron Hanson, A-a-r-o-n H-a-n-s-o-n. I am the sheriff of Douglas County. I'm so glad that Senator Wayne is bringing this bill. I have long experience with the issue of post-traumatic stress disorder or post-traumatic stress injuries. I think a lot of people prefer the latter because it is an injury that, that people can receive treatment and can, and can recover from and function with. I was hired as a police officer in 1996 and over that almost 27 years,

especially in the early half, we would see officers that we knew. Didn't connect the dots at the time, but they were involved in traumatic incidents, officer-involved shootings, violence inflicted on them and we would eventually see them start to self-medicate with alcohol, start to regress, get divorced and sometimes lose their jobs. And eventually we started to look at it and we realized, oh, this is, this is post-- this is probably trauma. This is post-traumatic stress injury. So we created a peer support program in the Omaha Police Department. I was on the-- one of the first officers to be on that team. They trained us up. They brought in professionals and experts and I learned the signs of post-traumatic stress injuries. And thank God I did because eventually I was involved in a very violent situation, more so than the typical violence and homicides that I saw. I was directly involved in the death of someone very close to me on duty in which I had to give CPR to as he died and I-- that traumatized me. And luckily, within that first 30 days, I recognized the symptoms and I was willing and able to connect with appropriate resources and I, and I, I recovered, got better. As I started spending time on the gang unit, though, I started noticing these young men that I were dealing with-- that I was dealing with. Hyper vigilant, self-medicating, self-harm, poor decisions. I knew that-- that's when I started getting the first inclination, boy, this, this post-traumatic stress injury, this trauma is really impacting our community even deeper. But it wasn't until I started dealing with sex-trafficked young teenage girls and seeing their cyclical behavior of running constantly, becoming engaged in risky, dangerous sexual behavior, self-medication, drugs, alcohol and doing it over and over and over. Did I not-- I didn't realize until then this was the same type of trauma, just for sex-trafficked girls as opposed to young gang-involved men. The trauma injuries are real and they run deep and we are not going to address it or get ahead of it by ignoring it or just addressing it on the surface and just admitting it exists, but not really trying to get in deep to address the injury and try to help people recover. I'm a believer in not only the fact that post traumatic stress injury is real. I'm a believer that with appropriate resources and attention, that we can help people to recover. It is probably right now one of the biggest barriers I see for the young people that I worked with a lot and still continue to see from an executive position of sheriff. If you have unaddressed post-traumatic stress injuries, you can't work. How can you work when you're constantly on the run or couch surfing or self-medicating until 3:00 in the morning? Can't hold down a job. If you can't hold down a job, how are you ever going to have a chance of breaking the cycle of

poverty and how is that going to help us in the long run? So I'm very appreciative of LB792. It's important. I sure hope it does pass because I'd love to see this in Douglas County and eventually all across Nebraska. I'll take any questions that you may have.

HARDIN: Thank you, Sheriff Hanson. Any questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Sheriff Hanson. Not so much a question as thank you for sharing your personal story. I think it's really important for people in, in an effort to destigmatize giving help for people, to see people in positions of power and authority acknowledging that this can happen to anyone. So just really appreciate you sharing that with us today.

AARON HANSON: Well, thank you.

M. CAVANAUGH: Thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman, and thank you, Sheriff, for being here as well. My question is this-- does this-- because the violence has been a concern not just in Nebraska, Omaha, for some time to-- how can this help us to break the cycle of young people who experience violence who then learn violence and turn around and use violence? Is this, is this an opportunity to break that vicious cycle?

AARON HANSON: I think it is, with appropriate, with appropriate support. And so, for example, you brought up a great question earlier is how, how can we expect young people that are struggling with a mental health injury or trauma injury, how can we expect them to be honest about it? Well, some will be if we have the appropriate environment for them to be able to speak freely and in a confidential setting. But I can tell you this, in my experience, the, the best red flag of these injuries is when we see these young people becoming system involved, whether in the juvenile court system or the adult court system. So if we can use those, those red flags, those law violations which usually do result from that trauma, hopefully we can zero in on that population and say, hey, well, now you're-- no pun intended, you're a captive audience now. We're going to give you the assessment that you need, not just treat you as someone who broke the law, but also treat you as someone that's probably very badly in need of therapy for a trauma injury. And, and I think that type of smart approach will pay off. I can tell you this personally. Some of my best

friends that are PTSI survivors that lost their careers, that red flag happened. There was DUI arrests. There was criminal arrests. These were even people that had a career as a police officer. And it was because of that engagement in the system, that interaction into probation for serious charges that actually gave them the support that they needed to get them better, get them sober and get them the therapy that they needed to live, to live a healthy lifestyle.

RIEPE: Do you feel as a law enforcement officer-- and maybe beyond the county to include the city of Omaha because this bill is directed towards Omaha-- that you would be in a position if you put someone in a cruiser, brought them in-- or maybe even on the street, said, look, if-- you, you need to do this and if you do this, it's almost like we won't press charges if you agree to go to this counseling. Is-- do you have that latitude as a law enforcement?

AARON HANSON: You know, I'm a big believer in smart diversion programs or smart problem-solving court programs. I think as long as you have something that would be set up, it's got to have support.

RIEPE: And leverage.

AARON HANSON: Anybody, especially addicts or trauma-impacted people. If you give them the opportunity to walk away from an arrest that day, they'll tell you all day long that they're going to give it their best shot and then two hours later, they'll, they'll throw the piece of paper away. But if there was some type of organized diversion effort that had good structure and, and guarantees of participation or expulsion from the program or more-- or better problem-solving courts, Douglas County, we don't have a mental health problem-solving court. It'd be great to have one in Douglas County. But yeah, I do think that is, that is good leverage to be able to use to help push people back into a healthy lifestyle if their trauma condition is also causing criminal behavior.

RIEPE: Um-hum. OK. Thank you. Thank you, Chairman.

HARDIN: Other questions? Senator Ballard.

BALLARD: Thank you, Vice Chairman. Thank you for being here, Sheriff.

AARON HANSON: Sure.

BALLARD: I'll ask you kind of a hypothetical of if you had infinite resources, what would these programs look like? What would you-- from

the sheriff's department's perspective, what would, what would you implement?

AARON HANSON: Well, it depends on what level you're looking at. If we're, if we're talking juvenile level, if we're talking especially juveniles that are engaged in the juvenile justice system, I think we'd, we'd-- infinite resources would, would mean specialized infrastructure, essentially the Boys Town PRTF model times ten. And also the ability to allow the healthcare providers to actually keep traumatized young people in those PRTF plans until they're actually healthy, not, not looking at a ticking clock. Too often, there's this arbitrary 90-day period and then you're done. I've talked to people that are in positions to know and they'll freely admit that, hey, there are some kids that need to be in PRTF for six months to a year just to get, get them healthy again. So I think more flexibility on that. Definitely specialized infrastructure, alternatives to detention where young people can get healthy and get the psychiatric therapy treatment that they need, that they can't just walk away and run away again and start the cycle all over and, and get traumatized even more. Similar on the adult level. I mean, I do think we need specialized-- whether it's for individuals that are on adult supervision, I think transitional housing that's especially focused on psychiatric therapy and support would be smart. But then also, we need to be smarter about how we do design our, our corrections facilities too, making sure that, that we're focused on, on improving people's mental health and addressing trauma while they're in those, while they're in those situations. And then finally, for people that aren't system involved, we, we do need better transitional housing. I've talked to parents of adults that struggle with mental health and trauma. And again, too often it goes from inpatient treatment to back out on the street and the cycle starts all over again. There is no gradation to get people from inpatient treatment to a healthy lifestyle at the end of the tunnel.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. You hit a button here for me. You talked about the Boys Town PSD [SIC]?

AARON HANSON: PRTF, the psychiatric residential treatment facility.

RIEPE: Oh, I thought it was a PSD-specific program [SIC] and I was going to just ask, is that a program that we can build on? And where I'm coming from that is I always try to look at what, what is already

out there to try to build on because, you know, learning can take years and tie too much time.

AARON HANSON: Right.

RIEPE: But maybe then to try to keep it out of maybe DHHS so you keep it away from some of the bureaucracy. If there are any DHHS people, I apologize to you. But, you know, you can get it more personalized, more, more down to the community and maybe then therefore make it more responsive and provide more leverage.

AARON HANSON: Well, I think Boys Town has a great model. I think that too often times are stymied by the private insurance ticking clock that maybe wants to get people out quicker than, than they should. But I definitely think the Boys Town model is, is, is definitely worth closer inspection.

RIEPE: OK. Thank you.

HARDIN: Senator Cavanaugh.

M. CAVANAUGH: Thank you. Just want to acknowledge that Senator Riepe and I are very strange bedfellows sometimes.

RIEPE: Be careful now.

M. CAVANAUGH: Not in that-- professionally.

RIEPE: Yes, thank you.

M. CAVANAUGH: And that I, too, would love to see an expansion of the Boys Town PRTF, especially after everything that we saw with YRTC. Unfortunately--

RIEPE: Yes.

M. CAVANAUGH: --they are not no eject, no reject facilities. And as you--

AARON HANSON: Right, that--

M. CAVANAUGH: --well know--

AARON HANSON: --that is a challenge.

M. CAVANAUGH: --that is a big challenge with those kids. So just wanted to put that on the record that I agree and disagree with my dear colleague.

AARON HANSON: Senator Cavanaugh, I'm actually glad you brought that up because that is, that is a great point. That is another barrier that we do need places that are built to be tough for these tough, traumatized kids. And again, it's easy to say these are tough kids and boy, they're too tough. Well, they're, they're tough because of the way they, the way they were forced to be raised, the environment they're raised in. They're, they're tough because they're very traumatized. So it is difficult when you do have private facilities that will go, nope, that kid's too tough, too traumatized. That, that doesn't help.

M. CAVANAUGH: Yeah.

AARON HANSON: For sure. So a good point, Senator. Thank you.

M. CAVANAUGH: I wish it was different.

HARDIN: I have a question.

AARON HANSON: Yes.

HARDIN: You're sitting in kind of a unique position because not only are you a law enforcement officer, but you've experienced it yourself, the PTSD. I ask the question myself from the perspective that I used to be a police chaplain in a major city. And my question has to do with the personal experience you went through that there's a difference between something that's focused on PTSD as a treatment versus something else. Can you tell us what that switch was like, where it was like all of a sudden, you were being intentionally treated for PTSD as opposed to seeing the psychologist on the staff for just general sorts of therapy or counseling? Tell us-- would you be willing to share with us what that was like?

AARON HANSON: Sure. Yeah, because I think it's, I think it's important. And I, and I, I consider what I went through as PTSI, an injury. Kind of like you pull your hamstring, you, you wrench your back, PTSD-- I understand why people don't like the stigma of PTSD versus PTSI. What I had was, was an injury and I, and I dealt with it quickly through-- well, in my case, I couldn't sleep and so for 30 days, I couldn't sleep. And I found myself trying to find ways to go to sleep legally, but-- and, and it got very difficult. The lack of

sleep further exacerbated that, that trauma period I was going through. And I was getting flashbacks as I was sleeping and I would wake up in a startle and just be swinging wildly. And, you know, I realized, hey, look, we've got-- luckily, unlike kids that live in poverty-impacted neighborhoods, too many of them, I had an option and I got up and I called EAP people and they put me on the right track. But again, that's because I had the luxury of training. And I do sometimes shudder to think where would my life trajectory have gone if I had not been blessed with the perspective of specialized training as a peer support officer? Would I have just internalized that trauma and where would I be today? And so I think that, that's important because it touches on a lot of things we talked about. I, I was aware of it. There was no stigma to me because I had dealt with other officers with it and I knew exactly who to call. I called quick enough and they walked me through how to, how to address it and I did. And so think about if we can repeat that cycle for young people, destigmatize this and make it more accessible for young people in our community. Great. I mean, hopefully it's going to reduce not only crime, but increase prosperity.

HARDIN: Thank you. Appreciate it.

AARON HANSON: Thank you.

HARDIN: Anyone else in support of LB792? Welcome.

CHARITY EVANS: Thank you. Chairman, committee members, my name is Dr. Charity Evans. That's C-h-a-r-i-t-y, Evans, E-v-a-n-s. I am chief of acute care surgery and trauma surgeon at Nebraska Medicine. Much of what you've heard today, I'm going to echo, bringing you from a different lens. I'm testifying today on behalf of Nebraska Medicine, which is a nonprofit integrated healthcare system that includes two hospitals, the Nebraska Medical Center and Bellevue Medical Center, with nearly 70 specialty and primary healthcare centers and clinics in Omaha area and beyond. Nebraska Medicine, we are a level I trauma center. We admit nearly 3,400 traumatically injured patients per year. Of those patients, approximately 250 of them were traumatically injured by violence, most commonly gun violence and stabbings. Level, level I trauma centers such as ourselves, we're fully equipped to care for patients' physical injuries through resuscitation, surgery and physical recovery. However, there is still a very large need to more adequately address the patients' psychological and secondary to the trauma that was endured. So as an example, hypothetical example, let's consider a patient in their early thirties who was shot twice and with

multiple injuries. He was brought to our hospital by ambulance in critical condition. He underwent several surgeries. Ultimately, we were able to preserve their life. Once awake, they described intense nightmares, constantly reliving the shooting every night in their dreams. They felt fear that they weren't safe, even in our hospital, much less upon being released home. The patient cried easily, often argued with their spouse on the phone, not because they were mad at the spouse, but because they were simply mad. One day the patient reported that their young child was angry about their parent being shot and wanted revenge. That seven-year-old is in trouble. This patient and their family were suffering from post-traumatic distress. The course of post-traumatic stress is well-studied and it's actually quite predictable; 50 percent of patients who survive or witness a violent injury will experience symptoms of post-traumatic acute distress immediately following that injury. Of that 50 percent, another half will go on to have post-traumatic distress disorder, chronic distress for years, months and years following the injury. Unfortunately, post-traumatic distress is not limited to those who are violently injured. As you've heard, post-traumatic distress is also experienced by those who witness the violence, where the American-- the experience is marked by a sense of horror, helplessness, threat of serious injury or death. And it's estimated that at least ten people are impacted directly by one person who's impacted by gun violence. Because those witnesses are not physically injured and therefore not taken to a medical facility, it's very unlikely that they will ever receive care. So what does this look like? You've heard many stories. It's reliving the event, avoidance, increased arousal, can lead to depression, suicidal thoughts, drug abuse, estrangement, isolation leading to loss of job, loss of home and inability to care for oneself. When this is left untreated, PTSD can critically impact one's quality of life and result in grave functional and emotional impairment. Less than one-third of violence-- survivors of violence receive trauma-related behavioral support help. And again, I think it's for the reasons that you've heard. But we know that early intervention is essential to help survivors deal with the immediate consequences of violence and to prevent long-term disability. However, there's many barriers that exist to receiving these services. This is a reluctance to engage, long wait times, cost, lack of culturally competent providers. And furthermore, the most disadvantaged survivors of violent crime are the least likely to receive services. That includes people who are of low income, people of color, individuals with disabilities and those experiencing homelessness and who are unstably housed. Our system, in 2020, Nebraska Medicine launched

what's called ENCOMPASS Omaha. ENCOMPASS is the state's only hospital-based violence intervention program, offering culturally competent, intensive, long-term case management to hospitalized victims of violence. Our data shows that over 75 percent of victims display signs of post-traumatic distress in the hospital and yet only a handful of these victims went on to get adequate behavioral health services. At the hospital, we can repair the physical wounds, but alone we can't make them well. So one concept-- I heard this asked-- was the concept of a trauma recovery center. These exist nationwide, often in collaborations with the major trauma center, as we are an entry point. And these centers come together collaboratively to provide behavioral health case management, housing, employment, education and victim advocacy. As a major trauma center in Nebraska, we recognize the need to provide care to our patients who are victims of violence beyond their acute care needs. We're committed to working in partnership with other community-based organizations to address the needs of patients and families suffering from post-traumatic stress disorder. And we'd respectfully request your support of LB792. It helps us help them. So thank you for your consideration and I'm happy to answer any questions as well.

HARDIN: Thank you. Any questions? Senator Riepe.

RIEPE: Thank you, Chairman. I'm, I am having a meeting this morning with the CEO of one of the-- Nebraska's biggest hospital systems. And that would be a he and he shared with me the stress that staff has as well from the shootings or everything else that goes along with this. That kind of leads me into the when you have a trauma case coming into the emergency department, how far does the stress radiate out? I mean, to-- not only to staff but to family members. And, and it even goes beyond those who maybe come along with the victim to the hospital. I mean, I mean is it-- I mean, probably not talking of one or two. We're talking-- all varying obviously.

CHARITY EVANS: It is and, and if you've been a part of a trauma system or have been a patient yourself, you see how the providers descend upon you and how many are involved . Our, you know, average response is going to be 15 to 20 providers of all different ranges. And I would say then it affects all of us differently because all of us are taking in what we're seeing differently and I think the loss of life is probably one of the hardest. I'm seeing more and more of my trauma colleagues get on this side, move upstream in this, in this area of gun violence and of interpersonal violence for that reason. Because I think if we feel as though we're not only on the receiving end of the

gun violence in our community, that we're not having to just continually go and tell a mother that her son is dead, that maybe we're making a difference. And I know that that's our want as a system, as a program, to be involved in a program like this is to know that, that, that we're not patching them up, sending back-- sending the patient back to the same community where they were shot, sometimes back to the same home that they were shot in. It is very difficult for us to know that we saved their life, but we didn't fix it. We definitely did not make their life better. So I would agree we do have providers. We too, as mentioned by Sheriff Hanson, you know, have programs. But really, I think where the biggest impact where this is concerned is to stop that cycle. And the way we stop it is by intervening. Like in my patient's son's life, he's going to grow up angry. And so if we're able to intervene early before he's arrested, before there's gun charges, before there's drug charges, before there's truancy, then we're able to make an impact on these lives.

RIEPE: OK. Thank you for giving up your time to come here today. We appreciate it.

CHARITY EVANS: Of course, my pleasure.

HARDIN: Can I ask a question?

CHARITY EVANS: Please.

HARDIN: This is trauma so this is, I'm assuming, the front end of treatment. In this case, we're talking predominantly juveniles and kids. There's no two situations that are the same. Nonetheless, if-- could you paint a picture for us in terms of where this kind of care might typically transition to other ongoing kinds of care? What's that look like? And if this bill is passed, what might that process on the horizon look like?

CHARITY EVANS: Sure.

HARDIN: How does that script work?

CHARITY EVANS: Sure. So our program, ENCOMPASS Omaha, as I mentioned, is a hospital-based violence intervention program so our program begins at bedside. So once the patient is awake and alert and able to intervene, we have credible messengers, people who look like them, who come from their communities that come to bedside and start that process of trust building, of saying, what are your immediate needs? Are you safe going home? Is there an issue with retaliation? How do we

approach this? And then we start to work on more short-term things like food and housing, security, clothing and then look at long-term needs like education, employment. That patient eventually will transition from our hospital. And so while they remain a ENCOMPASS participant, at some point that transition occurs back to their community. And this is where a pilot like what's being proposed allows us a soft handoff and also allows us to continue in their care. So one model would say that they receive some of their medical services within this arena because I know that if I can catch them in a clinic visit, I have a chance to intervene. And so some of it may be that we mix in some of the medical opportunities or follow-up visits, whether that's physical therapy, trauma. Finding them a PCP is one of probably the most important so that they may have a medical home. And then that introduces them to an environment that they feel safe in. And so in a center or multiple centers, if you also have in that same center behavioral health, you also have legal medical advocacy. You also have other people who can provide this individual with wraparound services. Typically where the social determinants of health are concerned, we've got to solve three or four for the person to be able to come out of this cycle that they're in. Because, again, as my previous advocates mentioned, if there's no job, if there's no secure housing, if the housing is not clean, then it is very likely that the person will enter back into some cycle of something and enter back into survival mode. And so it's a seamless-- it can be a seamless process. We don't have somewhere to send these patients right now. And so we have our own mental health provider. But again, that person-- it's a single person and I mentioned over 250 patients. And so a program like this is key to pulling our entire city towards a healthier environment.

HARDIN: Thank you. Very good. Thank you, Doctor Evans.

CHARITY EVANS: Any other questions?

HARDIN: I don't think so. We appreciate it.

CHARITY EVANS: Very good, thank you.

HARDIN: Another supporter of LB792. Welcome.

DANIEL MARTIN: Hello. Thank you. My name is Daniel Martin, D-a-n-i-e-l, last name Martin, M-a-r-t-i-n. I'm a lieutenant with the Omaha Police Department and vice president of the Omaha Police Officers Association. I'm here representing the OPOA. I follow, you know, Sheriff Hansen when he talks about our mental health and I'll

give you guys some statistics in Omaha and, and what we're dealing with mental health and juvenile crime and some specific incidents that we're dealing with that deal with PTSD and juveniles. So in 2022, OPD responded to 7,734 mental health-related calls, many of which dealt with juveniles and PTS-related illnesses. I have-- our crime analysis unit right now is going through those 7,734 calls to pick out which ones specifically deal with juveniles and once I get that information, I'm going to forward it to everybody on this committee. Since 2018, we've seen 3,343 suicide attempts in the city of Omaha, 331 of those completed suicides. 2022 is our highest year with 64 completed suicides. Fifty-one percent of those means were by firearms and 77 percent of those were male. I crossed out a bunch of things that I was going to talk about because people have already gone over those and, and for the spirit of brevity here. When we talk about juvenile crime in Omaha, I think most of that we can deal with also deals with mental health crisis within juveniles. Since 2016, we had two juveniles-- in 2016, we had two juveniles that had four or more felony arrests on their record. In 2021, that number jumped to 22 juveniles so we saw an increase of 20 juveniles with four or more felony arrests so our recidivism rate is going through the roof when it comes to juvenile crime. A lot of these children-- kids that we see in these calls that we're going on have experienced traumatic incidents. I've mentored many youth through north Omaha when I was on the gang unit and the homicide unit, mentoring a young man not long ago who witnessed his 12-year-old cousin murdered right in front of him in a drive-by shooting. Since that incident, I've seen him now in several police reports with escalating incidents of police contact, whether it be fighting with the police, other gang violence, trying to find his way. And another family, I've seen their house has been shot up numerous times. Several of the kids in that family I've tried to mentor. One of those was sadly killed last year as he continued to escalate his crimes. So the recidivism rate among juveniles, especially those with I believe to be contributed to mental health, is increasing in the city of Omaha. Right now, there's about 140 beds, I believe, available for mental health psychiatric needs in the city of Omaha. Thirty-two of those are for adolescents and CHI currently has a waiting list of 15 people. So I think increased funding and community support among our youth, especially those experiencing mental health crises-- I can give you specific examples, if you want, of the calls that we go on involving mental health. One of the most egregious and one of the saddest things I've seen is a ten-year-old that's in the south projects. His mom doesn't know what to do. He's ran away 15 times. He's ten years old. He's killed the family pet. The siblings have had

to move out of the house because mom's afraid that he's going to kill the brother and sisters, Mom doesn't have a place to put him. Mom has to put locks on her door. She has to hide the knives. Kid took the family pet, was parading around the neighborhood on a stick. And that's just one of the examples of the many that we go on, a juvenile that is experiencing a mental health crisis. I'll be happy to answer any questions.

HARDIN: Thank you, Lieutenant Martin.

DANIEL MARTIN: Thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. My question is this, is give some statistics. Do you have any that would be for the catchment area specifically that this bill is seeking to address? Any percentage of those--

DANIEL MARTIN: Is the catchment area the entire city of Omaha or is it just--

RIEPE: I was just looking at maybe they-- because I think we've talked about-- Senator Wayne is talking about the near northside.

DANIEL MARTIN: Correct.

RIEPE: Do you have-- I mean is there-- what's the percentage or the whole number that's concentrated to that particular community?

DANIEL MARTIN: Are you, are you talking about the juvenile crime rate with recidivism?

RIEPE: Well, that would benefit from this. Maybe the gun violence.

DANIEL MARTIN: Yeah, obviously the majority of our gun violence is in north Omaha.

RIEPE: OK.

DANIEL MARTIN: Gun and gang violence and violent crime.

RIEPE: So the majority.

DANIEL MARTIN: The majority of gun violence is, is occurring in north Omaha.

RIEPE: OK. Thank you.

HARDIN: Other questions? Seeing none, thank you, Lieutenant.

DANIEL MARTIN: Thank you.

HARDIN: Another supporter of LB792. Welcome.

BILL REAY: Welcome. Thank you. My name is Dr. Bill Reay, B-i-l-l R-e-a-y. Thank you for allowing me to testify here. I am the president and chief executive officer of Omni Inventive Care, a community-based mental health agency. I've been providing and designing care for Nebraska citizens for 40 years, beginning when Charlie Thone was Governor and have been so doing consecutively since that time. I have worked with local, regional and state government systems across those decades and I have been directly involved in every child and mental health initiative in the United States since the mid 1980s. I'm not going to go over some of the issues that we've gone over, but I wanted to go over some of the science that I think is important as opposed to opinion and informed opinion. The science on exposure to community violence strongly indicates actual structural changes in brain development in young children and adolescents. Community-based violence also changes a person's sense of physical and emotional safety as similar to living in poverty and experiencing community violence affects both brain development and emotional development, which is commonly known as trauma. According to the United States Substance Abuse and Mental Health Administration. Most, if not all, of the science literature conceptualizes these stressful events that impact healthy development of children through adolescence. According to the United States Centers Disease for Control Prevention, gun violence is a persistent public health issue in the United States. Each year, approximately 100,000 Americans are injured with a firearm. And in the average, 178 people die and 348 are wounded by guns in Nebraska. Like those traumatic events, the impact of exposure to violence involving a gun on, on a youth development is exceptionally significant. A youth who witnesses a friend or family member being injured or shot by a firearm within two years are more likely to experience symptoms of trauma. That trauma, including a gun, is associated with the onset of post-traumatic stress disorder. Related, but separate is the fact that exposure to violence, ETV, has emerged as a key and stable predictor of violent offending. I want to repeat that. Just the exposure to violence has emerged as a stable and key predictor of violence offending beyond any other indicator, beyond any other indicator. The applied research strongly indicates that these

challenges for our metropolitan communities. Exposure to violence predicts involvement in violent offending above and beyond any other risk factor. Post-traumatic stress disorder is defined and recognized as a mental health disorder that can occur following exposure to actual or threatened death and it can coexist with other mental health disorders. So you can have somebody with post-traumatic stress disorder and also have some other disorder like conduct disorder. They're not mutually exclusive. They pile on, in other words. Youth who have PSDC [SIC] may also experience persistence avoidance of stimuli associated with that traumatic event. Comprehensive assessments of PTSD symptom, symptoms can be facilitated by using particular clinical skills. The National Center of PTSD produces useful assessment and there are over 40 treatments with some degree of evidentiary support for the symptoms of trauma, which should be required as a function of this bill, and I believe it is. When delivered in routine mental health clinics, trauma-focused behavioral therapy are effective. However, there are barriers to accessing those treatments. In Nebraska, there are too few specially trained practitioners to deliver evidence-based interventions. Therefore, a stepped care approach, which could be used by parent-led treatment approaches which have been very, very successful in large cities across the country, including San Francisco and L.A. To build a sustainable and accessible program, community partnerships must have key stakeholders to develop treatment strategies that are consistent with the community priorities and the science. Various practitioners and partners will need to be interviewed and meetings will have to take place in schools as well as law enforcement and churches. These efforts presented are designed to assess and treat PTSD in a community. However, assessment and treatment can't be implemented without a complete understanding of the need to place a substantial effort on the prevention of violence. So anyway, I have a few other things in my written testimony. I want to thank you for the opportunity to testify and I can entertain any questions you may have.

HANSEN: Thank you for your testimony. Are there any questions from the committee? All right, seeing none--

BILL REAY: OK.

HANSEN: --thank you very much.

BILL REAY: Thank you.

HANSEN: I came here just in time to harass my good friend.

MICHEAL DWYER: You should have stayed away.

HANSEN: Welcome.

MICHEAL DWYER: Good afternoon, members of the Health and Human Services Committee, Chairman Hansen. My name is Micheal Dwyer, M-i-c-h-e-a-l D-w-y-e-r, and I'm a 38-year member of the Arlington Volunteer Fire Department as a firefighter/EMT approaching 2,400 calls in my career, including one this morning and also including two horrible calls in the last ten days. What I, I'm going to try to do is perhaps add to the perspectives that have already been given, which are awesome and I'm humbled to be able to be part of that voice so I only want to add to that. Really quickly, the call ten days ago was a father of three who committed suicide. The call Friday night was a vehicle accident: mom, three kids in the car, mom and the infant child deceased. And the two of the kids, we fought for almost two hours to get them out of the vehicle and treatment and they're both alive. There was approximately 38 responders on the call and I don't know specifically, but about 70 percent of those responders are volunteers or people like me that are sitting on the couch watching a basketball game when the pager goes off and then we have to respond to something like that. Monday night, we participated in critical incident stress debriefing. So it's a microcosm almost of what we've been talking about. The good news is it's a great opportunity to just flush all of that crap out, particularly among specifically the people who responded to the call. The bad news is that it's, it's a tremendous service, but it's not, it's not very wide and it's not very deep so there's no real clinical and specific support after that other than typical mental health counseling you might seek privately. As I understand, LB792, while it may not be the intent, this would provide tremendous support to volunteer fire and EMS services in the state of Nebraska, even if it's located in one of the metro cities closer to the eastern part of the state. The initial services are good, but clearly, in an age when we're so short of volunteer fire and EMS responders that have to, by the nature of our business, respond to stuff like this week, we can't afford to lose anybody. Without violating any of the confidentiality of critical incident stress debriefing, I can tell you that there are men and women and families this week that are having hard conversations with each other about whether or not they can continue to do this or not. We're not in a position in our department, and from my knowledge in the state of Nebraska, to lose any of those people, particularly something as horrific as PTSI. And I-- by the way, I like that description. I think that's it. I apologize for my chicken scratches. I'm not very

organized because I had a call this morning. But I would encourage your support for LB792 and would be happy to take any questions.

HANSEN: All right, thank you for your testimony. Are there any questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman. As a volunteer group, do you have a resource out there where, with a call, telephone call they can send in some expertise to, to help sort through this? Not just in your community, but because the state is comprised of a lot of volunteer trauma people who are working with the, you know, emergency rescues.

MICHEAL DWYER: So, Senator, I'd like to be able to say yes. And CISM, CISD, the debriefing process that lasts about two hours typically within 72 hours of the call, would be the-- sort of the answer to that. But honestly, beyond that, I don't know of any other direct counseling services that, quite frankly, if I was struggling, that I would call. This is my 12th CISM debriefing. After 38 years, you see some stuff and so I've been down the process. My wife tells me that now I have a fairly predictable response and so she knows when I'm outside those lines and, and watches for that. But to answer your question directly, not to my knowledge, no.

RIEPE: OK. Thank you. Thank you, Mr. Chairman.

HANSEN: All right. Any other questions from the committee? All right, seeing none, thank you very much.

MICHEAL DWYER: Thank you, Ben.

HANSEN: Take the next testifier in support. Welcome.

JENNI BENSON: Good afternoon, senators. My name is Jenni Benson, J-e-n-n-i B-e-n-s-o-n. I serve as the president of the Nebraska State Education Association and I'm here representing NSEA's, 28,000 members, teachers, education support professionals in Nebraska. I want to thank Senator Wayne for introducing this legislation to assess and treat post-traumatic stress disorder. I have 30-plus years as a special education teacher. I know that students come to school with high levels of trauma and have more difficult time learning, socializing, enjoying school as a whole. I believe it's important we have programs such as this pilot for this legislation that we can assess and treat childhood trauma, trauma from violence, abandonment, psychological/physical abuse and the trauma that children deal with due to hunger, neglect or any kind of family situation. As I listened

to the other testifiers, I am sure, as you do in your own, when you hear these stories, you think of people that you know. And I think of my students. I think of my grandchildren who were adopted out of foster care at nine years old. They are 19 years old. I think of myself as a, as a survivor of childhood trauma. And what I'm hearing as, as we're talking about this and as a teacher for all these years is what I'm hearing is it doesn't just affect the person. It affects the family. It affects being able to go to school. It affects my grandkids on a daily basis. And I will tell you that myself and my grandkids have had therapy every week since they came into our home. But the trauma and the physical things that the one gentleman were talking about, the change in their personalities and their changes as young children going through trauma. I wanted to tell one story about a student I had who was a first grader so he was already receiving special education services from me. And he came to school one day and he just seemed sad. And I said to him, I said, What's going on today? He said, my mom stabbed my dad last night and this is the only place I could come today so they brought me to school. And that, as a teacher, causes trauma as well because you're dealing with students who are going through this and you're going through it with them. And unfortunately, in schools and, and in communities, we look at things in silos instead of looking at them as an overall service model that we need for our families. We're very judgmental about families. We're very judgmental about where they're coming from and what they're dealing with. And as this young man came to me as a first grader and school was his safety net, but then he didn't have a family to go home because his father was, was dead and his mother was now in prison and then he went into the foster care system. And I often think of him and I don't know where he's at. I look up some of my other kids that I've had and ones I taught in Austin, Texas, in my first year. I look them up because I can find them on social media because they had very unique names. But other kids, I don't know what happened to them. But I know what's happening with my grandchildren and 19. I see it every day. I know what I deal with myself from the things that have happened. And I just ask you, when you're listening to these stories, to really put a human face on the things we're talking about because these are happening daily to our children and our children should be our most important priority in everything we do in this Legislature. Thank you.

HANSEN: Thank you for your testimony. Are there any questions from the committee? All right, seeing none, thank you very much.

JENNI BENSON: Thank you.

HANSEN: Anybody else wishing to testify in support of LB792? Any other-- anybody else wishing to testify in support? All right, seeing none, is there anybody who wishes to testify in opposition to LB792? All right, seeing none, is there anybody wishing to testify in a neutral capacity? All right, seeing none, I believe Senator Wayne waived closing.

HARDIN: He did.

HANSEN: He did. All right. And so with that, we did have some letters for the record. We did have four letters in support of LB792 and one in the neutral capacity. So with that, that will close our hearing on LB792 and we will now open it up with LB523 and welcome Senator Hardin. Welcome.

HARDIN: Thank you, Chairman Hansen, and good afternoon, fellow senators of the Health and Human Services Committee. I am Senator Brian Hardin. For the record, that is B-r-i-a-n H-a-r-d-i-n and I represent the Banner, Kimball and Scotts Bluff Counties of the 48th Legislative District in western Nebraska. I'm here to introduce LB593. LB593 is a bill that was brought to me by the Nebraska Hearing Society and that I believe is essential to provide clarity, no pun intended, to those licensed hearing instrument specialists who are operating throughout the state of Nebraska and assisting our population with the management of their cerumen or earwax. This legislation does two primary things. First, it adds the ability for a licensed hearing instrument specialist to remove earwax. And second, ensures that licensed hearing instrument specialists and audiologists can order the dispensing of over-the-counter hearing aids. The International Hearing Society holds that the removal of earwax is a necessary component of the practice of hearing aid dispensing, as proper management ensures optimal outcomes for the hearing aid user and the operation of a hearing aid. Earwax management has always been a part of the practice of hearing aid dispensing. For example, IHS Professional Practice Profile for Hearing Health Professionals depicts the scope and components of a hearing aid specialist's practice. The basis of the document was the 1999 National Board for Certification in Hearing Instrument Sciences Role Delineation Study of Hearing Aid Dispensers, which surveyed 100 licensed and active hearing aid specialists to capture the frequency of tasks performed. The results indicated there are 16 broad procedures that are commonly performed. One of the procedures is to administer cerumen management in the course of examining ears, taking ear impressions or the fitting of hearing instruments. Educational content in licensed hearing instrument

specialist distance learning courses, training manual and international licensing exam includes cerumen management and IHS holds reviews and approves continuing education courses on this topic regularly. Most states do not specifically mention the management in their statutes. However, licensing laws in general authorize the performance of services that involve at least a limited degree of this sort of management in the performance of said services such as otoscopic evaluation, taking ear impressions for ear molds and cleaning hearing aids. Appropriate management is inherently essential to the performance of all these services. So I would argue that this management is implicit in the performance of the services of a licensed hearing instrument specialist. The bill makes it clear that the licensed hearing instrument specialist must have appropriate training to remove earwax and that they must have a relationship with a medical liaison to ensure that the patients have access to more specialized medical care should it become necessary. The bill also adds language into Section 12 [SIC] of the bill that states as follows: a licensed hearing instrument specialist or audiologist may order the use of too of devices pursuant to 21 C.F.R. 801.109, as such regulation existed on January 1, 2023. The purpose of this technical language is to clarify that Nebraskans will not be negatively impacted by a recent federal rule which allows for over-the-counter sale of hearing aids. This language seeks to remedy that point by including language that mirrors federal statute found in the recent 87 FR 50698 rule regarding medical devices, ear, nose and throat devices, establishing over-the-counter hearing aids and a clarification letter that the U.S. Food and Drug Administration sent to states where this could be an issue. There will be those following me in testimony that are much more familiar with the process that I've just discussed so I encourage you to ask your questions of them. I'm happy, though, to try to answer any questions you might have. Thank you.

HANSEN: All right, thank you for your opening. Are there any questions from the committee? Senator Riepe.

RIEPE: I'm not going to let you off easy. My question is it's noted in here in some of my review, it says, an increase in the scope of practice. So my question obviously then is has this been through the 407 review?

HARDIN: I believe it's teed up and so someone else would be able to-- so the answer is not yet--

RIEPE: OK.

HARDIN: --but soon is what I understand.

RIEPE: And my other maybe a question or concern, why did you elect to make it-- the liability insurance mandatory as opposed to a good business practice would have to be if, if you have exposure, you want to have liability. But I don't-- I'm not big on mandates and so that was a concern. The other one is just more of a-- you know, I've had earwax removed and it was candled and it wasn't done by anyone that-- it was done in a local salon, you know, that-- so there wasn't any licensing. There wasn't any threat of, of-- what is it-- uncontrolled bleeding or any of that. I mean so I'm kind of saying who's protected here? Is the public protected or is the-- who's-- who benefits out of this?

HARDIN: My sense is that we are about to hear the answer to that question with those who are following me.

RIEPE: You should run for politics.

HARDIN: I should. I should. My sense of this, Senator Riepe, is that there was a pragmatic issue that was brought to me. And it was-- imagine that you're in a nursing home and imagine that the person who's available to come see you when you're there because-- they're coming to see you because you can't hear. And so you have these darn things checked out, these hearing aids. And they come and they check out your hearing aids and they basically say the hearing aids look just fine. However, inside your ears, there is something that's actually blocking the hearing aids. They're working great; your ears are plugged and we need to unplug them. There are audiologists and those folks that are kind of the specialist in this category. There are hearing aid technicians who don't have that same type of qualification as the audiologist does, but do they have enough qualification to be able to help you hear again by removing that earwax? And so there's kind of a pragmatic sense that this bill came about as a-- kind of in response to helping people hear.

RIEPE: With this licensure requirement, though, would that keep someone from doing-- like, at the salons where they can do a simple candle. It's a very simple, do-nothing procedure. There's no intervent-- you know, there's--

HARDIN: Chances are what they might be doing at those salons might be naughty already. I don't quite know the answer to that question. In a

nutshell, I think that's what we're about to hear is the back and forth on who should be allowed to do that.

RIEPE: Well, for $25, you can find out. OK. Thank you.

HARDIN: Thank you.

HANSEN: Any other questions? All right, seeing none--

HARDIN: Thanks.

HANSEN: --stay to close?

HARDIN: I shall stick around.

RIEPE: Good.

HANSEN: We'll take the first testifier in support of LB593.

JANIE YORK: Just in case. Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. I am Janie York, J-a-n-i-e Y-o-r-k. I am appearing before you today as vice president of the Nebraska Hearing Society. I am a hearing instrument specialist providing on-site hearing care for seniors living in elder care communities. I provide care on-site, as it is both difficult and costly for individuals in this setting to go out for appointments. Thank you for listening to our comments today on this important topic. During my service, I provide hearing aid care and cleaning, ear examinations, tests and new hearing aid fittings upon request. Most of the new hearing aids I fit are provided through Medicaid. Cerumen management is essential to providing all the above services. Hearing aids, when passed through cerumen at the base of the ear canal, will not function, as they immediately become plugged upon-- with wax upon insertion. Eardrums that are occluded with wax cannot receive the soundwaves necessary for hearing. When excess wax is present at a hearing test, it will not be accurate and impressions of the ear cannot be made for hearing aids. At this time, when excess cerumen is discovered, the resident must be referred out to an ENT or audiologist to have wax removed. When this happens, a chain of scheduling needs to occur. First, the transportation coordinator needs to work with the referring doctor to schedule an appointment that fits the transportation schedule. This also needs to coordinate with a family member to come and meet the resident at the appointment. This causes delays in services, costs time for the family and incurs additional expenses for the residents, as there is a fee for transportation. To

help you understand the scope of this issue, last week I saw 47 individuals residing in three elder care communities. Of the 47 seen, 20 had to be sent out for wax removal. This is complicated and expensive and would be mostly unnecessary if I were able to provide cerumen management for these residents, none of which were happy about needing to go out for this procedure. Some will simply refuse and leave the issue untreated. If licensed hearing instrument specialists can gain the ability to remove excess cerumen, services can then be delivered in a timelier manner, hearing aids can be kept in better working order and hearing could be improved for those with the impactive cerumen. There will, of course, be times when complicating factors will still require a referral to an ENT or audiologist. I have excellent individuals in both professions that I trust and refer to. I would encourage you to adopt LP593 and give hearing instrument specialists the ability to fully serve our clients and stop asking them to spend extra time, money and effort for a procedure that could easily be taken care of at the time of their visit. Thank you for your time today. I would be happy to answer any questions you may have and please ask your questions using your teacher voice, as I am also a hearing aid wearer. Thank you.

HANSEN: Thank you for your testimony. Are there any questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman.

JANIE YORK: Thank you.

RIEPE: Along with my partner here, I too am a fiscal hawk. And my question is this: What would be your professional fee to remove wax from two ears?

JANIE YORK: What would be my professional what?

RIEPE: Fee.

JANIE YORK: Oh. For me, I work on a contract basis with my, my res-- my nursing homes that I work in. I go to nine nursing homes around the area. I charge an hourly fee and it would just be part of my services.

RIEPE: OK.

JANIE YORK: But I would not be-- the only additional fees there would be, would be if I was there an extra hour because I was doing wax removal.

RIEPE: OK.

JANIE YORK: But there are no charges to the resident. It's a service--

RIEPE: Somebody is paying here.

JANIE YORK: The, the facility is.

RIEPE: And you skirted this I think with me on this, but what's your hourly fee?

JANIE YORK: My hourly fee is $85 an hour.

RIEPE: OK. That's what I wanted to know.

JANIE YORK: I go in-- yeah, I go into the nursing home and they pay me and provide it as a service for their residents that live--

RIEPE: I was just more curious about what your hourly fee was, thank you.

JANIE YORK: Yeah, that's what my hourly fee is.

RIEPE: OK, thank you. Thank you, Chairman.

HANSEN: Any other questions from the committee? Seeing none, thank you for coming to testify.

JANIE YORK: Thank you.

HANSEN: We'll take our next, next testifier--

JANIE YORK: Thank you.

HANSEN: --in support. Welcome.

JOE KOHOUT: Chairman Hansen, members of the Health and Human Services Committee, my name is Joe Kohout, J-o-e K-o-h-o-u-t, and I'm registered lobbyist appearing today on behalf of the Nebraska Hearing Society. The testimony I'm about to give with-- and with Chairman Hansen's permission, was written by Scott Jones, who is a member of our association and unfortunately came down with COVID on Monday and so he is not able to be with us today. And so we, we definitely appreciate Senator Hardin bringing this bill forward. You may be-- all be asking what is cerumen and simply cerumen is earwax which causes the ear canal to be acidic and inhibits bacterial and fungal growth.

It also repels water from the ear, further protecting it from infection. A normal amount of earmax [SIC] is good for people to have. Cerumen is, is produced by the sebaceous glands of the hair follicles on the outer half of the ear canal and it naturally flows outward along these hairs. Older adults are more susceptible to impaction because-- due to the decrease in cerumen-producing glands, resulting in drier and harder wax. Why are we told not to use Q-tips to clean our ears? One of the problems associated with Q-tips is that they can push the wax inward, away from these hairs and against the eardrum where the wax can stick and harden. Not only can Q-tips do this, but, but hearing aids can also impede the natural movement of wax out of the ear canal. Do many people need to have ear wax removed from their ears? Yes, they do. Ear wax accumulation leads to 12 million patient visits and 8 million cerumen removal procedures annually in the United States. That's approximately 150,000 removals in the United States per week. Cerumen impaction is present in approximately 10 percent of children, 5 percent of healthy adults, 57 percent of older patients in nursing homes and 36 percent of patients suffering from intellectual or developmental disabilities. This bill will make the process of obtaining hearing aids more efficient and seamless for consumers, as well as less expensive. There are approximately 371,000 adults in Nebraska with hearing loss. I think I'm one of them. When fitting hearing aids, a hearing instrument specialist, specialist often must remove cerumen from the outer ear to properly fit a hearing aid. Presently, many consumers have to be unnecessarily referred to a physician to first clean the outer ear, despite hearing instrument specialists being capable to do so in a safe and effective manner. This is costly, unnecessary and time consuming for patients. Some patients do not drive anymore and have to pay for someone to take them to their appointments, which is an additional expense that can be hard on some seniors on a limited budget. In addition, those who are hesitant about getting hearing aids may give up completely because of the cost or hassle of seeing a second healthcare provider. Research shows that hearing aids can help to delay and minimize falls, dementia and depression, depression in older adults. Basic noninvasive cerumen management, because it affects the efficacies of hearing aids, is within the scope of practice for hearing aid specialists. We urge you to vote in support of LB593, which will help thousands of hearing-impacted Nebraskans to get more efficient and less expensive access to hearing aids-- hearing services and hearing aids. And I would just note, I know the committee received a letter of support from the AARP and I would just note that in that letter, there are a couple of points that I think are verified, right, of what I just read

of Mr. Jones' statement. And that is, first, that it does-- that hearing aids can lead to fur-- the lack of hearing aids or nonuse of hearing aids can lead to further health complications further down the road. But second is that in that letter, it talks about innovative approaches. And I think one of the things that we have to look at as Nebraskans is the fact that we have a very rural state and we have to take advantage of individuals who can't-- who are available and who are out doing that work now. And those are the folks that, that believe that this bill is, is needed and why it's here today. So thank you, Mr. Chairman.

HANSEN: Thank you. Are there any questions from the committee? Seeing none, thank you for testifying. Is there anybody else wishing to testify in support of LB593? All right, seeing none, is there anybody who wishes to testify in opposition to LB593? All right, seeing none-- I'm just joking. I see, like, a line of, like, five people here, so. Welcome.

NIKKI KOPETZKY: Hi. All right. Good to go?

HANSEN: Yep--

NIKKI KOPETZKY: OK.

HANSEN: --you're all set.

NIKKI KOPETZKY: Well, Chair Hansen and members of the Health and Human Services Committee, my name is Dr. Nikki Kopetzky. That is N-i-k-k-i K-o-p-e-t-z-k-y. I'm a board member of NSLHA, which is the Nebraska Speech-Language- and Hearing Association. We are the professional organization for all the audiologists and speech pathologists in the state of Nebraska. I'm also a private practice owner and I have-- did 15 years as director of audiology for one of the largest ENT clinics in the state and I am here speaking in opposition to LB593. I received my doctorate degree in audiology in 2008, but I have actually held a hearing instrument specialist license as well in Nebraska since 2003. So as such, I'm one of the few professionals in the state that is duly licensed as both an audiologist and a hearing instrument specialist so I feel I'm uniquely qualified to testify to the training program for both professions. I'm here to say that the training hearing instrument specialists receive on ear anatomy, indications for ear disease and contraindications for safe cerumen removal is inadequate to ensure the safety of Nebraskans. In truth, my own proper training on cerumen management did not occur until I completed my clinical fellowship as

an audiologist. That training occurred in person via hands-on experience doing cerumen management under the direct supervision of an ear, nose and throat physician. Why did we do it that way? And we did it that way because cerumen removal is very dangerous. The practitioner risks abrasion to the ear canal, perforation of the tympanic membrane or eardrum, uncontrolled bleeding in the ear canal and the introduction of bacteria that could lead to very serious infections. The training also needs to include infection control protocols as the instruments used for cerumen removal need to be properly sterilized and stored in a manner that keeps them free of potential bacteria exposure. LB593 states, "a licensed hearing instrument specialist shall obtain the training, knowledge, and skills necessary to perform cerumen management." LB593 does nothing to define the minimum requirements of that training. It mentions nothing about hands-on training or infection control protocols. Additionally, LB593 states, quote, if a licensed engaged in cerumen removal discovers any trauma including, but not limited to, continuous uncontrolled bleeding, lacerations or other traumatic injuries, the licensee shall, as soon as practical, refer the patient to the medical liaison, unquote. This statement alone makes it clear that this proposed scope-of-practice expansion does not take the true risks of cerumen removal by hearing instrument specialists as seriously as it should. I feel it's common knowledge that something like uncontrolled bleeding warrants more swift action than the as-soon-as-protocol timeline defined in the bill. In summary, I strongly oppose the scope-of-practice expansion for hearing instruments specialists in Nebraska. I believe passage of this in its current form poses health and safety risks to Nebraskans, and as such, I hope that you will join me in opposing. And since they haven't turned the light on me yet, I'm going to comment to some of the other things that were said. First, cerumen management doesn't need to be done by an ENT physician. It can be done by any medical professional with the right training. So that would be a nurse or primary care and those are easily accessible in those residential facilities. Cerumen management is not a billable code by hearing instrument specialists, so to speak, to your question of how much does it cost. You know, the, the billable rates are often determined by the insurance companies. And so as audiologists or primary care physicians, there is a CPT code that we can bill insurance and insurance will pay whatever that contract is for that particular code. But if a patient is walking off the street to my practice to see me with a doctorate in audiology,with the proper training to do that, our current cost on that is $30 per ear, which is, I think, a pretty good deal instead of going to someone who is

unlicensed doing ear candling in a, in a salon. And so I'm kind of picking on you a little bit here.

RIEPE: That's OK. Everybody does.

NIKKI KOPETZKY: Ear candling, there's an excellent video on YouTube done by Dr. Cliff Olson. You should definitely watch it so you know never to do ear candling again. The problem with ear candling is when-- you didn't get to see the inside of your ear before they did it. And so had they done that, I'm not sure wax would have been present. Ear candling, you have a corn husk essentially. It's coated with wax. They light it on fire. The wax on the cornhusk melts down into your ear and then they put it out and then they light it again and the dry part of the husk draws that wax back out. And they show you all of this wax that they got out of your ear that actually was never in your ear to begin with. It was on the coating of the ear husk. And in the meantime, you risk, you know, lighting your hair on fire or third-degree burns to the side of your face or burning right through your eardrum. So please, if you don't do anything else, please don't ever ear candle your ears again. It's my big, huge health concern for you.

HANSEN: Any questions from the committee?

NIKKI KOPETZKY: I won't even charge you for that medical advice.

HANSEN: Senator Riepe.

RIEPE: Thank you. Thank you for the opportunity to respond. I never at one moment felt any risk. I didn't feel any sense--

NIKKI KOPETZKY: Well--

RIEPE: --of my hair catching on fire because of my hairspray or anything else and so.

NIKKI KOPETZKY: --when I was a kid jumping off the--

RIEPE: And I-- quite frankly, when I walked out, I was a very satisfied customer because I could hear better.

NIKKI KOPETZKY: That's lovely. But when I was a kid jumping off the roof of my grandparents' house into the pool, I also didn't feel any risk, but now I'm educated so I know better. And I really do encourage you to watch that video. It's frightening. I have seen all of those

injuries. I'm not making them up. I have seen third-degree burns on a face here in Lincoln, Nebraska.

RIEPE: Oh, this was in Omaha so it wouldn't happen there.

NIKKI KOPETZKY: Well, that's where I, that's where I'm at now. I'm, I am in Omaha now, so.

RIEPE: OK. Thank you, Mr. Chairman.

HANSEN: Senator Cavanaugh.

M. CAVANAUGH: I don't know what I missed when I was coughing in the hallway. Thank you for your testimony. I wanted to ask you to speak to the concern that was in one of the previous testifiers about you said that some of the in the facilities, the nursing homes, etcetera--

NIKKI KOPETZKY: Any nurse can do it.

M. CAVANAUGH: But-- and obviously, you're not going to know the specifics of all the situations, but if they're saying-- if Ms. York is saying that they have to be referred out, I'm assuming that means they don't have that staff available in the facility.

NIKKI KOPETZKY: That, that-- I wouldn't be able to speak to that, but-- you know, I'm not in those facilities; that is true-- but nursing staff are able to remove cerumen. And it is in their-- they're covered by their medical malpractice to do so. They need to do it under the direction of a physician so a physician does need to order it typically.

M. CAVANAUGH: OK.

NIKKI KOPETZKY: But nurses and across medical practices every day remove cerumen safely.

M. CAVANAUGH: OkK. And I did do ear candling when I was a teenager.

NIKKI KOPETZKY: Uh-huh.

M. CAVANAUGH: Just, just saying. I survived, but I don't know.

RIEPE: Did you burn anybody up?

M. CAVANAUGH: Not yet. Thank you for your testimony and for that clarification.

HANSEN: Any other questions? I have not ear candling and I'm glad I haven't yet. But I was thinking about it.

NIKKI KOPETZKY: The Cliff Olson video. I'm telling you, Dr. Cliff Olson ear candling. You will--

HANSEN: I got some questions for you though.

NIKKI KOPETZKY: Oh, OK.

HANSEN: You addressed the cost difference. What is the training or, like, continuing education hours it takes for someone to be able to perform-- now, is it seramin [PHONETIC] or serumen [PHONETIC]?

NIKKI KOPETZKY: It's serumen [PHONETIC]--

HANSEN: I was right.

NIKKI KOPETZKY: --but wax is fine.

HANSEN: I always thought it was serumen [PHONETIC], OK. To perform cerumen cleaning, what is-- like, how many hours do you need? So say you have somebody who is a hearing instrument specialist and then they need some training in order to clean ears to a certain degree. What kind of class do you need to take? Is it a weekend class? Is it, like, eight hours. Is it 16 hours? Is it--

NIKKI KOPETZKY: Yeah. So that's a hard answer for-- or a hard question for me to, to quantify because I'm also an audiologist and all of my training came as part of my audiology program. And so we had whole classes dedicated to just ear disease, indications of ear disease, OK? You have a little workbook for a hearing instrument specialist. The minimum degree entry for hearing a hearing instrument specialist in the state of Nebraska is a GED. The minimum degree entry for an audiologist is a doctorate currently, if you graduated 2007 or after. Prior to 2007, you could enter the field with a master's degree. My particular training, so I had all the, the, the classes and all of the ear disease and medical issues there. Infection control is usually a several hours course. You can take those online and learn infection control protocols, no problem. The real issue is the hands-on training. Ear anatomy is different. Even from your left ear to your right ear, it is much different. And so being able to know about that, use the microscope appropriately so you have a good vision-- and that's the other thing. The tools that you need to do it properly aren't readily available in a nursing facility. The code that ENT

physicians use to do cerumen removal is actually a surgical code because it's done under surgical microscope so that they have the vision to see the right depth. You need a lot of magnification. You can't just look in the ear with a little otoscope and dig around. You're, you're going to neck the ear canal. So it took probably it-- was for me, it was in pieces and it was over one year of a fellowship in an ENT practice. Every time someone came in with some wax, the physician would pull me in and say, OK, what's the approach? How are you going to do this? How do we do this safely? So you can't learn that in an online course. You can't practice the techniques. You can't see how steady the hand is. And it's just a big, big risk. And it's great when it goes fine, but it's really bad when it doesn't.

HANSEN: OK and then you mentioned that any nurse can do it. What's in their-- like, do they have it in their curriculum for ear cleaning? Like when you become a nurse?

NIKKI KOPETZKY: So the nurses, we're-- they're going to use usually lavage. So they're going to just take a basin and a little squirt bottle and pump it out that way. They cannot go in with instruments like we can as audiologists. So they're, they're going to do it to a point for sure, but what that-- that is not defined in this bill. It doesn't say irrigation only and it doesn't say do a tympanogram before irrigation to make sure that there's not a hole in the ear drum. The issue isn't really the ask. It's not defined on how we're going to ensure the health and safety of Nebraskans. The education is not defined, how you learn to do this properly, how, how it's managed. The thing about nurses is if you have uncontrolled bleeding, they know what to do.

HANSEN: How effective is it from using instruments versus using lavage?

NIKKI KOPETZKY: It depends on the type of wax. So if it's, you know, really hard wax, really nobody should be digging at that until it can get softened. So a lot of times, we tell patients we need to, you know, use ear wax softening drops or a protocol to get it softened so then we can wash it out. If it is down next to the eardrum, nobody should be digging in there unless they're an ENT. If-- think of, like, earwax when it's dry and hard. It's just like a scab, right? Have you ever peeled off a scab? It takes the top layer of skin with it. Do you want to take your eardrum with it? So, you know, it's-- it can be quite dangerous.

HANSEN: OK. I'm just-- I'm asking this question because you seem a little uniquely qualified since, you know, you're-- since you've been involved in both of these aspects. So would you be personally comfortable with a hearing instrument specialist just doing lavage without instruments?

NIKKI KOPETZKY: With the right amount of training and the ability of the equipment to do a tympanogram prior to make sure that the eardrum is intact. You know, I would have to see it outlined. But at this point--

HANSEN: Does a nurse do that?

NIKKI KOPETZKY: What?

HANSEN: Does a nurse do that--

NIKKI KOPETZKY: I don't know what the nurses'--

HANSEN: --do a tympanogram?

NIKKI KOPETZKY: --protocols are. I know that in most of the primary care facilities that we work with, they do have tympanometry equipment on board. I don't know what they have in the, the residential facilities. I mean, I suspect not.

HANSEN: OK. Just curious.

NIKKI KOPETZKY: Yeah.

HANSEN: I'm going to ask one--

NIKKI KOPETZKY: But again, I would still not want to risk the injury.

HANSEN: OK. I'm going to ask one more question. Even if you can answer, maybe somebody behind you can. And I should have asked to-- actually, the proponents. I was curious to know how many other states allow the scope of practice by hearing instrument specialists that they're trying to accomplish with this bill? Are there other states that allow this? [RECORDER MALFUNCTION] That's fine. Maybe somebody behind you can, so I'm just gonna put it out there now.

NIKKI KOPETZKY: I can Google it while you're talking to the other people, maybe pass the word along.

HANSEN: All right. And the great thing about like being on HHS Committee, we do get free medical advice, so that's [INAUDIBLE]

NIKKI KOPETZKY: Yeah, there you go. No-- no more ear candling, right? That's the lesson for today.

HANSEN: OK. All right. Thank you very much, appreciate your testimony.

NIKKI KOPETZKY: Thank you.

HANSEN: Is there anybody else who wishes to testify in support of LB593?

_____: Opposition [INAUDIBLE]

_____: Opposition.

HANSEN: In opposition, yeah. Welcome.

SANDRA MILLER: Thank you. Chair Hansen and members of the Health and Human Service Committee, my name is Dr. Sandra Miller, S-a-n-d-r-a M-i-l-l-e-r. I'm here to testify in opposition to LB593. I have practiced as an audiologist in Nebraska for 25 years. The current scope of practice of a hearing instrument specialist, to be further defined here as HIS, in the state of Nebraska is related to the sale of hearing aids. LB593 proposes an expanded scope of practice to include cerumen removal. It does pose a health and safety concern for Nebraskans. To begin, the-- to begin practicing, the state of Nebraska currently allows for an HIS to obtain a temporary license and begin practicing with supervision. The only requirement is a high school diploma or GED. You can apply for a temporary license and start practicing-- I just have to say that-- no medical background, no associate's degree, no technical training. I can personally attest to the negative outcomes that come from limited education requirements. I served on the HIS board and I proctored practical exams for this profession's licensure for ten years. The initial failure rate for the practical exam I encountered was well over 50 percent. Failures from candidates who had been in the field practicing to gain competencies included faulty equipment setup, not understanding testing procedures, to not using appropriate-sized otoblocks when taking impressions, which could potentially lead to an eardrum rupture. Adequate training and supervision are not being provided currently in their scope. Broadening the scope to include cerumen removal, which is a medical procedure, with no defined training protocols, supervision requirements, or evaluated competencies, will put Nebraskans at risk.

I would comment to how many people are across the-- the United States is this allowed. I don't know the number. What I'd tell you is the biggest takeaway I would take from-- when I was on the board, I would tell you I'm an advocate for this profession because I want to elevate it. I think that they get a bad rap and I think they should be elevated, but the elevation should come from training and adequate training. After I would complete being with them, I'd want to take them all home and train them the right way when there was a failure rate of 50 percent. So expanding the scope of practice without really laying out what that means, it just scares me a little bit. What I also would tell you is other states are allowing it, I do know of. I do not know how many, but their training requires an associate's degree before they get their license. We have people who have a GED or a high school education and now they're allowed to do procedures like this. This is where my concern is. So as the bill stands, I urge you to oppose LB593.

HANSEN: All right. Thank you. Are there any questions from the committee? Senator Riepe.

RIEPE: Thank you, Mr. Chairman. One of the questions I have, somewhat related here, it says, you know, with-- given the high price of hearing aids, it's afforded an opportunity for others to enter the market on over-the-counter hearing aids. And I know the high price of hearing aids has been a congressional concern and the subject of many articles. Through this use of the-- is there a way to drive that cost down through the hearing instrument specialist as opposed to the audiologist?

SANDRA MILLER: That's a really good question. I think in-- in regards to when over-the-counter hearing aids came out, as our practice, we just said, this has been on the market for a long time and now it is FDA-regulated. Is it allowing greater access to patients, is one of the questions, and I think that I would tell you yes because there may be less costly. There's no difference between what they're offering and what we're offering. The products are the same. We offer over-the-counter hearing aids in our office, so there's nothing in terms of product difference between the two of us. What's really interesting is the penetration rate over in Europe where they get free hearing aids is the same as it is here in the U.S., and so just because we've made it available doesn't necessarily mean people are running down the road to get hearing aids.

RIEPE: OK. Thank you. Thank you, Mr. Chairman.

HANSEN: Any other questions? All right. Seeing none, thank you.

SANDRA MILLER: Thank you.

HANSEN: Welcome.

MACY SCHOTT-MILLER: Hello. Chairman Hansen and the members of the committee, my name is Dr. Macy Schott-Miller, M-a-c-y S-c-h-o-t-t, dash, M-i-l-l-e-r. I'm here to testify in opposition to LB593. I am a doctor of audiology practicing here in the great city of Lincoln. I want to take a little bit of a different spin to this, so I want to talk to you guys about a personal story that I have of a patient who came in to me in regards to improper cerumen, or wax, removal. For my story's purpose, I'm going to go ahead and just call him John. That makes it easy. John came into our office one day experiencing severe ear pain and bleeding after having cerumen removed by a hearing instrument specialist, which currently is outside of their scope of practice but was completed anyway. Upon inspection, John had a significant amount of blood inside of his ear canal where I could not even visualize his eardrum. He currently was on a blood thinner, which was never addressed by the hearing instrument specialist before they chose to remove the wax. As I have appropriate training for cerumen management, as well as managing any bloodborne pathogens, I completed proper cleaning of his ear canal. Post-management, it was also noted that the individual who completed the wax removal had ruptured poor John's eardrum. Due to this, I also worked in conjunction with an ear, nose and throat physician to safely manage his ear health. His ear canal was left with a ruptured eardrum, as well as multiple hematomas of the canal. He was unable to wear his hearing aid for weeks while his ear healed, which caused a significant issue in his ability to work and converse with his peers. I wish I could say this was uncommon for us to see, but unfortunately it's not. Even just last week I had a patient come in who was quite scarred from an experience he had with improper wax removal and was kind of terrified to have anything else done. He wasn't even sure he wanted hearing aids then because he was like, this was so scary for me, I didn't want to move forward. So as all my other colleagues says, and as more that will come, I do believe that this increase in scope of practice without the appropriate guidelines does risk Nebraskans' health and safety, as I have seen firsthand, so I do oppose LB593 and I hope you join me. Thank you.

HANSEN: Any questions from the committee? Are there any certified cerumen removal classes that you know? I'm trying to figure out how to make this bill better, even though you may not want to, but [LAUGHTER]

like what kind of language can we put in this bill to make sure people are adequately trained--

MACY SCHOTT-MILLER: Yep.

HANSEN: --or other kinds of things to make sure that your concerns are addressed? Even if we don't, it's still sometimes good for other people to hear.

MACY SCHOTT-MILLER: Um-hum, definitely.

HANSEN: So do you know?

MACY SCHOTT-MILLER: So the training we go through, which you've already-- we've already heard about, is extensive. So to make this bill better, what we want to see, I know Tennessee does have some really nice guidelines laid out for their hearing instrument specialists for removal for wax. That's kind of a nice bill to look back on if we were to kind of try to improve this, such as you cannot remove wax past the second bend of the ear canal, right, the type of tools you would use, the training. Now, is there a certified course? Not necessarily, because all of our training we get is through school. Right? So I mean, could there be something where in conjunction, right, they attend some of the seminars that we attend, they attend some of the same trainings that we have, can they have hands-on experience with an ear, nose and throat physician? You know, Otolaryngologists are busy. I don't know, you know, how much extra time they have to additionally train on this, but--

HANSEN: OK. I just looked, just briefly online. It looks like there are classes for it, but then there's classes for all kinds of stuff, right?

MACY SCHOTT-MILLER: Sure. Yeah.

HANSEN: Now whether it's appropriate or whether it's not, but there might be some that are certified by the American Audiological Association--

MACY SCHOTT-MILLER: Yep.

HANSEN: --or whatever you mean, and so those might be appropriate, so I don't know what Tennessee has done and--

MACY SCHOTT-MILLER: Very much so, yeah.

HANSEN: --so where they can at least have the ability to do-- because what they're trying to propose to me seems like a very reasonable ask, to some extent, and it would help not only save the taxpayer money, but also might help the patient and help, you know, X, Y, and Z. So if they're able to kind of accomplish some of what they're trying to do in a re-- responsible manner, is what I'm trying to figure out here, so-- so--

MACY SCHOTT-MILLER: Um-hum, yep, I think we just need some additional guidelines within the bill to make this safe, right? And I think our biggest issue is we want that hands-on experience, right? Like, so how are they going to get this hands-on experience with a licensed professional and how long is that going to happen, right? Because just a two-hour course, I'm gonna tell you, I've looked in a lot of ears and seen a lot of crazy things where I'm like, wow.

HANSEN: Yeah.

MACY SCHOTT-MILLER: Even sometimes I have to go a little bit further, right? So it's where is that personal experience going to come from and who's going to do it, so.

HANSEN: Yeah, and sometimes you can even clarify it in the bill, like, yeah, you cannot go past second-- or-- or when you--

MACY SCHOTT-MILLER: Exactly.

HANSEN: --recognize something, know when the proper referral process is, because we've done this before--

MACY SCHOTT-MILLER: Yep.

HANSEN: --with many kinds of scope of practice, whether it's dental hygienist knowing when to refer to a dentist, right--

MACY SCHOTT-MILLER: Yep.

HANSEN: --and the stuff that they can do. So sometimes that can help at least kind of provide some guidance, so appreciate you answering the question. Thank you.

MACY SCHOTT-MILLER: Yeah.

HANSEN: Any other questions from the committee? All right, thank you very much.

MACY SCHOTT-MILLER: Thank you.

HANSEN: Appreciate it. Is there anybody else wishing to testify in support-- or opposition? Welcome.

DESIREE SU: Chairman Hansen and members of the Health and Human Service Committee, my name is Dr. Desiree Su, D-e-s-i-r-e-e S-u, and I am here to testify in opposition of HB593. I am a doctor of audiology practicing here in Lincoln, Nebraska. As a newly graduated professional in the doctorate of audiology profession, I'm here to express my grave concern in regards to the passing of LB593. The bill, as it currently is written, is anticipating to expand the scope of practice for hearing instrument specialists to include cerumen management as a provided service. Currently, legislation does not specify the specific educational requirements needed for an HIS to perform this service. As med-- as a medical provider, I have had the opportunity to receive adequate training through my doctoral program. My cerumen management course was an intensive in-person course, so like a three-credit-hour course that happened throughout the semester, with additional independent learning modules. Under the curriculum, the following opportunities were provided: lectures, hands-on lab simulations with actual-- you know, the demo head where you could practice different types of cerumen types, so sticky, dry, hard, things like that. We had hands-on experience and were monitored by an audiologist who was trained under an ear, nose and throat physician. And we were, during our cerumen management, directly supervised clin-- had direct supervision where we were able to learn various cerumen techniques and how to utilize certain tools. It is necessary to rely on evidence-based practice during the clinical decision-making process of cerumen management. Prior to cerumen management, a practitioner must have an-- have appropriate training in the area of bloodborne pathogens, this meaning the-- understanding the importance of sterilization, disinfection, and following appropriate infection control protocols to protect others and ourselves from infectious diseases. Another area that we need to be aware of is ear anatomy. We must be able to take into account the ear anatomy from the right to the left ear and how the different configurations occur, and also to bring awareness to the areas of nerve intervention-- innervations and areas that are more susceptible to bleeding. When blood is involved, the patient is more susceptible to infection and other medical complications down the road. The final area that we need to rely on is understanding pharmacology, understanding the influence of different medications and how that can impact us down the line if we were to have a bleed or a nic and how that can lead to uncontrollable

bleeding. By encompa-- encompassing the educational knowledge within-- with adequate cerumen techniques, we are able to understand the full scope when providing this service. My personal education and experience have allowed for competency and confidence when performing this service without endangering the overall health of my patients. Therefore, as this bill stands, I urge you to oppose LB593.

HANSEN: Thank you for your testimony. Is there anybody from the committee have any questions? I think my comm-- I think my committee may be grossed out by earwax, so I think they all left me here. So thank you for your testimony, appreciate it. Is there anybody else wishing to testify in opposition to LB593? Welcome.

TOM ASPER: Chair Hansen and members of the Health and Human Services Committee, my name is Dr. Tom Asper, T-o-m A-s-p-e-r, and I-- here to testify in opposition to LB593. I am a doctor of audiology practice in Lincoln, Nebraska. I am speaking to you and questioning the bill in terms of an arrangement with the medical liaison. According to the bill, a medical liaison is an otolaryngologist or licensed physician if no otolaryngologist is available with whom a cooperative arrangement is established by a hearing instrument specialist. As the bill stands, it contains no clear direction or context on how this arrangement would be-- would occur or made. Currently, if you were to contact any otolaryngologist in town for the soonest appointment, this roughly is six-week wait. Many primary care physicians are also currently at their maximum patient care abilities in which this adds strain on their already active schedules. There needs to be additional information defining how this working relationship will be implemented. In addition, has the idea of medical liaison been discussed with otolaryngologists in the state of Nebraska as currently the NMA is opposing this bill? Therefore, this poses a great risk to our patients and I am in opposition of this bill. I urge you to oppose LB593. Thank you for your time.

HANSEN: Thank you for your testimony. Are there any questions from the committee? All right. Seeing none, thank you very much. Take our next testifier in opposition. Welcome.

AMANDA ROBINSON: Hello. All right. Chairman Hansen and members of the Health and Human Services Committee, my name is Amanda Robinson, A-m-a-n-d-a R-o-b-i-n-s-o-n, and I'm here to testify in opposition of LB593. I've worked for 17 years as a direct assistant to ear, nose and throat physicians in Lincoln, Nebraska. Through my firsthand accounts, I have witnessed the impacts of improper wax management. Initial

symptoms reported by patients include pain, pressure, drainage and decreased hearing. Additional negative outcomes include, but are not limited to, ruptured eardrums, hematomas, otitis externa, otomycosis, otherwise known as fungus, and abrasions of the ear canals. Many of these instances could be avoided if the individual removing the wax had the appropriate medical knowledge and training to perform the procedure, such as ear, nose and throat physician, an audiologist, or a primary care physician. I believe passing LB593 will only encourage improper wax removal unless specific requirements, standards and education are clearly defined and established. As the bill stands today, I am in opposition of its passing. Thank you for your time.

HANSEN: Thank you for your testimony. Are there any questions for the committee? Seeing none, thank you. Take our next testifier in opposition.

MEGHANNE WETTA: I hope we continue the no questions asked. I'm very nervous--

HANSEN: Not anymore.

MEGHANNE WETTA: --like this is not like my-- me sitting in front of you is-- I'm not comfortable. Ask them. I tried to get out of it a million times. But I do think that what I have written might help us kind of define some of the things that you've asked about. What are we really talking about in terms of what the bill is saying and what are we looking for? So, Chair Hansen and members of the Health and Human Services Committee, my name is Dr. Meghanne Wetta, M-e-g-h-a-n-n-e W-e-t-t-a, and I'm here to testify in opposition of LB593. I am a doctor of audiology and I practice in Lincoln. I appreciate your time and allowing us to share our concerns. As LB593 currently stands, we feel it lacks definition, clarification and direction. And from here on out, I will refer to a hearing instrument specialist as an HIS. Line 16 on page 4 indicates a requirement for training without any specifics. It does not clarify who will or what entity will be approved for training or how long each session should be regarding the topics indicated in lines 18 through 24. Should training require test taking, which helps define that not only has the HIS, quote, sat through training, but can also prove their competency through passing test scores. Specific infection control and pharmacology implications need to be addressed. In line 25, page 4 states that the licensee or the HIS shall maintain documentation of this training, but who is responsible to check on the documentation and when do the patients and/or any other medical professionals know the training has been

completed? Should it be required that this training is-- this training certificate is displayed in their office to show completion? There's no clarification regarding current HIS versus those who are new to the occupation and are seeking their license. Are current HIS holders required to complete this training or will they be grandfathered in? Will new HIS license seekers go through the same training process, then be tested on cerumen removal at their current practical exam requirement? This is very important to show skill, ability and understanding, which means initial testing for the HIS license, for those seeking that license, will need new equipment and testing will have to be elongated to show skill competence and passing requirements will have to be updated. There should be clear definitions on cerumen. It can be defined as removal of wax-like secretions from the glands of the ear canal and not any type of foreign body. There is no clear delegation of depth into the ear canal that the HIS is allowed to remove from. There are no definitions where the HIS should immediately refer for certain contraindications to an otolaryngologist or to a general practitioner. Contraindications can include, but do not have to be limited to: anyone under the age of 19; anyone who has had surgery in the last six months; or anyone where there is complete impaction of where that eardrum cannot be seen. Which instruments are allowed should also be defined. With new technology, there are video otoscopes that are easily accessible and can be used. This could be a requirement for an HIS to take a picture before the procedure, to also be required to show those to the patient and keep these pictures in the patient's chart. An informed consent form should be required to be signed by both the HIS and the patient before the procedure is performed. This form should identify that the HIS has met their training requirement, that they are not an audiologist or a physician, and that the patient has seen the pictures from that video otoscopy showing the cerumen and its need for removal. The list of contraindications should also be gone over in that form. It should be prohibited that an HIS can-- cannot have a patient sign-- excuse me. It should be prohibited that an HIS can have a patient sign any form that eliminates liability if the patient is harmed. Circumstances should be identified where the HIS must immediately stop the procedure and immediately, not in practical time, refer to an otolaryngologist or licensed physician or, I guess in their words, that medical liaison. Continued education requirements regarding cerumen management should be explicitly required for growth, exposure, and new techniques. And lastly, I have been on the receiving end of multiple HIS chart notes which have lacked any medical intake, including medications, case history, and review of systems. It should be

required that any person wishing to form a medical procedure, such as cerumen removal, be required to ask and chart the impact of medications, a review of their 12 body systems, and any medical history per patient. As I have pointed out multiple concerning and vague parts of this bill which clearly do present a health and safety risk for our community, I urge you to dismiss the bill. As it stands, I am in opposition of LB593 and I thank you for your time. And I'm open for questions.

HANSEN: Thank you for your testimony. Dr. We-- Dr. Wetta asked us to ask her very specific questions. [LAUGHTER]

MEGHANNE WETTA: As many as you can.

HANSEN: Are there any questions from the committee? Senator Riepe.

RIEPE: I will be brief. Is your office closed this afternoon?

MEGHANNE WETTA: It isn't-- well, we left the staff there, but all of us--

RIEPE: What's left of the staff?

MEGHANNE WETTA: All of us providers have-- have come.

RIEPE: OK. Thank you, sir.

HANSEN: Yes. Any other questions from the committee? I-- I think you brought up a point that's one I was trying to get to, is I don't know what "shall obtain training"-- I-- I don't know if that needs to be specified in the bill or what kind of training class, because they say in here what-- including principles of cerumen management, etcetera, etcetera, etcetera, but I just don't know how they received that training. And I'm assuming there's certain kinds of courses out there that deal with all this kind of stuff, and they probably get a certificate of completion when they do that, which is probably what they're talking about here, that they have to document evidence of satisfactory complete-- completion of the training. I was more curious, and this is something that you may not know either, like the amount of hours that-- that it is and--

MEGHANNE WETTA: I don't-- I have no idea the amount of hours. I mean, so we came up through traditional ranks of, you know, getting your bachelor's and then some of us got our master's, then our doctorate, so our exposure has been very different. Our continuing education,

though, through some of our societies, we have gone early for some of our continuing education. We have spent 6 hours on a full day of just learning a specific technique regarding cerumen and or u-- utilizing a specific type of instrumentation. And on the hearing instrument side, I'm pretty sure that the IHS, which is their national society, I believe, I'm sure they have put something together to try to squelch this conversation, like I'm sure they have some type of classes that they can take.

HANSEN: OK, from the national association.

MEGHANNE WETTA: Yeah, I think it's-- yeah, I think it's International Hearing So--

HANSEN: OK, because the ones I just looked at really briefly looks like it was like five to six hours or six to eight hours and upon completion they get certain certification, all that kind of stuff.

MEGHANNE WETTA: Yes.

HANSEN: So I just didn't know, because there's all kinds out there, but sometimes we usually rely on national associations. OK, that's the only question I had. All right. Thank you for your testimony.

MEGHANNE WETTA: OK. Thanks.

HANSEN: Is there anybody else wishing to testify in opposition to LB593? Seeing none, is there anybody wishing to testify in a neutral capacity to LB593? Seeing none, we'll-- we-- we will welcome back up Senator Hardin to-- with his close. And for the record, we did have some letters, 2 letters in support, 12 letters in opposition, and 1 neutral testimony letter for LB593.

HARDIN: Thank you, Chairman Hansen. This is a scope of practice bill, which I understand creates heartburn for the members of this committee. Scope of practice bills can be turf war bills. Usually there is one group with a superior training and experience that graphically illustrates worst-case scenarios and another with inferior training and experience that makes the case for greater access to a, quote, simple procedure. This leaves those of you on this committee wondering how likely these awful scenarios may ha-- happen. Google is somewhat helpful, and then we find argument and counterargument on both sides of the case. And in this case, six of the seven people who objected are from the same practice here in town. Certainly, each of these brilliant professionals has made a meaningful case for keeping

the practice solidly in their sole domain. It does appear to have been a company-wide field trip today. Clearly, we want to create the best bill which serves the safety and well-being of Nebraskans. Thematically, the scope of practice bills tend to benefit from the 407. That's forthcoming. We're glad to work towards meaningful amendments that can create some consensus. Thank you.

HANSEN: Thank you for that. Any questions from the committee? Seeing none, that will close our hearing for LB593 and we will now open it up for LB765 and welcome Senator DeKay to open. Welcome.

DeKAY: Welcome. I gotta start by saying I appreciate the facilities I get to be in this afternoon, so.

HANSEN: Yeah.

DeKAY: Fir--

HANSEN: We do what we can.

DeKAY: Chairman Hansen, members of the Health and Human Services Committee, I am Senator Barry DeKay, B-a-r-r-y D-e-K-a-y, representing District 40 in northeast Nebraska, and I'm here today to introduce LB765. LB765 amends the Statewide Trauma System Act to clean up and clarify language that makes-- to make changes to how the new Trauma Advisory Board and Department of Health and Human Services deal with the state trauma rules and four trauma care regions. This bill was brought to me by the State Trauma Advisory Board. The heart of LB765, which you will find in Sections 16 and 17 of the bill on page 10, would replace the regional trauma advisory boards with a regional trauma committee. Under current statutes, a trauma advisory board exists within each trauma care region. The statute created them in Section 71-8251, which would be outright repealed by this bill. Members of the State Trauma Advisory Board brought to my attention that these regional boards are largely redundant and feel many of the duties and powers could be consolidated at the state level. Additionally, attendance at meetings is inconsistent and the thought is that there would be-- could be greater voluntary participation with a committee-type system, since it would offer more flexibility for members than under the current board system. The regional trauma committees would be tasked with maintaining a trauma system quality assurance program, established and maintained by the healthcare facilities designated as advanced, basic, comprehensive and general-level trauma centers. The quality assurance program shall

evaluate trauma data quality, trauma care delivery, patient care outcomes, and compliance with the Statewide Trauma System Act. These duties are already carried out but would now be taken up by the regional committees. The regional medical director position, of which there are four in the state, would remain and take up a few of the duties currently carried out by the regional trauma advisory board. This bill proposes that each director serve as a member of their respective regional committee, receive notice of the suspension or revocation of medical facilities as designated by the DHHS, and participate in the quality assurance program just described. I also want to stress that with the elimination of the regional trauma advisory boards, each of the four trauma regions would still be represented at the state level since all four directors serve on the State Trauma Advisory Board. You will see that-- you will see that on the handouts I provided. LB765 would also eliminate the requirements of a State Trauma Advisory Board to both draft a five-year statewide prevention plan and review a regional trauma plan. Neither set of plans have been created or updated as of late, and the state board feels that both requirements are redundant to put it into statute. The board also recommended language be changed to facilitate coordination between the State Trauma Advisory Board and the Board of Emergency Medical Service-- Services to advise DHHS on the development of the Statewide Trauma System, as opposed to just monitoring. It was felt that this provision would not create an overlap or conflict between the two boards. Finally, you will see some changes like striking the requirement to treat people without regard to insurance or ability to pay. These requirements already exist elsewhere in the statute, so the board feels that this language is redundant within the context of this act. Many of the other changes in the bill are simply just cleanup found by the board or Bill Drafters that eliminates the planning and administrative duties associated with establishing a Statewide Trauma System Act that were included in the original legislation. The language is no longer needed since those duties were completed during the implement-- implementation of the act. Ultimately, LB765 is a cleanup bill. A couple quick items I also want to add is that the bill would result in a cost savings of $16,000 annually for the Department of Health and Human Services once fully implemented in fiscal year '24-- 2024-2025. This information come from the fiscal note which I received this morning. It would also eliminate the State Trauma System Cash Fund as it is no longer used by DHHS. If there are any questions, I'd be happy to try to answer them for you. Testifiers that were going to be here, that could answer this better than I can, had to go back to Omaha, so I'll try to answer what questions you have; otherwise, I

will refer them to the handouts and to the testifiers and get the information to you. Thank you.

HANSEN: Thank you for your opening. Are there any questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: Thank-- sorry. Thank you. You might not-- this might be a follow-up question, but you said that it strikes the cash fund because it's no longer being used. Do you know how long it's been not being utilized? It's fine if--

DeKAY: Yes.

M. CAVANAUGH: You do? OK.

DeKAY: What's--

M. CAVANAUGH: The cash fund, the trauma-- you said it eliminates the cash fund and I'm just curious if you know how-- you said it hasn't been-- you said it towards the end of your remarks.

DeKAY: Yeah, it-- it would result in a cost savings. I don't know if it completely eliminates it, but it does have a cost savings of $16,000.

M. CAVANAUGH: OK.I think I-- I meant--

DeKAY: It would also-- and I did-- it also would eliminate the State Trauma System Cash Fund that is no longer used by DHHS.

M. CAVANAUGH: That was the question. Do you know why it-- do you know how long it has been--

DeKAY: I-- I can't tell you that.

M. CAVANAUGH: Sure.

DeKAY: I would have to have--

M. CAVANAUGH: OK. That just piqued my interest. Thank you.

DeKAY: I will get that information for you, Senator Cavanaugh.

M. CAVANAUGH: OK. Thank you.

DeKAY: Thank you.

HANSEN: OK. Senator Riepe.

RIEPE: Thank you, Chairman Hansen. Welcome, Senator. Good to be here. My question is this. I-- I think I heard in your presentation that it centralizes the oversight, the authority on it.

DeKAY: Right.

RIEPE: And everything that we generally hear is people wanting to decentralize versus centralize. Can you help me with that a little bit in terms of--

DeKAY: Well--

RIEPE: --is that acceptable to outlying folks, if you will?

DeKAY: Well, what it would do, it will-- it will-- the State Trauma Advisory Board, it would eliminate that and make it a committee deal so that the committee members-- right now, you have doctors and everybody and their schedules don't permit them, so in order to have it put together like this so they could reach a quorum and make, you know, run-- run an advisory board the way it needs to be run, is how they're-- is why they're wanting to centralize it in that aspect. Does that answer your question?

RIEPE: But they're in agreement on that?

DeKAY: Yes.

RIEPE: OK. That's fine, as long as they agree. Thank you. Thank you, Chairman.

HANSEN: Any other questions from the committee? Seeing none, thank you. Gonna stay to close, right?

DeKAY: Thank you. I will stay to close.

HANSEN: All right. OK. We'll our te-- our first testifier in support of LB765. Is there anybody wishing to testify in favor of LB765? OK. Seeing none, is there any who wish to testify in opposition to LB765? Seeing none, is there anybody who wish to testify in a neutral capacity to LB765? All right, Senator DeKay, you're welcome back to close.

DeKAY: Sorry it took so long. [LAUGHTER] Senator Cavanaugh, I do have some information for you on that. The State Trauma System Cash Fund was created by the original trauma legislation from LB626 and 30-- and [SIC] 38 in 1997. LB191 was in 2001, consolidated this fund under the Nebraska Emergency Medical Systems [SIC] Operations Fund and includes the uses of associated with Statewide Trauma System Act. LB765 eliminates the original fund, which is no longer used by DHHS.

M. CAVANAUGH: Thank you. Appreciate it.

DeKAY: Thank you.

M. CAVANAUGH: Thank goodness you closed.

HANSEN: Are there any other questions from the committee? I have a couple of questions, and maybe if you can't answer, somebody can get back to me about it. I was hoping somebody from the trauma board would be here because I'm kind of curious to know what they do. It's one of those-- one of those boards you don't hear a whole lot from him, any that's created, you know, 23, 25 years ago, and I'm always kind of curious as to the purpose of the board, if it's still, you know, necessary. I expect--

DeKAY: There were going to be two testifiers here from that-- that organization. They had to go back to Omaha today, but their letters of support are part of the handouts there, so.

HANSEN: OK, and-- and that makes total sense, and-- and no worries. I was just-- maybe sometime we can kind of invite them here and kind of discuss to the committee about-- more about what they do--

DeKAY: Right.

HANSEN: --so we can have an idea of maybe sometimes how to make decisions on bills like this. But that's always questions we can ask after the hearing, too, so.

DeKAY: OK.

HANSEN: All right. Any questions from the committee, just to make sure? All right, seeing none, thank you very much.

DeKAY: Thank you, Chairman Hansen and committee. I appreciate your time today.

HANSEN: Yeah. Thank you. All right. And not looking like we have any letters in support or opposition to LB765, so with that, we will close the hearing for LB765, and we will now open it up for LB586 and welcome Senator Hughes.

HUGHES: Good afternoon.

HANSEN: Welcome.

HUGHES: And this is not a scope of practice, so you are so welcome. All right. Sorry. OK. Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. I am Jana Hughes, J-a-n-a H-u-g-h-e-s, and I represent the 24th Legislative District. Before I continue my testimony, I would like to thank my colleague just to the west of me, District 34, Senator Lippincott, for co-sponsoring LB586. You know what? I better-- even though I have like super big font, I better put these guys on. OK. I am here today to introduce LB586 to help alleviate the growing healthcare workforce crisis in nursing here in Nebraska. According to a study from the Nebraska Center for Nursing, Nebraska will experience a workforce shortage of 5,435 nurses by 2025. The Nebraska Legislature has worked hard-- hand in hand with the healthcare community over the last several years to invest in initiatives to recruit and retain nursing professionals in Nebraska. These efforts include loan forgiveness programs, scholarships using ARPA dollars, and support for continuing education and professional development. These efforts have helped and are greatly appreciated. However, the bottleneck in nurse-- in Nebraska continues to be the severe lack of clinical sites and clinical faculty to train our nurses. And I'm just-- I'm going to go off script here a little bit. So what happens when you're going through nursing training is you'll get into nursing school and-- and in the middle of your nursing years-- it usually takes as like a four-year degree-- you have to do clinical sites and-- and that means you're inside, in a hospital or a nursing home or whatever, with a clinical person over you, overseeing, typically eight students, like an 8:1 ratio. And so a lot of times these programs can only have-- you know, however many clinical sites they have times eight is how many kids can enter into a nursing program. So even if we have extra kids that want to go into nursing, if you don't have those clinical sites available, a nursing program cannot take them in, so just wanted to kind of side note that. LB586 tackles that issue head on. LB586 provides $3 million from the General Fund for fiscal year '23-24 and $7 million from the General Fund for fiscal years '24-25 to the Nebraska Center for Nursing to increase both new-- or clinical sites and clinical faculty to train our nursing

workforce. The Nebraska Center for Nursing is a state-level organization that was established in 2004 by the Legislature in response to a nurse-- nursing shortage then, as well as to improve the quality of nursing education and practice in our state. The Nebraska Center for Nursing's mission is to enhance the health and well-being of Nebraskans by promoting excellence in nursing through workforce development, education, research and practice. The funding provided to the Nebraska Center for Nursing by LB586 would specifically address the clinical site and clinical faculty issue by incentivizing clinical nurses to become clinical nurse faculty, incentivizing the development of staff nurses and becoming clinical staff by partnering with existing nurse faculty, expanding simulation training for nurse clinical education, and incentivizing healthcare facilities to support the Nebraska Center for Nursing to provide additional sites for clinical education. LB586 also directs the Nebraska Center for Nursing to establish a committee of experts to examine how to best utilize the funding provided to ensure that the goals of this bill are achieved. LB586 will help ensure that even more nursing students have access to clinical education in Nebraska and can continue to receive high-quality education to provide quality care to patients. Thank you, Chairman Hansen and members of the committee, for the opportunity to introduce LB586. There are proponents of this bill behind me that can speak to the specifics, although I'm happy to take any questions.

HANSEN: Thank you.

HUGHES: OK.

HANSEN: Are there any questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman. I only have a couple of specifics.

HUGHES: This was kind of your wheelhouse, I think--

RIEPE: Oh.

HUGHES: --back in the day.

RIEPE: You gotta have fun. Why did you-- why did you settle in on the number $10 million other than being a nice round number?

HUGHES: It is a nice round number. That is-- that can-- I will let some of the people, I think, behind me can answer that more specifically.

RIEPE: OK.

HUGHES: I'm-- I'm going to refrain from having an answer.

RIEPE: May I give you another specific?

HUGHES: I know you don't like to take any money from the General Fund--

RIEPE: No.

HUGHES: --but, yes, go ahead, Senator Riepe.

RIEPE: It talks-- you said at least in one document, we have-- it says sites for nursing throughout Nebraska. Does that mean all of-- all-- your-- it's kind of a statewide program, not just--

HUGHES: Well, you would want your clinical sites for nursing near wherever your nursing schools are. So that would-- because those kids-- when you're in that nursing program, you're-- you're doing sometimes in class and then clearly sometimes in a clinical setting. So, for example, it would-- so it would have to be where our clinical nursing programs are or where the nursing programs are.

RIEPE: So like west of here would be from Kearney or Kearney--

HUGHES: Well, Kearney has a nursing program.

RIEPE: Yeah.

HUGHES: And so it could be-- it could even be some of the smaller towns around Kearney. I mean, you could drive-- you know, a kid could-- a student could drive 15-20 miles to a clinical site around. I think kind of the incentive is-- you would think hospitals or clinical sites would be willing to take on these kids, right, because ultimately the-- these are who they'll be able to hire at some point. But clearly, if you've got some clinical staff in your hospital, it-- it slows you down, right? I mean, if you've got students around you, you're not cranking through what you need to get through, and so this is just trying to help some of those sites offset that, if you will--

RIEPE: OK.

HUGHES: --you know, when the students come in, so.

RIEPE: OK, very good.

HUGHES: Thank you.

RIEPE: Thank you.

HUGHES: It's a good question.

HANSEN: Any other questions from the committee?

RIEPE: Thank you, Chairman.

HUGHES: I know that money question would come up.

HANSEN: All right, seeing none, I'll see you at close?

HUGHES: Yep, I'll be here.

HANSEN: Thank you. Take our first testifier in support.

HUGHES: And I hear we're going to ice skate home, FYI.

HANSEN: Welcome.

JEREMY NORDQUIST: Good afternoon. [INAUDIBLE] All right. Good afternoon, Chairman Hansen, members of the Health and Human Services Committee. I am Jeremy Nordquist, J-e-r-e-m-y N-o-r-d-q-u-i-s-t, president of the Nebraska Hospital Association, here today representing our 92 member hospitals in Nebraska and 50,000 hospital employees in support of LB586, and want to thank Senator Hughes for bringing forward this important legislation. Our hospital leaders will tell you that this is the most challenging time they've all-- every one of them, whether they've been in the profession for 5 years or 40 years, this is the most challenging time they've seen in their careers. Costs have been up 27.3 percent since 2020; reimbursement from government and comm-- commercial payers aren't keeping up; and as this committee has heard several times about the issue of over 225 patients at any point in time sitting unnecessarily in our hospitals, in acute-care hospital beds without reimbursement. But when you ask these hospital leaders what's their top concern, they will say, without a doubt, workforce because workforce is a majority of their cost. Workforce costs are driving the overall cost to provide care and the lack of workforce is significantly restricting the capacity we have in our hospitals, nursing homes, rehab facilities. So certainly our hospitals need, you know, provider rates today to stay afloat. We need aid to help get patients to the right place today. But the long-term solution to these problems is an investment, continued

investment in workforce. So the nursing crisis right now, Senator Hughes said, projections are 5,400 by 2025. But I've been at least every week checking Indeed.com for over the last year of how many nursing jobs are posted in Nebraska, and today it was 6,272 nursing jobs posted, and it's been between 6,000 and 7,000 nursing jobs posted for all of 2022. And our hospitals will say, when I cite that to them, they're like, that's not all the jobs, because if we don't fill the first ten jobs, we're not posting the next ten jobs, so we certainly need to expedite our issue, but-- and here's-- here's the stat that keeps me up at night, is almost one out of five of our nurses are over the age of 60. So we're certainly facing a crisis today, but with no action this will be a crisis for the next decade. With the right action, we can help alleviate some of that crisis over the next decade. So last session, as Senator Hughes mentioned, ARPA funding for scholarships, loan forgiveness and nursing, and the rural health building in Kearney, which will break ground this fall, all important investments. In the interim, I traveled and met with a number of our nursing deans and other folks in healthcare higher education and asked them what was the biggest holdup to getting more nurses through their programs, and the answer was clinical faculty in clinical nursing sites, and that's what brought us this bill here today. LB586 will jumpstart our nursing workforce and it will benefit all the programs in the state. It's not picking one nursing program over another. Our community colleges can quickly expand with more clinical sites and graduate more RNs in just two years. Our bachelor's programs would benefit by more-- placing more graduates around the state, and even our graduate nursing programs would benefit with additional need for faculty and incentives to get those faculty through. And we designed-- I-- LB586 to have flexibility because it's not going to be one-size-fits-all. We-- I was just at a conference over the weekend down in Texas about rural hospitals and rural healthcare and workforce came up and this concept was floated around a lot, having flexibility to work between the higher ed institutions and individual hospitals to put together the clinical programs that work for them. We have one hospital out in western Nebraska who said, look, we're running in the red right now, but we're spending so much on recruiting our workforce and trying to get more nurses in, we're willing to take-- eat the whole cost of the nurse faculty member, we'll pay for that person to be on our staff, we'll basically let them be faculty members at the-- at the institution, because those ten, eight to ten nurses that are underneath that faculty member, we think will be able to keep some of them. So it's worth the investment because otherwise we're going to go out, spend thousands and thousands of dollars trying to recruit

nurses, and we think if we can train them here, we're going to keep a lot of them here. So there's different models, and I think some of our hospitals are willing to put some skin in the game. But certainly having this flexibility and a pot of money like this will go a long way to expanding the pipeline of nurses in our state. With that, happy to take any questions.

HANSEN: Any questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman Hansen. Senator, I know that when you have developed some workforce plan that included nursing homes, and I think that was very good thinking on your process. Does this plan then-- is that part-- is this bill part of that plan or could be or how does that work?

JEREMY NORDQUIST: So I-- I would let maybe the-- the nursing programs speak after about the potential to train in nursing homes. I-- my understanding is most of it is through hospitals and maybe some other health facilities, but it isn't-- I-- I-- I don't know [INAUDIBLE]

RIEPE: But does this $10 million-- or does this effort, does it compete with your plan?

JEREMY NORDQUIST: No, no.

RIEPE: The other one that I picked up on, I think I heard you say that one of the maybe hospital administrators said that they would be willing to pay to-- so is that less than this number from the [INAUDIBLE]

JEREMY NORDQUIST: Yeah, so you asked about the-- the number, and I, you know, wish I could say it was more than back-of-the-napkin math. And the reason we ramp it up is it-- you know, we think it'll take a little bit of time and-- to-- to get some of these programs off the ground. It's not going to all happen in year one. We also think, you know, that-- that there's a role for some simulation training, and several of our institutions have invested in that already. But for those-- if we're branching out to certain hospitals that don't have that technology, there-- there could be some one-time technology cost, so that's somewhat factored into that. But, yeah, I-- I think, you know, I don't want to sit here and start negotiating down the number that's needed, but I do think-- I do think there's certainly the possibility to do that. And I think there are hospitals that are willing to say, if we're gonna have the workforce we need a decade

from now, we're willing to, again, even though we're running in the red, you know, we'll find ways to support some of this as well, so I think maybe we could look at-- at some partnerships.

RIEPE: Historically, clinical placements have been more difficult for mental health than they have for physical health. Is that still the case?

JEREMY NORDQUIST: That's a good question that I can come back to you on. I'm not 100 percent sure about that.

RIEPE: I see a head shaking back here, but--

JEREMY NORDQUIST: Yeah. Yeah.

RIEPE: OK.

JEREMY NORDQUIST: All right. Any other--

RIEPE: Thank you for being here. Thank you, sir.

HANSEN: Yeah. Any other questions? I have a few questions.

JEREMY NORDQUIST: Yeah.

HANSEN: Mainly on page 3, the middle part of the bill. I'm hoping you can explain some of this more to me. The center shall expand clinical training sites. What are clinical training sites?

JEREMY NORDQUIST: So basically just the-- the facility that the nurses are going to, so-- and again, maybe somebody can give a technical definition. This is a layman's definition, but where the nursing students are going to do-- to do training. And to have a site, you have to have faculty, a clinical faculty member, which has to be a nurse with, I believe, for most programs, it's two years of-- of workforce and then they either have to have a master's or be working towards a master's. Some of that is set by national accreditation bodies, and then the-- the challenge that comes into mix here, and again, the deans that come after me will be able to speak to this better, but is-- is pay. Recruiting people to do that, they get paid significantly less than if they were to remain a full-time bedside nurse, but-- so the clinical training sites is basically just opening up capacity at a-- at a hospital with a faculty member, with preceptors, which are the staff nurses in the hospital that actually are supervising the work of the nurses.

HANSEN: So we're talking about a hospital.

JEREMY NORDQUIST: Yeah, for the most part, hospitals, yeah.

HANSEN: OK. I didn't know if it's like a school or anything like--

JEREMY NORDQUIST: Oh, sorry.

HANSEN: I'm just clarifying that. So--

JEREMY NORDQUIST: One-- one word answer: hospitals.

HANSEN: Yeah. And in order for them to be a clinical training site, they do need clini-- clinical nurse faculty.

JEREMY NORDQUIST: Um-hum.

HANSEN: OK. How many hospitals have clinical nurse faculty already?

JEREMY NORDQUIST: Where--

HANSEN: Is it like-- out of the 92 that you just said, is it 1? Is it--

JEREMY NORDQUIST: No.

HANSEN: --20? Is it--

JEREMY NORDQUIST: No, it would-- I would-- we're actually going out with a full-- fuller in-depth survey on that right now. If I had to venture to guess, I mean, certainly, all-- I would-- all the PPS hospitals, of which we have-- our system hospitals, we have five PPS, so that's about 12, 13 there, and then a number of the critical access do. I would probably say it's 20 if I were to-- 20, 25 maybe.

HANSEN: OK, so 20 hospitals will be eligible for this program.

JEREMY NORDQUIST: But we could expand more, so that-- that's one of the things, so--

HANSEN: Trying to bring them on board.

JEREMY NORDQUIST: If you're-- you know, if you're a smaller critical-access hospital in rural Nebraska, we could send nurse-- nurses to train at your facility as long as you have that faculty member that meets-- and again, sometimes the faculty member comes from

the institution, the hi-- the higher ed institution. Sometimes they're employed by the hospital and the hospital takes on some of that, or the school pays the hospital to have somebody take on that, so there's unique models of how you can have that clinical nurse faculty member there to-- to cover.

HANSEN: OK. I'm asking these because I feel like it-- it seems, not broad, but-- I understand the purpose of what we're trying to do, but I'm wondering if there's just a few hospitals that could eat up almost all this money before some of these rural hospitals have a chance to even get a clinical nurse on staff--

JEREMY NORDQUIST: Yeah.

HANSEN: --to get people there to facilitate because you have expand simulation training for nurse clinical education. I don't know if there's too many places that do that currently, is there?

JEREMY NORDQUIST: So tho-- that would probably be operated by the larger facilities, certainly, but we-- that's why we did put language in the bill to give a preference, I think, is the-- was the language, towards those counties that have-- are underserved by nursing.

HANSEN: Yes.

JEREMY NORDQUIST: So it would still be left up to the advisory board in the State Center for Nursing on how to allocate those dollars and which projects and programs need dollars to expand.

HANSEN: And you said that was a board that-- you had a committee--

JEREMY NORDQUIST: Yeah.

HANSEN: --establish a committee.

JEREMY NORDQUIST: Yeah.

HANSEN: Is that committee made up of half rural, half urban nurses, or does it matter?

JEREMY NORDQUIST: You know, I don't know that we have that. I think it's-- but--

HANSEN: Or committee members, excuse me, not nurses.

JEREMY NORDQUIST: I think it's-- it isn't that defined, but I think that certainly could be something we could-- we could work on. Yeah.

HANSEN: And I'm just-- I'm just asking these out of curiosity's sake--

JEREMY NORDQUIST: Yeah.

HANSEN: --so.

JEREMY NORDQUIST: Yeah. I will say one of the challenges with going too far rural-- and again, the deans would be great to explain, as they've worked with different hospitals in the past, is we-- we run into housing issues trying-- you know, what-- what housing is available to get a nurse out there for a short period of time to train. There sometimes aren't a lot of options. We've had hospitals actually look at acquiring housing or building housing to- to do that, but that-- that becomes a little bit of an issue If you get too far.

HANSEN: That makes sense.

JEREMY NORDQUIST: Yeah.

HANSEN: I just want to make sure they at least have the opportunity for this--

JEREMY NORDQUIST: Yep.

HANSEN: --because they might be able to facilitate that process of getting housing if they know, hey, hey, we can actually get clinical nurse faculty in here before somebody else kind of takes a lot of the funds. Incentivize clinical nurses to become-- OK, so what does that mean, incentivize clinical nurses to become clinical nurse faculty? Does that mean you're paying for the education?

JEREMY NORDQUIST: Yeah. So that's a issue that's been around since I was on the Appropriations Committee. We actually have a fund in the state for it. I don't know that we've ever put any real dollars into it. But, yeah, again, it gets back to the-- right now, the-- the structure, and we're not the only state that-- pretty much every state's this way. They're going to get paid less, so why-- why-- what's the incentive for you to go get a master's, to become a faculty member, if you're going to end up making less at the end of the day to teach?

HANSEN: Makes sense.

JEREMY NORDQUIST: Yeah.

HANSEN: And if I can ask one more?

JEREMY NORDQUIST: Yeah.

HANSEN: I'm-- part (d) Incentivize hospital facilities to support the center in carrying out this subsection--

JEREMY NORDQUIST: Yeah.

HANSEN: --that seems pretty broad, because then they--

JEREMY NORDQUIST: Yeah, so I think on that one, and we could tighten up that language and work with the committee on it, is, you know, there's-- there's some capital expenses, some onboarding for maybe equipment, some IT issues, so not a lot of costs. And, you know, we've-- we've had a lot of conversations with-- with the deans. You know, our hospital folks will say, look it, you know, it's- we lose efficiency of our workers when we bring in more students, so there's a cost to us. But the folks in higher education will say, look, we don't want to get into a spot where we have to pay hospitals to take our students, so I-- you know, I think our hospitals aren't looking nec-- for-- for a handout or dollars here to say, hey, we're going to start paying you $1,000 to take every nursing student, but there are some like onboarding, you know, small capital costs that I think we can-- that that would be speaking to.

HANSEN: OK. Cool. All right. Thanks for answering my questions actually.

JEREMY NORDQUIST: Yeah. Yeah, no problem.

HANSEN: Thanks for testifying.

JEREMY NORDQUIST: Yep.

HANSEN: We'll take our next testifier in support of LB685. Welcome.

THERESA DELAHOYDE: Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Dr. Theresa Delahoyde, T-h-e-r-e-s-a D-e-l-a-h-o-y-d-e. I am the dean of undergraduate nursing at Bryan College of Health Sciences in Lincoln, Nebraska, and I'm also the current president for the State Board of Nursing. I have been a registered nurse for 26 years and I've also been in nursing

education for over 20 years in the state of Nebraska. Bryan College of Health Sciences is proud of its history, having trained Nebraska nurses for almost 100 years. I come to you today on behalf of not only my institution, but also the 13 institutions represented by the Council of Independent Colleges Foundation, in support of LB586. Bryan College of Health Sciences has two locations for our nursing program, one in Lincoln, where Bryan Medical Center is our primary clinical partner, and one in Hastings, Nebraska. Bryan Health System has hospitals in Crete, Grand Island, Kearney, Central City and Lincoln. Building the workforce of today and tomorrow is our top priority. We all know there is a shortage of nurses in our state. The more rural the area, the greater the shortage. LB586 would expand those resources-- expend those resources to the Center for Nursing to allow for greater investment in the most rural areas of our state. These funds would be used to implement innovative models of education through incentivizing nurses working in rural healthcare facilities to become nursing faculty, to help academic programs expand their clinical site offerings across the entire state. At present, schools of nursing who would like to have a rural clinical rotation are impeded from doing so due to a lack of clinical nurse faculty, rural housing options, and travel expenses of a daily hours-long commute. With the funds from LB586, this could alleviate those barriers. As dean of undergraduate nursing, I work closely with facilities across our state, including rural facilities who desire nursing students. Rural clinical opportunities create an exposure for students to learn about rural nursing and determine if it's the right fit for them. It also provides an opportunity for the healthcare facility to begin to establish relationships with potential future employees. On the other side of the clinical relationship, there are nurses in rural facilities that would have the time and flexibility to serve as clinical nurse faculty on their days off. They simply don't have that opportunity to serve as clinical nurse faculty unless they live close enough to a large city or wherever there would be a nursing program in the state. And I did provide you a map, which comes through the Center for Nursing, and that is indicative of all six nursing programs in the state and where they're located and what branches that they have. Another way that the Center for Nursing will be able to address the nursing shortage through the funding is by increasing the number of nursing refresher courses available to nurses who've been out of practice and desire to return to the nursing profession. At present, there are only two board-certified refresher courses offered in the state for licensed nurses who have been out of practice. Increasing accessibility for nurses who may have retired early or left the

nursing field but desire to return will remove barriers to entry and aid in the building of our nursing workforce. LB586 is a piece of the puzzle that is solving the nursing shortage here in our state. These resources will support our Nebraska nursing students, their educational institutions, our existing nursing workforce, and most importantly, the patients they are dutifully caring for. As you hear from myself and others today, I ask that you be moved to take action in support of LB586. And one other thing I just want to mention. On that map that you see there are ADN programs, which are associate degree programs, those are the two-year nursing degrees. There are LPN programs; those are the licensed practical nursing programs; that is a one-year, practical nursing. That is not a registered nurse. Those nurses work independently, but they work collaboratively with registered nurses. It's a different licensing than the registered nurse. And then you'll also see the BSN programs on there, and that's a Bachelor of Science in Nursing and that is a four-year degree, so you can see that we have a wide variety across our state of different programs. And if we have the ability as academic programs to hire staff nurses who work in these rural facilities on their days off to be our faculty, that would help us. We could increase the number of students that we could actually admit into our programs because we would have additional clinical sites. The other thing we definitely would need, as I mentioned, would be housing, because, for example, as we're located in Lincoln or Hastings, to send a student out to Scottsbluff, we will do that for their final preceptorship when they're spending over 200 hours, but we don't do that with a clinical group. So I do want to say there is a difference between a preceptor and a clinical nurse faculty. A preceptor is a nurse, staff nurse at that facility that the academic institution partners with and agrees to take on that student and care for that student or care for those patients, whereas a clinical nurse faculty is someone who is hired by the academic institution to take a group of students to clinical and facilitate clinical that way. So thank you for your time and I welcome any questions that you have.

HANSEN: Any questions from the committee? Yes, Senator Riepe.

RIEPE: Thank you, Senator. You just talked about a preceptor. Is that on a one on one or do [INAUDIBLE]

THERESA DELAHOYDE: Preceptors are one on one, yes.

RIEPE: One on one.

THERESA DELAHOYDE: And so that's not what we're talking about for this bill.

RIEPE: Yeah, OK.

THERESA DELAHOYDE: So I want to be real clear with that. Sometimes those words get interchanged, but we're not talking about incentivizing preceptors. If you started doing that and paying preceptors, your nursing programs would-- would run out of money really quickly. We wouldn't be able to afford that, so.

RIEPE: On the list that we have-- I think maybe you provided or some-- my question would be this. Are sites more difficult for schools like Wesleyan and community college? Bryan has sort of a captive audience there by having an acute-care facility, so.

THERESA DELAHOYDE: Sure. Sure. Yeah, I would-- I would-- I can't speak on behalf of those programs, but I know it is more difficult--

RIEPE: I would think so.

THERESA DELAHOYDE: --if you aren't connected with a healthcare facility.

RIEPE: OK.

THERESA DELAHOYDE: So we are very fortunate to have that.

RIEPE: And the one other question I have, if I may, Mr. Chairman, is, how do you address the issue when, for example, at Bryan, when the infusion is one service that's pulled out of the hospital, so you lose clinical material by sometimes private investment from private companies? Even physicians, if you can imagine that, will cherry-pick and take off the more profitable, but with that, they take the clinical experience.

THERESA DELAHOYDE: Sure, sure, yeah. We can use some of those sites, as well, for--

RIEPE: If they will agree?

THERESA DELAHOYDE: --clinical experiences if they will agree, yes, and if they'll do a clinical contract with us.

RIEPE: And has it been your experience that they will agree?

THERESA DELAHOYDE: Most of the time, they will. So we have our nursing students in a multitude of places. So you asked about long-term care and we-- we have them in there. We have an assisted living, hospice, home health, community sites, schools, correctional facilities. The majority of the clinical, though, for all nursing programs is still acute care, which is within hospitals, and that is where the majority of new grads that graduate in the state do practice in when they first get out.

RIEPE: Well, as a complement to Bryan, I understand that 90-some-plus percent of your graduates stay in Nebraska.

THERESA DELAHOYDE: Yes.

RIEPE: So that's a real compliment too.

THERESA DELAHOYDE: Yeah.

RIEPE: Thank you very much. Thank you, Mr. Chairman.

HANSEN: Any other questions from the committee? Yes, Senator Hardin.

HARDIN: Agencies-- did I just mention a dirty word?

THERESA DELAHOYDE: You're talking travelers?

HARDIN: Just comment on it. I-- I get it. You're talking about helping us--

THERESA DELAHOYDE: Yeah.

HARDIN: --get more nurses and we're all going to applaud that for sure, but--

THERESA DELAHOYDE: Sure.

HARDIN: Necessary evil? I-- I threw out that term--

THERESA DELAHOYDE: Yeah.

HARDIN: --that phrase. It--

THERESA DELAHOYDE: Yeah.

HARDIN: Go ahead and comment, if you would.

THERESA DELAHOYDE: It is. I mean, travelers are a necessary evil and there's always going to be some travelers, but what we want to do is get away from those healthcare facilities having to use so many travelers. And so if we could graduate even more students from our programs and they stay in the state and they are-- have exposure to even more places thinking, oh, I could work here, then we could hopefully have less use of travelers and save money for our healthcare facilities.

HARDIN: For the sake of the uninitiated and that lovely camera up there, what would be the potential downside of an agency and those nurses that would--

THERESA DELAHOYDE: Well--

HARDIN: --come in on a temporary basis as--

THERESA DELAHOYDE: --the downside to the-- for the agencies is really for the healthcare facilities. They're paying so much money to have those travelers in those facilities--

HARDIN: OK.

THERESA DELAHOYDE: --that then they-- they can't sustain that. And so they need to have their own workforce, those healthcare facilities, and not use travelers. And so if we could fill those positions with these nursing students as they graduate to go in and work there, you're always going to have them pulled away with those incentives and the pay for traveling, but I think if we can get a better handle on it, we'll-- we'll-- we won't need as many travelers throughout the state.

HARDIN: Thank you.

THERESA DELAHOYDE: Yeah.

HANSEN: Any other questions from the committee? I have a couple.

THERESA DELAHOYDE: Sure.

HANSEN: What's the difference between clinical nurse and a clinical nurse faculty? Is it education or is it like pay?

THERESA DELAHOYDE: Those-- those are actually the same thing. So a clinical nurse, it depends on how you look at it, but you could say a

staff nurse is a clinical nurse. So a staff nurse is someone who's taking care of the patients in the hospital, so you could say that person's a clinical nurse. But any-- I was a staff RN, as well, working-- working on the-- on the units as well. When you actually become faculty, then there's different terms. It could be nurse faculty, it be-- could be clinical nurse faculty, it could just be faculty, so there's lots of different interchangeable words that are used for that. Anybody who is with students, a group of students, and they are partnered with that academic institution will have faculty within that, and clinical faculty would be those individuals who are only doing clinical. They're not teaching in the classroom.

HANSEN: OK. Why wouldn't all the hospitals do that then? Why wouldn't they, like, partner with an education facility and say [INAUDIBLE]

THERESA DELAHOYDE: Well, right now, the way the model is, is that the educational facilities are the ones that hire the faculty, and then we go to the healthcare facilities and ask them if we can ha-- use their site for a clinical site. And then we provide the faculty who go into that clinical site. That person gets oriented if they don't work there already, and they take students and they take care of patients and that sort of thing, and it's a win-win for both. We're training the students and then the students are getting exposure to that healthcare facility so that hopefully maybe they may even think about going there and working there afterwards, so.

HANSEN: OK.

THERESA DELAHOYDE: I don't know of very many hospitals that actually have their own clinical faculty, aside from a dedicated education unit, and that's a very different model. And so a dedicated education unit, there's only a few of those in the state, and that's where the hospital has invested in nurses, staff nurses who are also faculty, and that unit is entirely trained to take on students. And so it's a very different type of a model, as well, so different than what we're talking about doing in terms of bringing a group to a clinical site. That takes a lot of investment, as well, and that's a little hard to maintain, so.

HANSEN: OK. All right.

THERESA DELAHOYDE: Yeah.

HANSEN: Thank you.

THERESA DELAHOYDE: Uh-huh.

HANSEN: Any other questions from the committee? Seeing none, thank you very much. Take our next testifier in support. Welcome.

LINA BOSTWICK: Hello. Thank you. I am Dr. Lina Bostwick. Thank you, Senator Hansen and committee. I am here testing [SIC] on behalf of Nebraska Nurses Association. My name, like I said, is Dr. Lina Bostwick, L-i-n-a B-o-s-t-w-i-c-k, and we are in support of this bill, which-- LB586, that provides duties for the Nebraska Center for Nursing regarding clinical training sites. I have been a nurse for 39 years in full-time positions, and that has included direct care and nursing management and nursing education now for the last 18 years, therefore, have been part of the everyday work where we are at a loss for nurses and we work with shortages constantly. In all sincerity, we probably don't need to even remind anyone in our community anymore about the scariness of the continuously growing nursing shortage we have in the state. The Center for Nursing Strategic Plan is a living and breathing document that includes the promotion of education and resources, advocates for the profession, and is a strong site, if not the number one site, for current and accurate supply and demand data for nurses for the state of Nebraska. This is accomplished through the Nebraska nurses collaborate-- in Nebraska Center for Nursing's collaboration with the Nebraska State Board of Nursing, which initiates licensing and ren-- renews licensure. The Center of Nursing has been known to be a strong collaborator in our state with every health-related organization. Its reputation is one of trust and expertise. The Center for Nursing has a car-- careful vetting process where the board members represent both urban and rural nursing. And to answer your question, Senator Hansen, it probably is about 50/50 that represent on that Center for Nursing Board, urban nurses and rural nurses. And based on the Center for Nursing's supply and demand model, 2022, we know that there is a shortage of at least 4,191 nurses, and that includes registered nurses, advanced practice registered nurses, and licensed practice nurse-- nurses. As of January 2022, the number of individuals who hold a Nebraska license, nursing license, is 31,420, for which Nebraska Nurses Association represents. The 2022 Biennial Report, which is part of what I handed out, illustrate-- illustrates 2,600 fewer nurses-- that meaning RNs, APRNs, and LPNs working in Nebraska, when compared to 2018-2019. There is a 6.9 percent of nurses that are-- are highly likely to leave their primary employment over the next 12 months compared to that of 5.9 percent in 2018, and that has a lot to do with nurses that are working very hard and overtime in this shortage, and also we know that COVID-19

certainly had an effect on them. The Nebraska Nurses Association supports LB586 as it would extend the overall health of Nebraskans by growing the number of practicing nurses, and we would like to ask the committee to move LB586 to the General File. I'd be happy to answer any questions if you have them.

HANSEN: Yes, Senator Riepe.

RIEPE: Thank you, Chairman. I have a question. Do licensed practical nurses require the same clinical training? Are-- so are they taking up a full billet of-- I see a head shaking no.

LINA BOSTWICK: Their length of-- their program is shorter--

RIEPE: Yes.

LINA BOSTWICK: --and the clinical hours that they have would also be less--

RIEPE: OK, so they wouldn't--

LINA BOSTWICK: --in most-- in most-- in-- yeah.

RIEPE: --necessarily compete with--

LINA BOSTWICK: No.

RIEPE: --someone who's trying to train for-- to be a registered nurse.

LINA BOSTWICK: Right. And one thing you might want to know, too, is, you know, our operations are 24/7 in most places, hospitals, nursing homes and, therefore, we do use all 24/7 shifts available, mostly day shift and evening shift, but sometimes night shifts, to be able to get the clinical practice in for our students.

RIEPE: I think that's been one of the criticisms of bachelor's programs is sometimes they're-- they're trained to be nurses Monday through Friday as if it's a-- a blue-collar or a white-collar office job, when, in fact, when they go to their first job, they probably go to the night shift--

LINA BOSTWICK: Yeah, it's very--

RIEPE: --which is a great disappointment.

LINA BOSTWICK: Yeah, and you know that that is a true reality and, yes, when you are maybe gra-- a high school graduate and you really don't know for sure exactly the realities of what a nurse does and that 24/7, those schedules, but you do learn fairly quickly. And so sometimes there's even rotating shifts that are offered, so you do day/night and-- days and nights, so--

RIEPE: It's a way to get more clinical time--

LINA BOSTWICK: Yes.

RIEPE: --tough to get faculty, but--

LINA BOSTWICK: Yes.

RIEPE: Thank you, Chairman.

HANSEN: Yep. Any other questions from the committee? All right.

LINA BOSTWICK: OK.

HANSEN: Thank you.

LINA BOSTWICK: Thank you.

HANSEN: Welcome.

STACEY OCANDER: Thank you. Good afternoon. I am Dr. Stacey Ocander, S-t-a-c-e-y O-c-a-n-d-e-r, and I'm the dean of health careers at Metropolitan Community College in Omaha, Nebraska. So I say health careers because I'm not a nurse and our division encompasses all of the health programs equally: nursing, respiratory therapy, medical assisting, fire science, paramedic, and the list goes on. Sixteen years ago, when I interviewed for my position, one of the questions that the faculty asked, fairly, was, what's your background? And I knew they were asking that to see, did I sway more towards one profession than another when it came to advocacy? My background's in athletic training and sports medicine, the one program we don't have, and so they knew that my voice would be neutral. And I tell you that because LB586 and the Nebraska Center for Nursing is about being neutral. So when you asked earlier, will this just be kind of in the big systems and not in the rural parts of the state, I think it's important to remember we're talking about an entity that represents the goodness and livelihood of all of Nebraska. So with that, first, I-- I would like to thank Senator Hughes for bringing this forward,

and Chairman Hansen and the members of the Health and Human Services Committee in allowing me to be here in support of LB586. When I first considered and wondered about LB586, I honestly asked myself, will this finally be the solution to where myself and my peers no longer had to send out nonacceptance letters? There's nothing worse than sending out nonacceptance letters to qualified applicants. And-- and I'm not talking about the ones that haven't met the qualifications for admission, but qualified applicants, sometimes by a hundredth of a point, and that's the worst feeling to have to do that, and then to know that I have to do that because of clinical spots. And so when we talk about clinical spots, we said earlier, is it just the hospital? No, we're using school-based health centers, federally qualified health centers, long-term care, assisted living, the wound centers, the poison center. Our programs are evening and weekend. We run all the time until public safety calls and says, can you get them out of the building at 10:00 p.m., and-- and we believe that that's because that's how our business runs each and every day. So the shortage of clinical spots, clinical faculty, and sustainable practices is not limited to just nursing or one hospital system, one assisted living or long-term care facility or a specific educational institution or program. It's not limited, perhaps, to the nursing school that someone in your family attended to or may be applying to, hoping they're going to get the acceptance letter from us; nor is it limited to the facility that has to leave beds unfilled because of a shortage of healthcare providers to care for those residents or patients. This shortage is felt across our entire state, among all levels and professions of healthcare. It's about healthcare education, as a whole, throughout our entire state. LB586 allows a neutral entity, the Nebraska Center for Nursing, with a focus on serving all the people in Nebraska, to design and implement sustainable strategies to tackle the issue-- it's not a new one and we've been hearing about it for years-- to create models that can be replicated, whether it be for nursing, respiratory therapy, certified nurse aide, case management, and the list goes on. As the dean of health careers at Metropolitan Community College, from 2019 through August of 2022, remembering, in the middle of a pandemic, we prepared 3,169 credentialed or credentialed-eligible healthcare providers across eight programs who are workforce ready. I should be screaming from the rooftops over that success, and I am, except, for those 3,169 future healthcare providers, I also had to send out rejection letters to 704 qualified applicants because I could not secure enough clinical spots. We need to take a targeted look at who and how clinical spots are designated and assigned and begin looking at students, not as additional bodies on an understaffed

hospital floor, but really as our future healthcare providers. Why would a student want to work for a system if they were never allowed to do a clinical rotation within that system? I wouldn't. Has our quest for advancement or recognition created unintended consequences? Have we overlooked talented healthcare providers currently on our floor who could serve as clinical instructors if we choose to design innovative and supportive pathways for their development? We all like to do something a little bit different each day. We know the incoming generation wants to do that as well. In closing, I believe LB586 is the start of providing these opportunities to support the future of healthcare, support for hospitals, long-term care and assisted living facilities and clinics and educational systems to stand up sustainable practices to solve this healthcare worker shortage, not only for now but for the future. We should not wait for someone to invite us to some national solutions table. We need to set the table and be the solution for our state that other states want to follow. I would like to thank Senator Hughes for introducing this bill and thank all of you for your time, and I'd be happy to answer any questions.

HANSEN: All right. Thank you for your testimony. Are there any questions from the committee? Yes, Senator Riepe.

RIEPE: Thank you, Chairman. I've had the good fortune of being on the University of Nebraska Med Center's campus for their infectious disease, and they have simulated models there for training and teaching. You know, my sense is, whether that's artificial intelligence is ready for that or not, but I venture-- and I-- I'm asking for your response, I'm not trying to lecture here-- that that's going to have to be one of the answers or part of the answer going forward, is simulating modeling so that the students, when they do go out for clinical, is maybe in addition to that, so that they're getting the personal, warm feelings, but you can do a lot of that basics in the lab.

STACEY OCANDER: Yeah, you're absolutely correct.

RIEPE: Thank you.

STACEY OCANDER: I'm very proud of the facilities that we have at Metro. If you want to take a field trip, I'm happy to have all of you. We have two synthetic cadavers, the only ones in the state. I'm proud of those, because, as we know, with our Native population, they cannot touch a deceased body once the spirit has left. So when we sit around and we wonder why there's no Natives in medicine, it's because we put

up a barrier to make sure it didn't happen, unfortunately. Now that they're synthetic, they look just like humans, except the nerves are bigger because you have to be able to see them and a nerve's the size of a hair-- excuse me-- a hair. We've increased our reach. We've increased our reach through our simulation lab. We're using virtual reality. But the key statement that you made was "in addition to"--

RIEPE: Yeah.

STACEY OCANDER: --not "in place of," and I think probably everybody sitting behind me-- I know Dr. Delahoyde is like, you better believe it, girl, and that's because it has to be in addition to. Every bell and whistle and great tool is wonderful if you have the basic knowledge behind it and you understand the why. It's easy to understand the how. You just check off a list, right? But do you understand the why? And that's how we keep people safe across our state. But you can come for a field trip any time. I'd be happy to have you all.

HANSEN: Any other questions from the committee? I appreciate you bring up the-- the Nebraska Center for Nursing Board. You mentioned them as a neutral entity. The questions that I asked, and I think the reason why I asked them, is they might be a neutral entity; however, per the parameters of the bill they have to follow, it sometimes may not create a neutral situation or distribution of funds. So the reason I ask most things is, like, how do we make sure that it's equally distributed among rural, which is what we're trying to do, along with urban? And so you-- because you kind of alluded to that in your testimony--

STACEY OCANDER: Um-hum.

HANSEN: --that was the reason why I was asking that question. And so sometimes we have to kind of clarify language in the bill--

STACEY OCANDER: Absolutely.

HANSEN: --to make sure that, OK, we're not leaving some people out or money doesn't getting all used up by only a small group of-- even though the intent is different, so I just wanted to clarify that. But I appreciate you bringing them up because, from my understanding, they are a very neutral entity that would serve very well in helping facilitate the funds for the bill, too, so.

STACEY OCANDER: Right. And can I just add to that? So if you notice, one of the members on there is a representative from the Nebraska Community College Association, of which my college is not part of, but I have faith in the other community college deans to know that are sitting in the rural part of our state. They're going to represent all of our needs equally because we meet regularly. So I don't have to be the one sitting there as long as I know that I can trust my colleagues that will represent the people in the urban areas and the rural areas. So the makeup of com-- of that committee seems to be a little vague. Those of us that are in the weeds of it, we understand what that means in terms of maintaining neutrality as we move forward. It's not an urban issue. It's a statewide issue.

HANSEN: OK. Thank you very much, and thank you for your testimony.

STACEY OCANDER: Thank you.

HANSEN: All right. We'll take our next testifier in support of LB586. Welcome.

JED HANSEN: Good aft-- thanks, Chairman, and thank you for-- for your rural advocacy, Senator. Jed Hansen, I'm with the Nebraska Rural Health Association, so I really, really appreciate that-- that-- that look. But good afternoon, Chairman, other members of the committee. Jed Hansen, J-e-d H-a-n-s-e-n, not a known relation.

HANSEN: Yep. Thanks for clarifying. [LAUGHTER]

JED HANSEN: Nursing is a passion of mine. I have a Ph.D. in nursing. I work clinically as a nurse practitioner. I'm a former emergency department nurse. I've worked in hospital administration; in fact, in the last ten years, I'm not sure that there are any roles that I haven't taken on outside of a clinical instructor. But my wife is also an ER nurse with the VA system. Really, it's all our household now. It's no secret that-- that we have a nursing workforce issue in the state. We've heard some numbers, you know, the 10 percent fewer nurses today than there were just three years ago at the onset of the pandemic. We have anywhere between 1,000 to 1,500 nurses that are planning to leave over the next year as a result of-- of workforce conditions or wanting to try something new. These numbers are even a little bit bleaker in our rural communities. And as we look at our aging population, roughly 60 percent of our nurses in our rural hospitals are within ten years of retirement, so we know we need to do something now to be able to feed that pipeline. There have been

several legislative bills that have either come up this year or that will continue to come up in future sessions to look at the nursing issue, this bill being one of those, and this is part of that solution and looking at clinical placement sites. And as it's been stated before, one of the things that is important to recognize with clinical sites is that they are a true bottleneck to nursing education. And the funds earmarked for this bill will help the Center of Nursing to-- to implement multiple new locations. And providing space for nurses to train in our rural communities promotes that same professional type of migration that we know takes place for physicians, where roughly 70 percent of physicians in our state that practice rurally didn't come from a rural community. They chose those communities-- those communities after receiving or going through a rural residency program. Unfortunately, that just isn't the case in western Nebraska. And, boy, there's some good debates on what's western Nebraska or not, which we can-- we can discuss. But for me, western Nebraska, if we look at what's west of Kearney, there's just one BSN program in the state, one BSN program and that's in Scottsbluff, and there are two other ADN and two other LPN programs, so not much for a pretty large swath of space. In total in our state, including Lincoln and Omaha, we have 18 communities that have some type of nursing education offered in them, and as we've had some discussions about where do these clinical locations take place, most of them do take place very close to those campuses and to those higher education centers that-- that those programs are being offered. I believe that this bill has the potential to expand that network so that we can get more nurses trained and more exposure for nurses that are training in our rural communities with the hope that we can then capture them and-- and get them to stay in our communities. There's part of this that-- this bill that some haven't touched on yet, and that's the role of this clinical adjunct or this clinical instructor, and it does three things that I think are important. One, it creates a pathway for job expansion to allow that bedside nurse to receive some level of promotion, some additional education, some additional promotion, and it keeps that nurse at the bedside while providing additional space. So it's not just that we're training new nurses, but we're also keeping nurses at the bedside that may otherwise feel they have to leave. I just can't underscore how important that is. Two it-- it-- well, I guess I kind of combined one and two there, so I apologize, but-- and-- and then, three, provides a much-needed extender for a lot of our academic centers. These are locations that are also-- and organizations that are also struggling to retain faculty. And so by providing room for someone to stay clinical and to be an instructor really is a win-win

for the state and a win for the nursing program. I think that overall, the flexibility of this bill is-- is wonderful, and i-- I really hope that you take strong consideration in supporting it. Thank you.

HANSEN: All right. Thank you.

JED HANSEN: Would be welcome to any questions.

HANSEN: Thank you for your testimony. Are there any questions from the committee? Senator Ballard.

BALLARD: Thank you, Chair Hansen. Thank you for being here. Thank you for staying with us past 5:00. So I'm assuming that we're not the only rural state with this issue.

JED HANSEN: No, no.

BALLARD: Have--

JED HANSEN: I would say that nationally-- nursing is an issue nationally.

BALLARD: OK.

JED HANSEN: And a lot of it is just that nursing is really, really hard. It's difficult to retain-- to recruit and then to retain high-qual-- highly qualified nurses without having them leave to go into roles like what I've gone or into-- to professional academic roles, and so this is a potential to bridge on that, that space.

BALLARD: Yeah. Have you seen any other rural states try to address this? Best practices, what-- what do you-- what have you seen across the country?

JED HANSEN: Yeah, and, you know, as far as specifics go, something that is kind of within this package that is best practice is really just getting that exposure out into rural communities. I've chatted with the Center for Nursing here and a few that have testified. There are some models where we could use critical access hospitals as kind of centers of training excellence, but then allow them to go out beyond those larger critical access hospitals, like a-- a Beatrice or a York or a McCook, into our even more remote or even smaller critical access hospitals. And really it's that exposure. It's being able to-- to get those-- those clinical nurses, that-- that infrastructure in place so that they can receive students. Some of the challenges are

that we don't have a clinical instructor workforce as robust as we need in the state. And then census, the number of patients that are in the hospital, and especially in our smaller critical access hospitals, in any given day, may or may not support having, you know, X number of students. And so to be able to have some flexibility in some of the funding in here, we can look towards housing that has been mentioned, transportation for students, just being able to make sure that they have enough gas in their car that they can get back and forth. So there-- there are some things that have worked in other rural states or that are being currently tried that I think the flexibility in this bill will-- will allow for.

BALLARD: Thank you for being here.

JED HANSEN: Yeah. Thanks, Senator.

HANSEN: Any other questions from the committee? Seeing none--

JED HANSEN: And then if I could, I just really quickly wanted to-- to provide just a clarification. So we've been talking about clinical nurses and clinical nurse instructors. So when a nursing student is being trained in a hospital or a long-term care facility, skilled nursing, wherever they may be, that clinical nurse instructor is there to help that student to help those students. So any given patient is still going to need their nurse. There's still a nurse assigned to that-- to that patient, so that nurse has that patient workload, then that clinical nurse instructor then has the workload of managing those students. Sol it-- there have been several questions about the different programs or why aren't clinicals-- or why aren't hospitals or clinics adopting that at a larger capacity, it's because, first and foremost, they have to make sure that they have the-- the staffing available to-- to support the patients that are in those beds, so.

HANSEN: OK. All right. Thank you.

JED HANSEN: Yeah.

HANSEN: So no other questions, thank you for coming.

JED HANSEN: Yeah. Thanks for your time.

HANSEN: Yeah. Thank you. Are there any-- any-- we'll take the next testifier in support of LB586.

JINA RAGLAND: Hi, Chair Hansen.

HANSEN: Welcome.

JINA RAGLAND: Members of the Health and Human Services Committee, my name is Jina Ragland, J-i-n-a R-a-g-l-a-n-d. I appear here today testifying in support of LB586 on behalf of AARP Nebraska. I'm coming to you-- I'm not a nurse. I'm not a medical professional. I'm here today as the consumer side of things for the aging 65 and older population of Nebraska. This is a vitally important bill. You've heard this number, but I think it's important. Again, according to the American Association of College of Nursing, we're facing a critical shortage of nurses. In fact, they indicate, in Nebraska, there will be a deficit of 5,000 nurses and nationally a deficit of 130 nurses-- 30,000 nurses by 2025. The nursing shortage, most severe in small towns and rural areas, affects both Nebraska's physical health and its economic health. The shortage has been worsened by rates of retirement, considering more than half of the nursing workforce is over the age 50 years old. And while the nursing shortage certainly existed before COVID-19, stress, workload requirements, and demands of the pandemic have undoubtedly exacerbated the problem. This comes at a time when the aging population in the U.S. and Nebraska continues to grow and there is more demand for nursing services across the country to meet the needs of older adults who often suffer from multiple chronicle-- chronic conditions, regardless of where they live and whether that be in their home or in a facility. That demand is going to continue to grow as, by 2030, one in every five Americans will be over the age of 65. Future nursing jobs will be greatly impacted by significant changes and new needs in the healthcare system and the practice environment. Nursing jobs and educational requirements may change as a result of the impending healthcare worker shortage caused by the rapidly aging population's increased healthcare needs. The demand for health services will change the system as older persons continue to util-- utilize a disproportionately big part of American healthcare. More than just making room for all these patients, the type of knowledge, abilities and services the healthcare staff must possess and the environments in which this care is delivered will change to accommodate these needs while still providing the highest quality of care. Compounding the problem is the fact that nursing schools across the country are struggling to expand capacity to meet the rising demand for care. Communities of color, as well as rural communities, have and continue to face challenges in accessing the healthcare and services needed there. There are documented disparities that are exacerbated by limited available-- availability of nurses, nurse practitioners, and minimal access to specialty services. AARP

Nebraska supports LB586, which would provide funding to the Nebraska Center for Nursing to broaden its mission to expand clinical training sites for nurses throughout the state. The bill directs the Nebraska Center for Nursing to focus this work in areas of the state where there are lower numbers of res-- registered nurses per capita. Innovative solutions to attract more nurses to the field and expand our state's capacity to train more nurses is a key to addressing the nursing shortage and further advance the greatest quality of care for many of our most vulnerable citizens: our aging population. We believe LB586 could be a part of that innovative approach with the ultimate goal, again, to assist all Nebraskans the ability to age in place. I would like to thank Senator Hughes and Senator Lippincott for introducing the bill and Senator Hughes for her work on this issue. I know she has a daughter going through nursing school, so this is important to her also. We would ask you, the committee, to support and advance the bill to General File, and I would definitely try to answer any questions, nonclinical, of course, if possible. But thank you for your time.

HANSEN: All right. Thank you for your testimony. Are there-- are there any clinical questions for her? All right, seeing none--

JINA RAGLAND: Thank you.

HANSEN: Thank you. Take our next testifier in support. Welcome.

COURTNEY WITTSTRUCK: Hi there, Chairman Hansen and members of the HHS Committee. My name is Courtney Wittstruck, C-o-u-r-t-n-e-y W-i-t-t-s-t-r-u-c-k, and I represent the Nebraska Community College Association, so that's the five colleges, as Stacey mentioned earlier. Metro is not a part of it, but we all work very closely together. I had my testimony already written, but because everyone ahead of me did such a wonderful job, I am kind of going off the cuff here, but I wanted to make sure that we're on record as being supportive of LB586. I thought I'd touch on a couple things that had come up throughout the hearings today, just that maybe would be good points to-- to discuss or to answer any questions on. You know, one, like I mentioned, bottlenecks in clinical trials are very, very problematic for our colleges and our students. In many cases, our colleges could actually expand locations and offer more locations, especially out in rural Nebraska, if they had more opportunities for clinicals. So in mo-- in many cases, that's the bottleneck, as you heard some of the others say, that's holding up more locations that could be turning out more nurses. Next, I thought I'd mention, so obviously community colleges,

we are proud to be a part of the solution for this healthcare workforce crisis, and the overall workforce crisis for that matter. And I would be remiss if I didn't mention some other legislation that's going on that could affect the solution here. So this solution, if it were to be implemented and if it were to be, you know, completely implemented, passed, it would be a great opportunity to expand into those areas that-- that-- in rural Nebraska that have a need for more nurses. The challenge for us would be-- is there are different bills that address our funding model, and if our funding model were to be significantly changed, as some of the other bills have suggested, that would significantly impede our ability to meet those local communities' needs. So when it comes to hey, I want to put-- you know, I have a serious need in Imperial for nur-- a nursing facility or for nurses. It would seriously impede our ability-- when that decision making was taken out of the hands of our boards of directors, the local people in those communities that recognize the local needs, that would seriously impede our ability to fulfill the purpose of this bill. An example, Senator Hardin, so let's say in your community, you're saying we have a great need for earwax removal specialists and we want-- and I never thought I would say this and I'm probably-- my colleagues are watching me and laughing now. But let's say you had a great need in Scottsbluff for earwax removal specialists, and you wanted to set up a program that you were talking about for some sort of licensure. Well, if we don't have-- if my local Western Nebraska Community College didn't have their board of governors that could meet and discuss why that's so important to their community and decide that they wanted to focus on that program and in-- install it in the school, it-- it likely wouldn't happen because that decision-making power would not be coming from that local community. So that's one example where whatever we are talking about here to fulfill this-- or to fill this workforce gap or this crisis would be hindered by some other legislation. Another thing I wanted to quickly point out is that when you look at what facilities are covering all of Nebraska-- and I wanted-- I know Jed and I kind of quickly spoke. Actually, community colleges, we-- we offer several programs that are west of Kearney, but they-- they're all part of the same, I guess, community college but multiple campuses. So when he said-- I don't remember what he said, two or three or something, we have multiple campuses, so it may have been one college that he was referring to, but a college that has multiple campuses, so anywhere in North Platte, Columbus, Grand Island, Kearney, Scottsbluff, O'Neill, Norfolk, and then we also rotate between McCook, Broken Bow, Valentine. So we have a lot of those rural, rural areas and we could

even add more. And when you look at groups that are able to fulfill the requirement of nurses that we have in training, in every corner of the state, that's the community colleges, and that's why-- I know I'm preaching, but that's why that local control is so important, because they can address that local need. And when you look at who stays in Nebraska-- I know I heard some other data that says, you know, how many folks stay in Nebraska-- in total, on average, not necessarily just nursing, but 88 percent of our community college students stay in Nebraska when they're-- when they're done with their studies, and even about 80 percent or a little greater than that stay in their area. So if they're out in western Nebraska, going to Western Nebraska Community College, getting their nursing degree, then 80 percent, approximately, stay in their area. So when we're talking about serving these other corners, that's an. Opportunity for-- for us to help and for you to help us help. So I don't know that I have anything else that I missed, so I'd be happy to ask-- answer any other questions that you all have.

HANSEN: Are there any questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for your testimony. Well, you piqued my interest. What are these other bills?

COURTNEY WITTSTRUCK: So-- so we had a hearing on one bill. That was LB783 and that was a bill that was brought by Senator Murman that proposes to take community colleges off of property taxes and put them on to state funds. And there's a number of reasons that-- I know we already had the hearing on that. There's a number of reasons why that would hurt the efforts for community colleges and for us to fill the need that nursing and healthcare and teaching, all of those, had. Like I mentioned, having that local control gives those-- those communities the ability to decide what do they need most. Maybe it's the earwax removal. You're never going to hear the end of that, but maybe it's the earwax removal, you know, class or-- or maybe it's a welding class or maybe it's a heavy equipment class. But having that flexibility to meet the community's needs and what that community's workforce is, because our communities in Nebraska are so unique, one may need-- need heavy equipment. One may need software, and giving those locally elected board-- boards of governors that flexibility, it gives them the agility to meet the workforce needs much quicker and specialize in whatever that local employer or workforce needs.

M. CAVANAUGH: Outside of LB586, which, obviously, you are a fan of, is there anything else that the Legislature could potentially pass that would also help?

COURTNEY WITTSTRUCK: Yeah, that would-- that's-- thank you for that question. So tomorrow there's actually a hearing for LB689 and it offers the same-- actually more property tax relief than LB783. LB783, part of the problem also, it would put us in default for our current bonds, so-- and they would also have to still allow a levy for some sort of capital for the bonds. So LB783 would not be able to completely take community colleges off of property tax. But LB689, it is-- was introduced by Senator Linehan, and it would provide a 100 percent income tax rebate for community college funds paid. So you're actually-- it would provide more property tax relief but then still leave in place this really important structure that would allow the colleges address-- to address their community needs. So that hearing is tomorrow and we'll be testifying at that, as will some other organizations.

M. CAVANAUGH: Thanks. Thank you for the information.

HANSEN: Any other questions from the committee? I can't remember for sure. Did we appropriate money from ARPA last year for tuition?

COURTNEY WITTSTRUCK: We appropriated for, let's see, dual credit. We also-- HEERF funds went for tuition. The ARPA funds last year were for capital and equipment because we are only able to levy two cents for capital and equipment. So if we want to do or we have-- if the community has a need to do a big project, they would have to basically save up for several years to be able to use that two cents and put it towards a big project.

HANSEN: Wasn't there-- no, something specific for nursing? Wasn't there something for nursing [INAUDIBLE]

COURTNEY WITTSTRUCK: There was one that we were going to do out west, but we didn't get-- now, if some-- if I'm saying something wrong, I might have someone that can--

HANSEN: That's all right. They can tell me afterwards, too [INAUDIBLE]

COURTNEY WITTSTRUCK: There were supposed to be one-- I'll be honest with you. There was supposed to be one out west with Western Nebraska Community College and where they're working to-- together with other organizations. The-- our ask for ARPA funds was cut down

significantly. And I don't want-- you know, I know beggars can't be choosers, and I know so many other people asked for money and didn't get it, so we're very grateful, but that the amount of money that we got was not-- was significantly decreased from our ask. That was on our original ask and I believe it got-- I believe it was cut because of the funds.

HANSEN: No big deal. They can tell me afterwards too. All right. Thank you for coming to testify.

COURTNEY WITTSTRUCK: Thanks, everyone. Have a good day.

HANSEN: Appreciate it. Take the next testifier in support.

KRISTIN ROHDE: Good afternoon.

HANSEN: Welcome.

KRISTIN ROHDE: Thanks for having me. My name's Kristin Rohde; it's K-r-i-s-t-i-n R-o-h-d-e. I am here representing the Nebraska Association of Nurse Anesthetists and we are supporting LB586. I've been a nurse for 20 years and a nurse anesthetist for 12 of those years. I'm extremely passionate about my patients, for whom I care, and for this great profession. Nurses are involved in every aspect of patient care. They are at the bedside 24/7. They ensure that patients have access to care across the state. Not only do we care for the injured, the sick and the dying, but we also care for these families of those patients. It's an emotionally and physically draining job at times, but for most of us, we absolutely love what we do and are very proud of how we do it. Over the past few years, however, we've all seen a dramatic decrease in the number of nurses hospitals and clinics have on staff. Nurses are getting burned out. They feel underappreciated, undervalued, and they are tired of not making themselves and their families a priority. The nursing shortage is real and it's hindering access to care for patients all over the country. Nurses are leaving institutions where they have dedicated years of their careers to finding entirely new careers outside of healthcare, or they leave to go take advantage of higher salaries and better staffing ratios in other states. I've been watching this unfold for years and I wonder how hospitals can sustain having to pay travel nurses, who have no loyalty to their institution, for much longer. LB586 is a great way to start. This bill will address several areas of nursing to help tackle the shortage of nurses in Nebraska. In order to train more nurses, we need more nursing instructors and more clinical

training sites. This will help nursing programs admit more students and will increase the number of nurses they graduate each year. When someone graduates with their BSN, LPN, ADN, they want to practice in a place where they are paid well, have appropriate staffing ratios, supportive staff and management, and be able to provide safe care to their patients. In order to keep these well-educated nurses in this state, Nebraska needs more nurses, period. This will lay the foundation for a great place to live and work for nurses who are already living here and will help make Nebraska a more desirable place for nurses to move and to work. It's not on my written testimony, but as someone who is a clinical nurse, or clinical nurse anesthetist, I have students that come with me all the time. When I was a nurse working in the pediatric ICU, I had nursing students that were assigned to me and I was their preceptor. And so whatever your schedule is, is what the students' schedule is. So I will be assigned a student over night shifts, I will have a student on weekend shifts, so it's not necessarily a great schedule for a nursing student or a nursing [INAUDIBLE] student. They work when I work. It allows them to really see what it's like to be a nurse, to see what it's like after hours, to be on call for trauma, so they really get a great idea of what their job will be like when they're done with school. I don't make any more money for doing that, but what it does for me is it helps pay it forward because someday I would love to retire, and if there's no one to take my place, I will probably die in my chair in the OR someday. So I don't want that. I would rather die on a beach where it's nice and warm. [LAUGHTER] So this bill, I think, just kind of helps maybe alleviate some of that stress, because when we have more clinical sites, essentially, you can have more students. And so that will help fill those gaps. We've addressed earlier, when you're exposed to different places, you have no idea what it's like to work there. So on my clinical rotations, I got to see what it was like to work in York, to work in Kearney, to work in Columbus, to work in Lexington. These are great places, and I don't think anyone has an idea of what those hospitals are truly like until they can see it. So if there's more sites like that, the students' eyes get opened to that and they might find a real passion for rural healthcare, which is where you learn to use all of the skills that you've given in training because there's no one else to help you. So it's a pretty great thing to be able to do that for our students.

HANSEN: OK.

KRISTIN ROHDE: Any questions, comments?

HANSEN: Hopefully this bill helps incentivize you dying on a beach someday. [LAUGHTER]

KRISTIN ROHDE: I don't-- I don't think it will.

HANSEN: Don't say that very often, but-- any questions from the committee? All right. Seeing none, thank you for coming to testify.

KRISTIN ROHDE: Thank you.

HANSEN: Is there anybody else wishing to testify in support of LB586? OK. Seeing none, is there anybody who wishes to testify in opposition to LB586? Seeing none, is there anybody who wishes to testify in a neutral capacity to LB586? All right, seeing none, we'll welcome up--

HUGHES: OK.

HANSEN: --Senator Hughes back up to close. And before she does that, we did have three letters in support, as proponents for LB586.

HUGHES: Excellent. So, Chairman Hansen and members of the committee, thanks for your time today. One clarification-- and I can't even remember. Maybe it was you that asked. Yeah, you asked. Last year-- you asked if there were ARPA funds given for nursing, and it was apparently five-- this is from-- someone in this room told me this-- $5 million for nursing scholarships, and the Department of Health gives those out and they're $2,500 awards and about half that money has been divvied out. So that-- that's for the front end, you know, someone to get a nursing scholarship. I'm going to go off script still too. So it seems like it's not as much of an issue of on the front end. The scholarships help get kids into it. But the one thing on the testimony of all of it that stuck out to me was when the gal from Metro said that they sent out 700-- 704 denial letters to students that were qualified to go into the programing, but they couldn't take them because there was no room, because of the-- you know, you need these clinical sites, which we-- we need. We want that in the program. But my question then is, of those 704 kids, how many (A) either applied to another school in nurse-- in some kind of nursing or health degree, or how many was like, well, I guess I'm not going to do that, I'm going to get this degree? And we've lost that, right? So I think that's the issue that we're talking about. LB586 will give us another tool in the toolkit to ensure that we can shrink the nursing workforce shortage here in Nebraska, and our ability to provide for a healthy, high quality of life depends on it. Colleagues, I urge you to support

in reporting-- reporting LB586 to the General File, and I thank you for your time. And I'm going to add one more thing. Senator Riepe, you had asked about the list of schools, and I think that came out. You guys got a list of schools across Nebraska--

RIEPE: Thank you.

HUGHES: --nursing schools, so-- OK. Questions?

HANSEN: All right. Thank you. Are there any questions from the committee? Seeing none--

HUGHES: All right.

HANSEN: --thank you very much.

HUGHES: This is my last bill, so thank you.

HANSEN: We should have took longer.

HUGHES: And I'm trying to think if my first one with this go-- I think my first [INAUDIBLE]

HANSEN: That will--

HUGHES: --so I began here and I'm ending here.

RIEPE: [INAUDIBLE]

DAY: It's a good place to be.

HANSEN: That will-- that will close the hearing for LB586.

RIEPE: Had we known that, we'd have been a little harder on you.

HUGHES: You would have been meaner? All right. Thanks, guys. Be safe driving home.

HANSEN: And that will close our hearings for the day.