HANSEN: All right. Good afternoon and welcome to the Health and Human Services Committee. My name is Senator Ben Hansen. I represent the 16th Legislative District in Washington, Burt, Cuming, and parts of Stanton Counties, and I serve as Chair of the Health and Human Services Committee. And somebody told me I have to be on my best behavior because we have a special person in the room today. So I guess I, I can't joke around too much otherwise I will get scolded. I would 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.

M. CAVANAUGH: Machaela Cavanaugh, District 6, west central Omaha, Douglas County. I'm here most days so you don't have to behave special for me.

HANSEN: OK. Good. Clearing that up right away.

RIEPE: I'm Merv Riepe, representing District 12, which is southwest Omaha and the city of Ralston.

HANSEN: All right. Also assisting the committee is our research analyst, Bryson Bartels, our committee clerk Christina Campbell, and our committee pages-- committee page for today is Delanie. A few notes about our policy and procedures. Please turn off or silence your cell phones. We will be hearing four bills today. Each of the tape-- on each of the tables near the doors to the hearing room, you will find green testifier sheets. If you're planning to testify today, please fill one out and hand it out to Christina when you come up to testify. This will help us keep an accurate record of the hearing. If you are not testifying at the microphone but want to go on record as having a position on a bill being heard today, there are white sign-in sheets at each entrance where you may leave your name and other pertinent information. Also, I would note if you are not testifying but have 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 day prior to the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. We would ask if you do have any handouts that you please bring ten copies and give them to the page. We use a light system for testifying, each testifier will have five minutes to testify. When you begin, the light will turn green. When the light turns yellow, that means you have one minute

left. When the light turns red, it is time to end your testimony and we will ask that you wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone and then spell both your first and last names. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters of the bill, then from those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given the opportunity to make closing statements if they wish to do so. And on a side note, the reading of testimony that is not your own is not allowed unless previously approved. And we do have a strict no-prop policy in the committee. So with that, we'll begin today's hearing with LB276 and welcome Senator Wishart to open. Good afternoon.

WISHART: Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Anna Wishart, A-n-n-a W-i-s-h-a-r-t, and I represent the 27th Legislative District, including west Lincoln and parts of southwestern Lancaster County. I'm here today to introduce LB276, which enables implementation of a delivery model for behavioral health services in Nebraska, known as the Certified Community Behavioral Health Clinic Act. Over my years in the Legislature and my time on the Appropriations Committee, I have witnessed the struggle of those in need of access to mental health and substance use treatment care and the struggles of the providers that provide this care to deliver that service. The Legislature needs to step up and fund a system that has been underfunded for years and attempt to build more capacity in our current system and expand behavioral health workforce as well. The Division of Behavioral Health conducted a rate study in 2016 showing between 15 to 40 percent under the actual cost of providing care for services. That's what our providers have to contend with, and yet they continue to deliver services to Nebraskans every single day. And that was the status over five years ago. Imagine what they are experiencing today with the inflation that all of us are experiencing today. The model in LB276 isn't new in our country or in this committee. I brought this bill last year and as you know as well as an interim study this fall. In 2017, the model was organized as a Medicaid demonstration project that included eight states in collaboration with the federal Substance Abuse and Mental Health Services Administration, SAMHSA. And this collaboration provided and continues to provide initial start-up grants for facilities around the country that apply and currently there are over 500 CCBHCs in the United States across 46 states. The CCBHC model requires outpatient mental health and substance use

treatment services, as well as primary care coordination, including monitoring of key health indicators, health risks, crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention and stabilization, screening assessment and diagnosis, including risk management, psychiatric rehabilitation, peer and family supports and housing. Really, the way I see it is I think we would all be hard pressed to find someone in this room that doesn't know someone in their life who has been touched by mental health or substance use issues. And when you think about those who have found a way to recovery obviously, it took a lot of personal fortitude to do that. But it also took a holistic approach of a lot of different supports in that person's life. And so that's really what we're talking about allowing these providers to provide that type of care and also get funding for that. Excuse me. Sorry.

HANSEN: You're fine.

WISHART: Now it is time to invest in a modest increase in Medicaid match dollars because this new delivery model has proven its effectiveness and savings to government entities across the country. And we're talking a lot this year, and we expect to talk a lot this year with the Judiciary Committee about our criminal justice system. We are seeing that programs like this are the solutions for helping to reduce overflowing and overcrowding in our criminal justice system, because a lot of people who enter into our prison system are people who are dealing with a mental health crisis. I-- since I originally introduced LB976 last session and LR366 last interim, I have worked with representatives from the Department of Health and Human Services in the past and current administration and I want to thank them so much for being here today in support of LB276, especially the Governor for, for joining us today with his support. Together, we have worked to eliminate the General Fund fiscal note, and I look forward to working with them to implement this transformative model. With that, I would be happy to answer any questions.

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

M. CAVANAUGH: Thank you. Thank you, Senator Wishart. You said that you've eliminated the General Fund fiscal note, could you speak to that a little bit more?

WISHART: Yeah, so if you look at the fiscal note from the department, we do anticipate that in the future there will likely be funding needs

for, for this type of service. But for the start-up costs, we were able-- the department was able to, to utilize cash funds and then there will be federal funds that we'll be able to draw down to support this program. And they can speak more specifically about the cash funds they'll be utilizing.

M. CAVANAUGH: OK. Thank you.

HANSEN: Senator Riepe.

RIEPE: Thank you, Mr. Chairman. Thank you for being here. The one question that I have is because we're seeing so much stuff from mental health coming from a variety of directions and with a lot of money being thrown at mental health is-- my concern is always the coordination of different providers and how do, how do we most effectively get the biggest bang out of our buck, if you will, and I don't, I don't know whether-- my question, I guess, would be does this-- where does this fit in with, like, the various regions or how, how-- what part of the puzzle is it?

WISHART: Well, I'm glad that you asked that question, Senator, because a lot of the concerns that you've expressed about silos and investing in different mental health programs that aren't working together, that's what CCBHCs do. So what's exciting about it is it truly is a holistic approach. So when you have somebody who's dealing with a substance use issue or dealing with a mental health issue, instead of just focusing exclusively on the healthcare aspect of it, you're also working with local law enforcement agencies. You're working with the public schools-- and the, and the schools in the district so you're having a collaborative approach that providers are able then to provide a total holistic system of support for that individual. And what we're seeing across the country in, in states that have implemented this type of model is it is that model that kind of glues all of these investments together so that, so that when an individual comes in and needs help they're getting that full array of supports that they need to get onto their own two feet and to be successful.

RIEPE: Obviously, you've addressed the issue before you came here and I appreciate that.

WISHART: Thank you.

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

HANSEN: Yeah. Are there any other questions from the committee? Can you elaborate on SAMHSA? What's the grant process with that and how much is that do you know? I, I was looking at the fiscal note a little bit there.

WISHART: Yeah, so--

HANSEN: Or if you can't, somebody else maybe behind you.

WISHART: Yeah, the CCBHCs who are following, some of them have, I believe, received some of those grants. So I believe they were-- it was a, it was a short-term grant process that was provided to a certain amount of CCBHCs across the country and the goal was to kind of pilot it, see its success. And then my goal with this legislation is this is working and, and so we should, we should make it a long-term solution.

HANSEN: It's more of like implementation of the project, right?

WISHART: Yeah.

HANSEN: OK. All right. I think that's all I had, so.

WISHART: OK.

HANSEN: Any other questions from the committee? All right. Seeing none, we'll see you at close.

WISHART: Thank you.

HANSEN: Thank you.

WISHART: Yes.

HANSEN: And you have invited testimony today, right?

WISHART: Yes.

HANSEN: OK. All right. So we'll take up the first invited testi-- testifier in support of LB276. Welcome, Mr. Governor.

JIM PILLEN: Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. Really appreciate the opportunity to visit. For the record, my name's Jim Pillen, J-i-m P-i-l-l-e-n. I have the incredible privilege of serving as the 41st Governor of the great state of Nebraska. Trust me, that's never going to be normal saying

that. I get goose bumps every time. And I'm here to support Senator Wishart's LB276. The state of Nebraska is an extraordinary special place. We have incredible land, we have incredible water, but the most is our incredible people. They obviously are our greatest strength and the greatest asset that makes Nebraska such a special place to live. I think that I would be one of the most guilty Nebraskans that would say and look and, and have so much pride and so much love for Nebraska and the people in Nebraska, that, that I'd be guilty wanting to say that everything's perfect. And I think the hard core reality, I won't go into my family's experiences, but I'm proud of a daughter that's a mental health specialist and what my wife has done in our family. And I think it's, it's really important for us to acknowledge that in the state of Nebraska and all of our communities, we, we, we have challenges and we have, we have people in need because of mental health and because of substance abuse. And those are hard, those are hard for us to acknowledge and acknowledge that a significant problem exists and a lot of people need help. And I think that's probably the strongest thing that I want to say is that it's really, really important-- that this, this bill is really important for us to step up and help and we need more mental health specialists. The good news would be several years ago, the federal government created the program that especially designated outpatient centers called the certified community behavioral health clinics. These are really a big deal because they can integrate the comprehensive, physical and emotional and behavioral health needed and can do it operating under a cost-based payment system. These clinics together, as Senator Wishart mentioned, starts helping put things more together instead of siloed, the, the expansion of services in underserved areas and communities where we don't have enough help, and then, and then building into community partnerships with schools and with the hospitals, with primary care providers, with law enforcement, and both-- and, and many public and private organizations. And the coordination, the collaboration is really important. These services are provided in person centered, family centered, recovery oriented with nationally developed criteria and standards. I think what's-- I think is important here is the, the timing and meaningful access to the services and the outreach of them, 24/7 access. If you're out and around the state of Nebraska and, and talk to law enforcement, so many of their time is pulled away, pulled away because of helping families that have, have behavioral health or mental health problems or emergency room, hospitals and emergency room so the acceptance of all patients regardless of their ability to pay, place of residence or age, including developmentally appropriate care of children and youth

as well. So this model uses a specialty cost reimbursement system that enhances the financial resources to address the current workforce shortage and increase the number of participating treatment centers. States have the opportunity to apply for the Medicaid coverage of these clinics, programs by amending their state's Medicaid. And I think the other piece is this is an embryonic for Nebraska. There's great examples of success in Kansas and Missouri, Oklahoma and Texas that's already been implemented. And the other part I think that's really significant is that this isn't a hope or dream, there's good data collected from these states that show that these clinics, clinics have significantly improved timely access to mental health and substance abuse. The 24/7 crisis support provided by these clinics help, you know, get people in the right places at the right time. I just simply believe under LB276-- the other pieces under LB276 cost-based model, approximately 65 cents is covered by the federal government. And I think that Director Smith will talk, but the Department of Health and Human Services have resources under the current allocation to take care of the rest. So it's a great opportunity to take care of, of getting, getting a lot of outside help. So I'm here in total support of LB276 because of creating the certified community-based health clinics under the federally funded model. There are a number of experts that will be able to address a lot more complicated pieces of this, but I'd be happy to answer any questions from the committee and appreciate the chance to be before you.

HANSEN: Thank you for testifying. Are there any extremely difficult questions we can ask Mr. Governor pertaining to LB276? Yes, Senator Cavanaugh.

M. CAVANAUGH: I hope they're not difficult. Thank you so much, Mr. Governor, for being here today. And you unfortunately have to suffer through us all calling you Governor whether you like it or not today.

JIM PILLEN: Jim works fine by the way.

M. CAVANAUGH: Not in committee, it doesn't. I want to ask you a question about asking you a question. I'd love to talk to you a little bit more about what your strategic vision is here. I'm mindful that there are people behind you that can answer some detailed questions, but are you OK with a few questions around a--

JIM PILLEN: Sure.

M. CAVANAUGH: --broader strategic? OK. I want to be mind--

JIM PILLEN: I'll do the best I can. If I don't know, I'd-- I'll be happy to say I don't know.

M. CAVANAUGH: I don't think they're, I don't think they're too hard. I don't know if you're aware, but I talked a lot this morning, like three hours, and a couple of the things that I talked about were some of the resources that we have available, specifically our TANF funds, which go-- we have $130 million-plus rainy day fund that can go direct to assistance to families. And I feel like I would be remiss if I didn't ask you when we're talking about behavioral health and the strategic vision, which I very much appreciate you coming and speaking to and elevating, we have so many societal and public health factors that are impacting our behavioral health. And is this something that we could work on between the administration and the Legislature to take some of those resources that we currently have available to us to help address the issues of poverty that are impacting behavioral health? Is that something that your administration is interested in pursuing in partnership?

JIM PILLEN: Yeah, so I think maybe what I--

M. CAVANAUGH: I'm putting you on the spot I realize.

JIM PILLEN: --what, what would come to my mind to answer that would be that as we had meetings with lots of members of the K-12 as we were learning more and as we worked on our-- that would have been back in December-- and Dr. Logan made an extraordinary, brilliant comment using a Thomas Edison quote and said that, you know-- and, and she was talking about a crisis of teacher shortage. And the comment was that Thomas Edison was, you know, if we would spend 95 percent of our time studying the problem and collaborating and trying to understand the problem, it would only take 5 percent to solve it. And I think that, that is really, really powerful. And so what our office is committed to doing once we get through this session is being able to convene a whole bunch of people that have spent their lives committed to these issues. And we're going to convene people so that we can come together and listen and try to really, really identify the problem and come away with some root problems as has some people that have been working on it their whole life, said, you know, we've been doing X and Y and Z and we, we just put a little dent in it. And maybe if we come together and really spend time more on the problem, not just thinking we're

going to come to the solution this afternoon that we really together can put a big dent in it so Nebraska's a place we can do that.

M. CAVANAUGH: I appreciate that. I think it's a well-known factor that poverty is definitely a social determinant of health and certainly of mental health and so I hope that we can continue to work with your administration as a Legislature to address those issues when we have those resources available to us.

JIM PILLEN: For Nebraska to be a great thrive-- have great thriving middle class cities, we have to, we have to lift, lift every member out of poverty and we have them, we have them in every community not just a couple.

M. CAVANAUGH: We do. Thank you so much for your time and answering my hopefully not too difficult questions.

HANSEN: Any other questions from the committee? Senator Ballard.

BALLARD: Thank you, Mr. Chairman. Thank you for being here, Governor. You mentioned a, a key word in, in your testimony about workforce shortage. Can you expand on that a little bit, especially talking about rural workforce shortage when, when looking at behavioral health?

JIM PILLEN: Yeah, well, I think that fundamentally, I believe that the role of government is to stay out of our hair, but to get involved where there's, where there's places of need. I-- in the state of Nebraska, we have a problem with teacher shortage. It's, it's not a great job, it's an incredible career. There's nothing more rewarding than impacting young people and yet here we are in a shortage. It's real-- well proven that we're going to be 5,000 nurses short by 2025 and healthcare fields of shortage and, you know, mental health specialist, it's a tough job. It's a special calling. And we, we have to be able to find young people that have the calling and probably need to have some help in being incentivized to-- with via education because, because we have to have more help in the fields, there's no ifs, ands, or buts about it.

BALLARD: Thank you for being here. Thank you, Mr. Chairman.

HANSEN: Thank you. Any other questions from the committee? Well, I appreciate you coming here. I think there's another Thomas Edison quote that's probably the worst that any government official could

probably say. It's: I have not failed, but I found 10,000 ways that won't work.

JIM PILLEN: Right.

HANSEN: It's probably the opposite of what you're trying to get to.

JIM PILLEN: I think pretty well the opposite. Right. Yeah.

HANSEN: All right. Well, thank you for coming to testify and your time.

JIM PILLEN: And let, let me just say to all the members, thanks for all your work. I don't think Nebraskans realize or fully appreciate, and I try to say it as often as I can, how hard everybody in the Unicameral works. It's a, it's a more than full-time job so thanks for all your efforts. Thank you.

HANSEN: Thank you. All right. We'll take our next invited testimony in support of LB276. Welcome, CEO Smith.

DANNETTE R. SMITH: Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Dannette R. Smith, D-a-n-n-e-t-t-e R. S-m-i-t-h, and I am the chief executive officer for the Department of Health and Human Services, DHHS. What an opportunity it is to be here today to testify in support of LB267 [SIC--LB276]. I am so proud that Governor Pillen was able to join us and lend his voice to our enthusiasm over the certified community behavioral health clinics, CCBHCs. Just this week, the need for community behavioral health services has been acknowledged by all three branches of government. From the Legislature's consideration of this bill, the Governor's testimony today, and Chief Justice Heavican's comments at the State of the Judiciary address on Tuesday, all three branches seem to realize that providing early intervention through community services can help prevent mental health crises and mitigate the need for law enforcement intervention. DHHS is committed to increasing behavioral health services statewide by creating a continuum of care. We are excited to work with providers and stakeholders to reimagine behavioral health in Nebraska. We know based on the successes in other states and in Nebraska, the CCBHCs provide a real opportunity to address behavioral health needs from a community perspective. Enhancing this model statewide ensures relevant services are available to the most vulnerable individuals, regardless of Medicaid eligibility, and from Kimball to Blair and from Valentine to Red

Cloud. Our federal partners have funded with much success the CCBHC model across the country. They have proven success with providing upstream preventative behavioral health services and a comprehensive approach. While there is a standard for CCBHC models across the country, our inclination in Nebraska is to fit the needs of the community so our constituents feel comfortable in accessing the services they need. Our constituents do well when they receive on-demand services within their community. On the contrary, we know that unaddressed behavioral health needs at the time of crisis can cause increased behavioral health challenges. We are championing the CCBHC model because we are committed to ensuring that behavioral health services are responsive to the community. At DHHS, our Division of Behavioral Health and Medicaid Long-Term Care as well as public health are working together to ensure the success of CCBHCs in Nebraska. Specifically, behavioral health and Medicaid will partner to provide access to CCBHCs statewide. Meanwhile, public health will work to establish appropriate standards and issue certifications to the CCBHCs to ensure public safety. Following my testimony with specific details on our collaborative state effort will be Interim Director of Behavioral Health Tony Green, Director of Medicaid Long-Term Care Director Kevin Bagley. We respectfully request that the committee advance this bill to General File. Thank you for the opportunity to testify today. I'd be happy to answer any questions.

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

M. CAVANAUGH: Thank you. Thank you for being here. While I kind of "telepathed" my question a little bit via the Governor, which is kind of fun to say that I did that. We-- I, I love this bill. I think it's great. It's a great concept, great idea investing more in behavioral health. But again, we have these social determinants of health, social determinants of behavioral health, and most of them are surrounded and pointing towards poverty. What, what is the plan, and maybe just a snapshot of it right now because I'm sure it's more in-depth than that, but what is the plan to use the resources that we currently have available and the legislation that we have pending for the department to start addressing those issues of poverty, especially as it relates to behavioral mental health?

DANNETTE R. SMITH: One of the-- I love the question that you asked the Governor about TANF, and I think one of the things that we're beginning to explore is, I think, something that's near and dear to the Governor's heart. One of the ways to certainly address poverty is

to make sure that you have good early childhood programs. And so part of what we're exploring if you want families to be lifted it up and out, one, they have to work and, two, they have to have good childcare. And number three, they have to have good mental health as well as primary care. And I think those are the areas that we're trying to address within the department. Today, Senator Cavanaugh, you're going to hear a lot from my team about why these CCBHCs are so important and why they're so connected to the work that we're trying to do in, in the department, which has to do with addressing as best we can those social determinants of health, but also ensuring that we're providing good behavioral health across the state from a perspective of being very preventative and making those services community based as much as we, we can whenever necessary. We have to use interventions. Certainly, we have PR-- our PRTFs, as well as our state hospitals, but our goal as much as we can is at the time that we see an individual, a family having a crisis, we want to address it as soon as possible. And one of the reasons why I'd like to see the CCBHCs is because it can be on demand at the time that the person is in crisis.

M. CAVANAUGH: I appreciate that. Thank you.

HANSEN: Keep going.

M. CAVANAUGH: OK. So we have several bills that address the poverty issue and I'm just curious if-- is there a greater vision for-- like, we have one bill that because we increased the eligibility for SNAP but it had a sunset on it, so this would extend the sunset. Are these things that the department feels are important to continue to invest resources in to address these issues? I ask because I, I think that behavioral health is enormously important, but I'm concerned that if we aren't actively addressing and combating poverty that it doesn't matter how much money we put into behavioral health, it's a black hole if we aren't lifting people up in poverty, kind of as the underlying issue.

DANNETTE R. SMITH: So thank you, Senator Cavanaugh, for that question. I don't have the bill in front of me and so I--

M. CAVANAUGH: That's OK.

DANNETTE R. SMITH: --don't want to address that--

M. CAVANAUGH: That's-- I under--

DANNETTE R. SMITH: -bill that I can't see.

M. CAVANAUGH: I appreciate that.

DANNETTE R. SMITH: But again, I respect that you acknowledge that there has to be a great balance between the economy of how families live here in Nebraska as well as their mental health. As always, the department is always committed to looking at how we can eradicate poverty. Of course, never been done, but I think what we want to do is to make sure that families have the opportunity to be self-sufficient, however they determine that looks like and to move out of poverty, whatever that looks like to them.

M. CAVANAUGH: And my final question, and I swear it wasn't planted by your staff member. Interim director, is that going to become permanent director or is there an ongoing search for the director of behavioral health?

DANNETTE R. SMITH: There currently is an ongoing search for the behavioral health director.

M. CAVANAUGH: OK. Thank you. That's very helpful.

HANSEN: OK. Any other questions from the committee? Looks like there isn't none. I might have one, but I think maybe Director Bagley might answer it. Can you expound a little bit on the fiscal note past the year 2025?

DANNETTE R. SMITH: You really want Director Bagley to expound on that. [LAUGHTER]

HANSEN: That's what I thought. OK. All right. OK. All right. Any other questions from committee? Seeing none, thank you for your testimony.

DANNETTE R. SMITH: Thank you.

HANSEN: All right. We'll take the next invited testifier in support. Welcome.

TONY GREEN: Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Tony Green. And I am the interim director for the Division of Behavioral Health within the Department of Health and Human Services, here to testify in support of LB276, which adopts the Certified Behavioral Health Clinic Act [SIC]. LB276 outlines provisions to implement a new provider type CCBHCs.

These clinics are designed to enhance access to comprehensive behavioral healthcare. This includes 24/7 access to crisis services, increase in care coordination to help individuals navigate the behavioral and physical healthcare systems, and the necessary social services to ensure individuals are on the right path to recovery. The enaction of LB276 is poised to make meaningful impacts on the estimated one in five Nebraskans with a mental illness and in the 88 counties considered mental health shortage areas. Across the country, over 450 clinics are operating as CCBHCs. In states such as Oklahoma and Missouri, the implementation of this program has seen substantial reductions in law enforcement involvement, hospital emergency department usage, and admissions to inpatient care. Nationwide, organizations participating in the program have showed increase in hiring and retention, including the addition of more peer support specialists, counselors, social workers, and psychiatrists. While the current language primarily impacts the Medicaid payment system, we in the Division of Behavioral Health will be working in close partnership with the Division of Medicaid and Long-Term Care to achieve parity in care for the non-Medicaid covered or low-income individuals in the state. We will further support their efforts during implementation by providing technical assistance and strategic direction to increase service equality and workflow in organizations that choose to adopt this program and serve DBH clients. In summary, the CCBHCs will be a vital component in the modernization efforts of Nebraska's behavioral health system and will bring more services to thousands of Nebraskans who suffer from severe mental illness and substance use issues. It aligns with the Division's goals of increasing client access to behavioral health services, reducing hospitalizations, and increasing value and innovation. We respectfully request the committee advance this legislation. I thank you for the opportunity to testify today and I'd be happy to answer any questions.

HANSEN: Thank you for that. Are there any questions from the committee? Yes, Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here, Director Green. And again, Director Green did not ask me to ask that question, that was purely a Senator Machaela Cavanaugh question. Under this program or even existing programs, can you walk us through when somebody is in a behavioral mental health crisis, are they-- is there some sort of navigator that helps them get those additional resources that I've been talking about that will help address some of the underlying societal issues that are facing these individuals?

TONY GREEN: With the implementation of this model?

M. CAVANAUGH: Yes.

TONY GREEN: Yeah, so--

M. CAVANAUGH: Or, or what is already going on?

TONY GREEN: Yeah, so this model really-- the exciting piece about it is, is the way that it is funded, which, again, Director Bagley can speak to, but it really will allow the flexibility within these CCBHCs to provide all of the service. While there is a core set of services that the, the department and SAMHSA would recommend these must be in the CCBHCs. The state will have some flexibility. I think the, the main component that you're going to really see a lot of benefit in my mind is really that case management aspect between all the various services that folks would be serving, whether on their physical or their behavioral health side. So I think that will be one of the key components to getting people connected and to some of those other resources that you're talking about, Senator Cavanaugh, that are kind of outside the treatment realm but are necessary to have successful treatment. So I think this model will look at that through case management and other ancillary supports.

M. CAVANAUGH: One additional question.

HANSEN: Yep.

M. CAVANAUGH: Case management, one of the issues that we've had in other areas of the Department Health and Human Services is recruiting a workforce around various [INAUDIBLE] of case management and some of that has been-- well, a workforce shortage across the state, but also the pay that we offer. And I'm not familiar enough with this bill, but is that going to be an ongoing concern if we enact this? Are we taking into consideration how are we going to recruit and retain case managers and is the pay going to be adequate?

TONY GREEN: What I can say is that-- I mean, other states that have implemented it have actually seen success in that area with this model because it is based more on a cost reimbursement system. That allows the providers to, to address some of those wage issues and recruitment and retention issues.

M. CAVANAUGH: OK. Thank you.

HANSEN: Yes, Senator Riepe.

RIEPE: Thank you, Chairman Hansen. Thank you for being here, Mr. Green.

TONY GREEN: You're welcome.

RIEPE: My question is this: What is your relationship with the six regional mental health centers? I'm trying to connect organizational structure and kind of who's first among equals, if you will, or who's in charge or--

TONY GREEN: Between the regional behavioral health authorities or--

RIEPE: We have six regions in the state.

TONY GREEN: Correct.

RIEPE: Yeah.

TONY GREEN: The six region behavioral health authorities.

RIEPE: Yes.

TONY GREEN: Right. So my relationship with them is, is, is really a collaborator. So we are the entity, the, the Division of Behavioral Health that provides much of the funding to those regions and oversees the administration of the block grants that are funding our mental health and substance use services.

RIEPE: OK, who has the goal and makes the rules and puts you in the catbird position, quite frankly?

TONY GREEN: I would say that starts at the federal government, yes, with, with many of the block grants and then we--

RIEPE: Oh, the big bird, huh?

TONY GREEN: Yes, we'll go to the big bird.

RIEPE: OK, that's all. Thank you. Thank you, Mr. Chairman.

HANSEN: Any other questions from the committee? Seeing none, thank you. We'll take our next invited testimony in support.

KEVIN BAGLEY: Good afternoon, Chairman Hansen, members of the Health and Human Services Committee. My name is Dr. Kevin Bagley, K-e-v-i-n B-a-g-l-e-y. I'm the director of the Division of Medicaid and Long-Term Care within the Department of Health and Human Services. It is my profound pleasure today to testify in support of LB276, which will add Medicaid coverage for the certified community behavioral health clinics. I also want to thank the previous testifiers as well for their comments and Senator Wishart and the stakeholders in the community who have been thoughtful in, in their collaboration with the department and, and their willingness to sit down and talk through this, this model and this legislation. We appreciate that. CCBHCs provide integrated mental health, physical health, and substance use treatment services to adults and youth. The delivery model has been piloted here in Nebraska already through federal grants. CCBHCs have shown they can improve access to behavioral health services for the entire community, including underserved, uninsured, military service members and veterans, and, of course, our Medicaid members. CCBHCs have criteria establishing the types of services they'll provide and define measurable outcomes. These include active outreach between the clinic and the individual, 24/7 access to crisis mental health services, coordinated treatment planning across all providers, including physical and behavioral health and standards for timely and meaningful access to services. The service delivery model also comes with a core set of quality and outcome measures that allow us to track and assess the impact on the community. We look forward to future reporting that will infuse additional transparency and accountability into the services we provide. In addition, establishing CCBHCs will allow for new jobs in the community and more opportunities for growth in rural communities across the state. Senator Ballard, to the question that you asked earlier, the cost-based reimbursement gives providers the flexibility to manage their operations, including hiring and salaries, outside the constraints of a fee for service traditional payment system, which gives them the flexibility to, to make decisions based on where the market is at the time, rather than having to come back before this committee and talk about rates. There will be a tremendous amount of work to prepare for the implementation by 2026, including significant work across DHHS to establish new service definitions and cost reporting structures, as well as seeking appropriate authority from our federal partners. The cost of this pre-implementation work is expected to be covered through ARPA funding explicitly allocated for improving community-based services. We expect the ongoing service costs to be roughly $12.7 million a year upon implementation with approximately $8 million coming from federal funds

and about $4.8 million from state funds. I've spent considerable time traveling across this great state learning about the experiences of our Medicaid members, providers, and other stakeholders. One of the consistent messages I've heard from all of those individuals was the need for better access to behavioral health and more thoughtful and effective integration of physical and behavioral health services. This legislation would allow us to start delivering on those needs. Thank you for the opportunity to testify today. I'm happy to answer any questions, including about the fiscal note.

HANSEN: OK. Well, we'll check and see, anybody have any questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman. Mr. Bagley or Dr. Bagley, thank you for being here. I would make-- first make a comment, and that is I'm always concerned when an organization is on a cost-plus basis that it's difficult to manage. You know, how much is enough? As Miss Piggy said, too much is never enough, and so I have a real concern with that. Also, I have a question about the ARPA funds to start to be seed money, but then this is not a one and done kind of a one year and done kind of a program. So I have concern with the long-term commitment and growth. And my third concern would be is at some point in time it seems to me that the three managed care companies that we have under contract, I don't know what we're getting from them, but all of these seem to be a la carte that we're getting all kinds of other programs that we're paying for, whether that or it's, you know, postnatal care or whatever. And so I don't know what they're getting paid for but we're, we're buying-- we're adding on a lot of money to them. And can you explain it to me, what are they accountable for?

KEVIN BAGLEY: Sure. Let me see if I can address, address that, that multipart question there, Senator. So on, on the question of cost-based reporting or cost-based reimbursement, so this, this would be really similar to how we reimburse our federally qualified health centers today. They're on a cost-based reimbursement. And so what we see is that, that gives them the flexibility to make operational decisions around hiring and all of that without the constraints of here is a fixed price for this particular service. And so things like care coordination that aren't explicitly paid on a procedure code are things that they just have to eat the cost of for federally qualified health centers and for these community-- certified community behavioral health clinics. This cost-based reimbursement model gives them the flexibility to make those hiring decisions. In terms of whether or not that gives an opportunity for costs for, for them to

kind of set their own costs and set their own reimbursement, I think, you know, again, looking at our federally qualified health centers, we haven't seen runaway costs associated with those. And part of that is because the way that we're able to manage that as a state is by doing some annual cost reporting whereby we would look at and define what costs are allowable and reasonable. And so we still have a considerable amount of control, but it also puts the flexibility squarely on the providers to make market-based operations decisions.

RIEPE: I think you also in your testimony said that they would then not have the-- and it's not a quote, let me say that, I'll paraphrase it, they would not have the responsibility to come back, say, to this committee or any other committee. To me, that's a dodge of accountability, you know, as a committee member, I might take exception to that.

KEVIN BAGLEY: So I, I think that's fair and I may have missed categorized that a little bit, but what that would mean from a rate perspective is that it wouldn't put a constraint on individual procedure codes where, you know, I know this committee and, and the Appropriations Committee frequently will have bills that, that talk about rate increase. And the reality is when we talk about Medicaid rates, those are all based on state appropriations. And so Medicaid is in a, in a position generally where we aren't going to change a rate without that appropriation. This would give us the ability to navigate the changing market conditions without having to, without having to have a bill every time a rate needed changing. Now I will say that does not remove the accountability on the part of the department to come before the committee for appropriation discussions, whether it's this committee or the Appropriations Committee, we would still have our budget constraints. And so that would still need to be part of the discussion.

RIEPE: But we still have-- if nursing homes or other people want rate increases, they do come back to share with us the reasons why. And so this sounds like an, an exception to it and I don't understand why it would be an exception.

KEVIN BAGLEY: I'd be happy to talk more about that.

RIEPE: Well, you can buy me lunch someday.

KEVIN BAGLEY: That sounds great.

RIEPE: OK.

KEVIN BAGLEY: The, the lunch here is excellent so I'll, I'll meet you in the cafeteria.

RIEPE: Or the, or the vending machines.

KEVIN BAGLEY: Or the vending machines.

RIEPE: OK, that'd be good.

KEVIN BAGLEY: So-- and the second part of your question, Senator, was around kind of how this fits in with our managed care organizations. So similar to how we navigate this with our federally qualified health centers, these CCBHCs would be part of the provider base we would anticipate and expect that our managed care organizations would collaborate with. And so they would work under that same service delivery model with our managed care plans. That would be part of our managed care plans' requirement that they navigate and collaborate with these CCBHCs. What we find is it's, it's difficult to do a lot of care coordination on the part of our managed care plan because so much of that care coordination needs to happen at a local community level. And so what they really find is that they need to be in the community and having providers that are already doing that work who are trusted by the patients who come to, to seek services and treatment from them is really the most effective way to do that. And so this gives an opportunity to kind of establish that relationship right out of the box.

RIEPE: In some ways, it sounds like a parallel organization to it. My-- I'm not real sympathetic, they're getting paid. They're getting paid well, handsomely would be my word for, for that accountability to manage that process.

KEVIN BAGLEY: And, and from those payments, they would need to make these payments so the, the--

RIEPE: OK, so it'd be a tumble down from--

KEVIN BAGLEY: It would. Yep. Yeah. This is not the department paying CCBHCs directly in addition to our managed care plans, our managed care plans would be paying them for anyone that, that falls under their, under their care.

RIEPE: OK, I've taken up enough time. Thank you. Thank you, Mr. Chair.

KEVIN BAGLEY: Thank you, Senator.

HANSEN: Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here. Full disclosure, I took some cough medicine before this committee hearing started, and I'm pretty sure we've quoted Thomas Edison and Miss Piggy today.

RIEPE: Who's more important?

M. CAVANAUGH: I would say Kermit, for sure.

RIEPE: That's right. Kermie.

M. CAVANAUGH: Kermie. The cash fund, which, which cash fund is being utilized?

KEVIN BAGLEY: That's a great question, Senator. So under ARPA, there was a provision that allowed the state to draw down enhanced federal match, 10 percent additional federal match for home and community-based services, which was written pretty broad, which also included community-based behavioral health services. And so as part of the roughly $90 million in General Fund that would have come back to the state for those, a portion of that we anticipate being able to use for the implementation activities. So I guess, Senator Riepe, also to your question earlier, those implementation activities are a one-time set of work to put together the templates for cost reports and the rules and requirements and policies. Once those are established, the maintenance of those is pretty straightforward and so that one-time cost would be covered through those cash funds without having to reappropriate any additional money.

M. CAVANAUGH: So, sorry, I think that makes sense, but I'm also confused because we have federal funds on the fiscal note and then we have cash funds which are generally state funds of some sort.

KEVIN BAGLEY: Yes, so--

M. CAVANAUGH: And you can't-- and you're supposed to use a percentage of state funds for administrative so can you walk me through that a little more?

KEVIN BAGLEY: I certainly can.

M. CAVANAUGH: Thank you.

KEVIN BAGLEY: So it definitely makes it look like we would be using federal funds to draw down federal funds. That is not what's happening. What happened is that enhanced federal match allowed us to bank essentially state General Fund.

M. CAVANAUGH: I'm catching up now.

KEVIN BAGLEY: Yeah.

M. CAVANAUGH: I gotcha.

KEVIN BAGLEY: And, and so those state General Funds can now be used with appropriate kind of authority and authorization from our federal partners toward enhancing community-based care. We currently have a request pending with them to do additional work and analysis on improving that. This would be something that would fall squarely under that request.

M. CAVANAUGH: So that enhanced FMAP that we have that alleviated some of the General Fund's budget, was that money from the last biennium or does that need to be-- can you walk me through that a little bit?

KEVIN BAGLEY: Yeah, so that, that money went into a cash fund that--

M. CAVANAUGH: Did we do that last year?

KEVIN BAGLEY: I believe so, Senator. I, I will have to defer to smarter budget minds than myself on that one.

M. CAVANAUGH: OK.

KEVIN BAGLEY: But yes, that, that is currently a cash fund. It is being used in a number of different areas and projects of the roughly $90 million that became available through that ARPA provision. This would be less than $1 million worth of, I believe, it's $400,000 in, in state General Fund coming out of that. Well, so not General Fund, I'm sorry, but cash coming out of that cash fund.

M. CAVANAUGH: Thank you. One more question. It's not directly for you, it's more for the department.

KEVIN BAGLEY: Sure. I'll see what I can do.

M. CAVANAUGH: Is if the department could follow up with the committee with how those $90 million are being allocated currently?

KEVIN BAGLEY: Absolutely. That's something that we've, we've kept close tabs on and review very frequently so we'd be happy to share that information.

M. CAVANAUGH: Thank you.

HANSEN: Any other questions from the committee? You got to be careful with the term "cash funds" around here.

KEVIN BAGLEY: I do.

HANSEN: All senators hear that they start drooling for some other purpose.

RIEPE: We're defensive.

HANSEN: Yeah. Yeah. Don't ask Senator Howard, don't touch her healthcare cash fund. So, yeah, I think you explained it already a lot of the future expenditures or what we're going to have to, what we're going to have to use for General Fund, because I'm looking at the fiscal note and it does look like by the year 2027 we'll be using about $4.5 million out of the General Fund.

KEVIN BAGLEY: Yeah.

HANSEN: And so that will automatically-- we have to appropriate that every year or every biennium, right? I'm assuming.

KEVIN BAGLEY: That, that's correct. So I'm anticipating your question, Senator, but I should respectfully let you finish.

HANSEN: No, that's all right. You can continue.

KEVIN BAGLEY: Thank you. So what we believe is that in a future budget, we'll be able to allocate the existing funding in a way that wouldn't require new money to be appropriated.

HANSEN: OK.

KEVIN BAGLEY: So we, we want to acknowledge that this does come with a cost, but we believe that cost can be covered through existing appropriation--

HANSEN: OK.

KEVIN BAGLEY: --in the future.

HANSEN: And I'm pretty sure we do this in other aspects of behavioral health, but are there other instances where we use the taxpayer money to pay for healthcare for non-Medicaid eligible people?

KEVIN BAGLEY: Yes. And so behavioral health is one of those areas. And so the, the fiscal note in, in kind of the notes there does lay out one portion that would be for Medicaid. That's the bulk of the services. We believe the bulk of the costs for the state would be for the Medicaid population. For the non-Medicaid population that is traditionally funded by the diversion of behavioral health, there is some funding there. And so that's where you'll see not quite, but about half of the, of the state General Fund cost comes and then a portion of the division of behavioral health funding would also come from federal funds through SAMHSA, I believe.

HANSEN: Yeah, in the, in the, in the fiscal note we're allocating to public health, is that's more for the set up and--

KEVIN BAGLEY: Yeah.

HANSEN: --of the program, right?

KEVIN BAGLEY: So part of what public health would be tasked with is ensuring that these clinics meet the certification criteria.

HANSEN: OK. And one more quick question.

KEVIN BAGLEY: Please.

HANSEN: You said this has been implemented-- this type of program has been implemented in other states. Have they been doing it for a long time?

KEVIN BAGLEY: So I'll, I'll answer that with specific dates and, and note that long time is always relative. So in about 2017 is when these clinics first really started operating across the country. There was legislation in 2014, I believe, that, that created the pilot program and then by 2017, we were seeing these operating throughout the country. So there's been about five years of experience, for example, in Missouri, which is a long time in, in terms of these type of programs. But it's also a relatively short time. We've seen in that five years a lot of success in the reporting and the data that's come out of states and we believe it would be a successful thing here as well.

HANSEN: OK. So you anticipate the federal funds that are being given to the states to continue, like at their current rate, you don't expect them to-- I, I say that because I know the federal government is-- doesn't have, you know, we're a little bit in debt.

KEVIN BAGLEY: Yes.

HANSEN: And so there are certain things already going to be on the chopping block, I would think, for future legislators to determine when it comes to helping, hopefully the federal government balance its budget. And this might be one of them I, I would think since, you know, they're not going to probably touch Social Security and, and Medicare. So you expect this to have its current allocation to the states and then so long as we're not going to take over more and more, next thing you know we're paying $10 million a year for this.

KEVIN BAGLEY: Yeah, I'm not aware of any current pending legislation that would change any of the, the federal funds participation rates associated with this. A big portion of those federal funds comes through the Medicaid expansion 90/10 match that we get. And so if that were to change and, and for that to change, it would take an act of Congress. And so in that event, I think we would be having a much larger discussion here with, with this committee and with the Appropriations Committee about the impact that would have on the state.

HANSEN: OK. Thank you for that. Are there any other questions from the committee? All right. Seeing none, thank you for your testimony.

KEVIN BAGLEY: Thank you.

HANSEN: All right. So I believe that's the invited testimony. So what we'll do now, we'll take our first testifier in support of LB276. Welcome.

ANNETTE DUBAS: Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Annette Dubas, A-n-n-e-t-t-e D-u-b-a-s, and I am the executive director for the Nebraska Association of Behavioral Health Organizations, otherwise known as NABHO. We represent 53 organizations statewide that include community behavioral health providers, hospitals, regional behavioral health authorities, and consumers. And we work to raise awareness and build alliances that support behavioral healthcare for everyone across our state. We want to sincerely thank Senator Wishart for her support

and leadership on this collaborative approach to providing behavioral healthcare and to say that we are over the moon excited about the support from the administration is probably an understatement. We are very, very pleased to have their support and we've been working closely with them to get to this point. So we're very happy for that. I'm not going to-- you have a copy of my written testimony and a lot of that has already been touched on, so I'm not going to go through that. I'll hit some of the high points. Included in your packet is the most recent 2022 Impact Report from the National Council that has information about all the CCBHC clinics across the country. There's also a brief summary from our current Nebraska CCBHCs, and then there's a graphic with information from Missouri's-- the impact from Missouri over the last five years. So I'll let you have some nice bedtime reading, but some of the things that I want to touch base on is the fact that we have five CCBHCs in the state of Nebraska right now, those are all funded through SAMHSA grants. So they're expansion grants, those were two-year grants which were renewable. So of the five that we have, we have three who finished their, their first-- or we have two who have finished their first two and received an expansion. We have one who's in the middle of their first expansion grant, if I'm remembering this all correctly, and then we have two clinics who were just recently awarded SAMHSA grants, and they're going to follow me and they're going to be able to give you a lot more information about what's going on in their particular clinics. But some of the points it was mentioned about the program areas and the required criteria, some of the points that I really want you to, to understand is, you know, there was a talk about workforce and staffing and a part of setting up a CCBHC is doing a local needs assessment. So you really are looking where the clinics are located. They're doing a lot of work in what is it that we need in our area and determining what those staffing needs are and then that care coordination. So they're working with, you know, physical health providers, they're working with the schools, they're working with, you know, all across the, the community in making sure that they're meeting the needs of, of those individuals. And I think one of the key components is the reporting. There is truly an accountability in the CCBHCs that we don't have in other areas of, of our behavioral health delivery system. So, you know, coming back year after year to ask for money through this, we're going to be able to show you these are the things that are working. These are the changes, maybe, that need to be made. There, there truly is a real accountability factor here that we're, we're excited about that's going to help improve our delivery system. So that's a requirement, this, this reporting and data tracking. And

then also a part of these clinics is they're required, you know, to provide those nine particular types of core services. But if they can't provide all of those core services, they have the ability to partner with other providers in their communities. So not every clinic is set up or maybe even wants to be a CCBHC, but there's opportunities for collaboration again with other providers in the community. So it, it truly is a community-based and we've talked about that for many, many years about a community-based approach. So as I said, there's, there's data in your, your packet about what's been happening nationally. But currently there are three ways to become a CCBHC so we have ten demonstration states that are in place right now that started originally. Then we have the expansion grants, of which we have five of the clinics, and then you have the demonstration option through the state plan amendment. And that's what we're hoping to, to achieve through this legislation to get a state plan amendment and really open up the ability for these clinics that are currently operating to take advantage of the PPS and, and really become full-fledged certified clinics. So as I said, I've got the clinics coming behind me who really will be able to give you the nuts and bolts of what's going on, but I will attempt to answer any questions if you have any.

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

BALLARD: Thank you, Mr. Chairman. Thank you for being here, Senator. Can you talk about one of your points on how LB276 will fill gaps in service, especially for underserved areas and look at-- especially looking at rural communities as well?

ANNETTE DUBAS: As I said, not every clinic will be, you know, able or, or, or fit the CCBHC model, but those clinics that are doing that community assessment really, you know, diving into, you know, what are the needs in the community, looking at those nine core services that are required, that's, that's where we see a lot of the gaps. Not all of those services are, are available.

BALLARD: OK.

ANNETTE DUBAS: So-- and that coordinated approach is, is what we see, and that's through the state plan amendment the state is able to set up, but how they see these clinics working, that certification requirement, etcetera.

BALLARD: OK. And then can you talk a little bit about expand-- expanding in rural, rural areas as well?

ANNETTE DUBAS: In rural areas?

BALLARD: Yes.

ANNETTE DUBAS: And we actually have one of the most recent CCBHC grant award winner is in the rural area so he's going to be able to tell you exactly--

BALLARD: Perfect.

ANNETTE DUBAS: --I mean, they're just getting, they're just getting started, but he's going to be able to share with you what they're seeing so far in their ability to meet the needs of those out in the rural areas.

BALLARD: Thank you so much.

ANNETTE DUBAS: You bet.

HANSEN: All right. Any other questions? I have one question.

ANNETTE DUBAS: Sure.

HANSEN: I don't know if you'll be able to answer it, but of course it's a department question after everybody just left.

ANNETTE DUBAS: Always.

HANSEN: In Section 5, line 27, "The department shall submit to the federal Centers for Medicaid and Medicare Services any approval request necessary for a medicaid state plan amendment to implement this section." Do you know if the department has sent in a approval request at all?

ANNETTE DUBAS: Not that I know. I mean, nothing-- I don't think anything can happen until this legislation is passed to begin the state plan amendment process.

HANSEN: That makes sense. OK.

ANNETTE DUBAS: Yeah.

HANSEN: I just didn't know if they've kind of implemented that yet or started it, so.

ANNETTE DUBAS: Yep.

HANSEN: OK. All right. Thank you. All right. Thank you for your testimony. We'll take the next testifier in support of LB276. On a side note, how many people are here testifying on this bill? If they can raise their hands, please. OK. Thank you. I just wanted to make sure there wasn't 30 people here, so. All right. Welcome.

CAROLE BOYE: Hi. Good afternoon, Senator Hansen and members of committee. My name is Carol Boye, C-a-r-o-l-e B-o-y-e. I am the CEO of Community Alliance in Omaha, Nebraska, and I'm testifying today in support of LB276. For those of you who aren't familiar with Community Alliance, we are a nonprofit mental health agency that serves the Region 6 area, which is Douglas, Dodge, Sarpy, Washington, and Cass Counties. We serve a predominantly adult population at this time, virtually all of them have a serious mental illness that includes people with incomes below the federal poverty level, individuals with schizophrenia and bipolar disorder, or people who have experienced homelessness, chronic health conditions, co-occurring substance use disorders. We began working our work towards CCBHC certification in August of '21 with the help of a federal grant. It's demanding. It's, it's a heavy lift, it encompasses significant clinical, operational, and financial resources. But our experience and, as you've heard, experience of states and colleague organizations across the country has led us all to the same conclusion, it's the right time and it's the right approach for those who rely on our behavioral health system and for our system as a, as a whole. So many things have already been touched upon, and I'm not real good at, at deviating here, but, but I'm going to try to do that in regard to some of the questions that, that have come up here. Why is it the right time? We've all heard the statistics: mental health, anxiety, depression, suicide, substance use, all of that is up. We're really getting to a point that we have to, we have to do something differently. But I think it's really important to understand that, that our system-- to kind of, Senator Riepe, going to some of your comments, our system right now is really fragmented and it's really complex. And you're right, there's 100 different services. You know, today we need to do this, tomorrow we need to do that and, and people keep coming up with ways that we can, we can handle that. I think it's really important to understand that CCBHC is not a new program. It's a framework by which you organize all of these different services differently and you work to coordinate

them based upon what this person needs, rather than slicing and dicing it based upon a level of service. That is probably the most promising and exciting thing about CCBHC. It gives us the opportunity to say what does John need today and let's get John that service. And if he needs something different tomorrow, let's get him something different tomorrow. Not a new service, but plugging them in, in, in a much more flexible and person-centered way. So I think, I think that's a really important piece of things. I think it's important to Senator Cavanaugh's concerns about, about social determinants of health. We have, again, so many programs, what CCBHC does is give you the opportunity and actually the mandate to coordinate all those services. I have some statistics in my testimony here that in six months, the data that we were able to collect in six months is that we reduced hospitalization days by 242 days over a six-month period of time over a relatively small group that we've served as we started out our journey on CCBHC and we reduced jail by 54 days among this small population. If I do some simple math, $1,000 a day for hospital, $100 a day for jail, which are really pretty conservative numbers, I very quickly get to in six months of, of [INAUDIBLE] like Community Alliance can point to nearly $250,000 in cost savings to the system. I think one of the, one of the clear benefits of adopting CCBHC on a statewide level is that we'll have the ability to standardize data collection and determine what has an impact, what does that have an impact, and quantify the costs and the cost savings across multiple systems. So that's another reason we are such a proponent of this. We have heard concerns about will it, will it grow, will it grow the budget? It will-- if you look at those cost savings and we can point to those cost savings, less jail, less emergency room, less chronic health disease, and all of that. We can, we can point to where those, those costs are going to get offset. Again, we, we have data already that supports it. States across the country have data that supports it. We've heard concerns that the adoption of this model could force smaller providers out. You'll hear from all of our colleagues, this is a collaboration, a partnership model. Nobody's going to force anyone out. We know we have capacity issues. It's a, it's a model where we have to work together better. We have to coordinate our services. I don't want to start a residential program for, you know, for this group of people. I want to work with people who know how to set up a residential substance use program or program for pregnant, pregnant mothers and just make sure that we're coordinating that care and they're not falling through the cracks. We've heard concerns about somehow we'll have CCBHCs all over Nebraska, they'll proliferate because, because we've, we've seen that in some areas with FQHCs, at

least a concern about that. I think the thing to emphasize in that realm is that we will have to go through a state system. The state will control who gets certified as a CCBHC. FQHCs, the feds decide who gets certified and, and where they can expand. So I think there's some controls on there.

HANSEN: Ms. Boye, your red light just came on so, your red light just came on so need you to wrap up real quick.

CAROLE BOYE: Red light is on, so I'm going to do, all I'm going to do is just close with I have been in this business for 40 years. I'm not sure that I have ever enjoyed sitting with government, with private sector, with legislatures, or with my colleagues and everyone saying, yeah, this is the right thing to do. The thought that has gone into this, I just want to, to publicly thank Medicaid and DHHS and, of course, the Governor for this because it's, it's a, it's a pleasure to be working, working and looking forward rather than just trying to keep treading water. So thank you.

HANSEN: Thank you. Are there any questions from the committee? Yes, Senator Riepe.

RIEPE: Thank you, Senator. Thank you for being here. Good to see you again. Is it fair to say-- you, you said this was the framework, is that fair to say it's like an air traffic controller kind of trying to--

CAROLE BOYE: There's a good portion of that, yes.

RIEPE: Is there a, a willingness on the other side, everyone likes coordination, but no one likes to be coordinated, so--

CAROLE BOYE: That's right.

RIEPE: --are there willing souls that are willing to be coordinated--

CAROLE BOYE: Absolutely.

RIEPE: --in your opinion?

CAROLE BOYE: Yeah. Yeah. You know, we as providers, we're, we're really not competitive. There is so much need out there, we know we have to work together and, and figure, and figure this out. And this again, just gives us a framework to do that a little bit more strategically and methodically.

RIEPE: OK. Another question that I had is this, from a cost savings, it's, it's difficult to measure--

CAROLE BOYE: Yeah.

RIEPE: --cost savings and so-- but we, you know, as an organization with fiscal responsibility we're always looking and saying how do we justify doing what we've done or will do or have done, you know, how do we justify that? How do we measure that, if you will, of paper, which sometimes it might be described as, you know? How do you measure improvements in health over a long term when we're not, you know, I'm having that--

CAROLE BOYE: Yeah.

RIEPE: I'm trying to figure out how do we get accountability?

CAROLE BOYE: At the risk of sounding a little bit argumentative, we don't do a very good job of measuring that now, so--

RIEPE: Yeah.

CAROLE BOYE: --anything would be an improvement from, from my perspective. But there are some things that we can measure. We, again, with our small population today, we can show improvement in controlling diabetes. There's a, there's an amazing correlation between taking mental health medications and the increase of diabetes. So that's an area that we're really concentrating on. And we can show medical improvement among the, the folks that we have, which then talking about managed care companies over time, what we want to do is we want to have them compare kind of before and after. What was your spend on diabetes control before or after we started working? And again, I'm going to go back to CCBHC model, I think has 30-some measures that we are prescribed to maintain and that would be statewide on all of that. So for the first time, we have real data and comparable data that we could try to, try to see if we can make a difference on that. Another thing in terms of, of physical health, we know people with mental illness die 20, 25 years younger than people without mental illness. We can start, start impacting even that mortality rate, we can show some definite, definite improvements. Law enforcement, homelessness, there's so many of-- there's such a high percentage in that. Again, if we can just start mitigating some of, some of that adverse impact with a more proactive and coordinated system, I think we are going to be able to measure it and come back to

you all and say, yeah, this was, this was worth it because we're seeing some of our other states starting to measure that pretty successfully.

RIEPE: May I ask one more question, Mr. Chairman? Is that your new facility on 72nd Street?

CAROLE BOYE: Yes.

RIEPE: That's a very big facility and like [INAUDIBLE], it was all built with private money.

CAROLE BOYE: Yes. It's all built with-- and, you know, when, when I'm sitting here saying I've never seen everything align so well between government and providers, I'm going to have to say something about the private sector, too, that they're all in on this and very supportive of this model, too. From, from a business perspective and the private sector perspective of the people that we have talked to, the people who are supporting us in a capital campaign, see this is critical to sustainability of, of what they are-- what they're helping to bring to bear.

RIEPE: OK. Thank you, sir. Thank you for coming.

HANSEN: Any other questions, any other questions from committee?

CAROLE BOYE: Thank you.

HANSEN: There's only been so many bills where you actually get to hold hands and sing kumbaya, so this might be one of them.

CAROLE BOYE: I know. I, I, I feel like I'm in some alternate universe right now.

HANSEN: It doesn't happen too often in politics.

CAROLE BOYE: Either that or we all go play the lottery or something.

HANSEN: Yeah.

CAROLE BOYE: Thank you so much.

HANSEN: Thank you for coming. Are there any other questions or-- testifiers in support? Welcome.

CHRIS TONNIGES: Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Chris Tonniges, C-h-r-i-s T-o-n-n-i-g-e-s, appearing before you today as president and CEO of Lutheran Family Services in support of LB276, an expansion of CCB--CCBHC as a statewide initiative. Lutheran Family Services is grateful for the Legislature's commitment to the overall mental health of the people of the great state of Nebraska in continuing to explore CCBHC. As you know, people with untreated and unmanaged mental illness often end up consuming a lot of the state's expenses in intensive services. Many utilize the emergency room or call to emergency services on a regular and consistent basis for their mental health needs. Many people become addicted to drugs or alcohol and even become homeless. We think that CCBHC is a way to combat this taxpayer expense by providing and even requiring care and service coordination and an outcome-driven approach to care. Lutheran Family Services currently serves clients out of our Health 360 campus in Lincoln through its CCBHC SAMHSA grant with a planning, development, implementation grant awarded for Fremont and greater Dodge County starting late last year. As part of our grant, we had three primary goals: one, improve the quality of treatment to improve the physical and behavioral health outcomes of people served; two, increase access to integrated CCBHC services for people in Lincoln, Lancaster County, and Fremont, Dodge County; and, three, expand CCBHC services to serve unmet needs in the service areas with all three goals targeting populations of focus. We continue to see success in all three goal areas having served over 4,000 clients with a 25 de-- 25 percent decrease in negative affect, which includes feelings of depression, homelessness-- hopelessness; a 20 percent increased satisfaction with self; a 10 percent functioning increase and a 10 percent increase in social connectedness. All key contributors to a healthy population. Attached to my testimony, you'll see a copy of our summary report, which is this smaller document, and a lot has been talked about the reporting requirements for CCBHC. I won't filibuster the, the committee with our longer page report, which is basically the annual summary in which we have to have an outside, outside entity do review and ours is done by UNL. CCBHC is a partnership model to better serve the whole client. LFS formed and formalized or redefined 19 different agency partnerships within Lincoln, Lancaster County alone to better serve the clients. The team is hard at work in formalizing these partnerships within Fremont, Dodge County, and having great success. According to our report, almost 77 percent of those served self-identified as having experienced trauma or violence. Not only has the team had immense success in providing better than anticipated outcomes to those served,

but those are-- but there are system savings all throughout CCBHC in large chunks through decreased utilization of emergency rooms and little pockets like reduction in mental and behavioral health visits for those covered by Medicaid because they feel more equipped to deal with daily life. This model of care has allowed us to provide open access which is our solution to the, the lack of timely access to mental health services. Open access allows people to be seen hopefully within the same day they seek treatment. This increased access provides for increased engagement with more opportunities for those that meet-- that need it. LFS recommends the Health and Human Services Committee advance LB276 that moves the state in the direction of implementing CCBHC and provides for a system of care that is both comprehensive but also data driven to focus on long-term client outcomes. Thank you.

HANSEN: Thank you. Are there any questions from the committee? I have one question.

CHRIS TONNIGES: Yeah.

HANSEN: Does your organization when somebody comes in for, for help or for services, do you help them ever look for work?

CHRIS TONNIGES: We do, yeah. So that's part of the care coordination component and Senator Cavanaugh was talking about the social determinants of health.

HANSEN: Yeah.

CHRIS TONNIGES: Part of this is, is looking at all of the social determinants of health and really figuring out from the client's perspective what is at the root cause of either their poverty or of the mental health particular crisis that they're in.

HANSEN: Yeah, I noticed that. Like, I was looking at what the, the university did and some of the demographics of who the people are, you know, come in for help and it looks like only 23 percent are employed full time and only 15 percent are employed, employed part time and the rest are unemployed.

CHRIS TONNIGES: Yeah.

HANSEN: So I'm like-- I just thought it was an unusual statistic for people looking. So I don't know, I was just kind of curious on that front that seems like a trend there, so.

CHRIS TONNIGES: Yeah, and we, we actually really feel this is part of the workforce solution is, you know, many of the individuals dealing with a significant mental health issue are unable to work because of the stability or because of the, the crisis that they're in. Part of CCBHC really is trying to identify where that instability is and whether that's coming from not being able to retain a job or, you know, the mental illness is causing the inability to retain the job is really providing all those wraparound services to solve for that particular individual need.

HANSEN: OK. Thank you.

CHRIS TONNIGES: Yeah.

HANSEN: Seeing no other questions, thank you for your testimony.

CHRIS TONNIGES: Yeah.

HANSEN: Take the next testifier in support, please. Welcome.

BOB SHUEEY: Good afternoon, Chairman Hansen and committee. My name is Bob Shueey, B-o-b S-h-u-e-e-y, and I'm the CEO of South Central Behavioral Services, providing services in the greater Hastings and Kearney areas. Thank you for the opportunity to speak to you today in support of LB276. As a recent recipient of a federal CCBHC planning and implementation grant, we are excited for the opportunities this model provides. The catchment area for our CCBHC implementation will include Adams, Clay, Webster, and Nuckolls Counties. As a relatively small rural provider, South Central Behavioral Services sees real value in the CCBHC model. It supports a full continuum of services to meet the needs of our community. It encourages partnerships, cooperation, and communication among diverse providers and it includes mechanisms to focus on measurable outcomes and, and sustainability of the system of care. We are now approaching the five-month mark of our initial CCBHC grant implementation in our agency and we are extremely excited about the opportunities and enhancements the model is already bringing. While hiring and adequate staffing issues remain, so far we have been able to expand our care coordination activities and provide more intensive care coordination services to some of our most complex cases. For example, we were recently able to have our new RN care coordinator attend a heart appointment with one of our day rehab clients who was diagnosed with severe, persistent mental illness, a chronic heart condition and diabetes. The nature of his condition makes relaying information between his various providers extremely

challenging for him. By being there in person, our nurse was able to provide his doctor with critical information about his medication compliance that would have otherwise gone unreported by the patient and also bring important instructions back from that appointment to share with the rest of our staff. These are the type of commonsense activities that are not well supported by the old model of care where everything is siloed and nobody has time to make sure that important information is shared between providers. This type of comprehensive care coordination is the heart and soul of the CCBHC model. Timely and easy access to care is also a cornerstone of the CCBHC model, and to this end, we are also working to redesign and expand our internal crisis response system so that we can better serve not only the community members who reach out for help through the 988 system, but also to community members who are involved in the legal system and, and those who simply walk in our front door and ask for help. The Adams County Jail is also very excited about the behavioral health support that we are working to provide them with. As a small provider in a small community, it would not make much sense for us to provide all of the required CCBHC services directly, but the CCBHC model is flexible enough that it allows us to partner with other local service providers to fill in the gaps in our service array. This means that we don't have to reinvent the wheel or duplicate a service being provided by a non-CCBHC provider, but also requires us to formalize these relationships in order to ensure that our clients don't face any barriers when they need the services of one of our partners in the community and also mandates that we share information between us that will help us treat the whole patient effectively and efficiently. I ask you to support LB276 so that the benefits of the CCBHC model can become a permanent part of the behavioral health landscape of our great state.

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

TAMI LEWIS-AHRENDT: Thank you. Thank you, Chairperson Hansen, members of the committee. My name is Tami Lewis-Ahrendt, T-a-m-i L-e-w-i-s-A-h-r-e-n-d-t. I'm the executive vice president and chief operating officer for CenterPoint, a Nebraska nonprofit and CCBHC. CenterPoint is celebrating its 50th anniversary of providing mental health, substance use, housing and primary care services this year and is deep into its third year as a CCBHC. You've heard my colleagues talk about so many important and valuable characteristics of the certified community behavioral health clinics, including their

coordinated care, innovative, innovative approaches and incredible outcomes. But perhaps the most critical to the ongoing success and stability of the model is the implementation of the PPS or Prospective Payment System. The PPS is a mechanism that allows Medicaid to pay CCBHC's providers, providers through a daily or monthly rate that is clinic specific and based, based on the expected cost of required services, as well as the expected cost of the included services and care provided. This payment mechanism ensures that CCBHCs have the financial resources to provide the kinds of services needed by their communities and specific to their populations. The Centers for Medicare and Medicaid Services provides technical assistance to states on how to determine the PPS rates. Because the PPS rate is cost inclusive, it also allows for and encourages innovation and individualization in care approaches specific to the clinic and the communities or populations it serves. It allows for contracts and agreements with partners and specialty fields and includes add-on services that aren't otherwise covered through traditional Medicaid rate structure. The PPS supports physicians that do not have a fee for service mechanism through Medicaid and allows agencies like CenterPoint to no longer rely on time limited position specific grants to provide critical care like nursing and street outreach and services that target social determinants of health. The PPS would allow us to negotiate a rate that is inclusive of the coordination efforts and access assurance activities that often do not result in billable revenue. Because the PPS is designed by Nebraska for Nebraskans, it can include not just service delivery requirements, but encourages efficiencies and can include quality metrics, state defined. Preferred payment systems often support a scope of service customized by the communities that CCBHCs serve and allow organizations to right size their programs and workforces to meet the needs of the people seeking care. The CCBHC PPS-- have I said enough letters today or can I-- I can go on--

HANSEN: We're used to them in HHS. There's many acronyms.

TAMI LEWIS-AHRENDT: --right-- is not a blank check. The state reviews the allowable costs proposed by clinics with the ability to benchmark clinics with each other to ensure value and efficiency. Because CCBHCs are inclusive providers of service, one-stop shops, if you will, the PPS allows services to be delivered in the same day, where fee for service programs prohibit or create barriers to same day services. It allows for services to be provided outside the clinic when that is what's best for the individuals. The PPS allows organizations to design family center services, which are not reimbursable under the

current Medicaid structure and to incorporate case coordination efforts with community partners, including school counselors, state caseworkers, probation officers, and other external providers. I've included a fact sheet from the National Council for Mental Wellbeing that offers a little deeper insight into what some states have included in their PPS and how it can be designed to meet the needs of Nebraskans. Thank you for your time and consideration of LB276.

HANSEN: All right. TYFYT. Thank you for your testimony. I had to throw it out there.

TAMI LEWIS-AHRENDT: Yeah. Yeah, I appreciate it.

HANSEN: Are there any questions from the committee? Seeing none, thank you for coming. Appreciate it.

TAMI LEWIS-AHRENDT: Thank you.

HANSEN: We'll take our next testifier in support, please.

TOM VENZOR: Good afternoon, Chairman Hansen, members of the HHS Committee. Tom Venzor, T-o-m V-e-n-z-o-r, and I'm the executive director of the Nebraska Catholic Conference, speaking here on behalf of Catholic Charities of Omaha, Catholic Social Services of Southern Nebraska, which are the social service agencies for the Archdiocese of Omaha and the Diocese of Lincoln, respectively. Both of those entities have had a long commitment to mental and behavioral health of Nebraskans, in addition to taking care of other material, physical, social, and spiritual needs. And between those two charitable agencies, they have 20 mental, mental and behavioral health experts on hand, such as interns, provisionally licensed professionals, social workers, licensed mental health practitioners and psychologists. And they provide a number of diverse services such as marriage and family therapy, substance use disorder counseling, mental health counseling, outpatient therapy, school mental health services, which include an array of services to students, families-- students, families, and schools in and of itself, as well as they provide community education and programming. As a National Catholic Partnership on Disability's Council on Mental Illness states in its mission: Following Jesus who embraced all, we reach out to accompany our brothers and sisters with mental illness and their families while assisting the Catholic community by providing resources and education for spiritual and pastoral support. And just so-- in, in all of that experience, I just give for context to recognize the work that we've been doing in this

field. And like so many others that you've heard, heard from already, we witness on a daily basis the increased mental and behavioral health issues that are facing Nebraskans. It's certainly occurring, as you've already heard, at a time when there's a shortage of professionals to meet these needs. And so, again, that's where we're at in LB-- I think LB276 would be a great remedy to the problem that we're seeing in our own ministry and the work that we do. So this bill, as you've already heard, would establish the community-based mental and behavioral health centers across the state. We think this will be a great impact, especially in our rural communities, especially as we focus on issues and their impact on those in poverty. We think, again, this is a great opportunity for those who otherwise lack the financial resources to obtain the help that they need in mental and behavioral health services. And as we continue to gain just a deeper understanding of these issues as a state, this is just an important opportunity as we can work toward a healthier Nebraska by adopting this type of legislation. And I kind of just want to add a, a, a few things, too, here, so our entities are not CCBHCs or anything of that nature. I'm not even sure if they would become CCBHCs moving forward. But I do want to just note that we just think on, on the whole, in generally speaking, this would be good for the mental health of Nebraskans, period, whether we would engage in that or not. And I think, as you heard earlier, kind of these comments about, you know, would this squeeze out some of the smaller entities that exist out there and I think is you've heard a lot already, there's a lot of community collaboration in this area. There's a huge need even for entities like us, this-- nobody that works in our area on these issues communicated that this is some sort of threat to the work that they do day in and day out. So again, these are-- all of us are coming together to kind of deal with these concerns. And then as well just in that realm of, you know, where, where we could provide additional help or be a, you know, provide a referral out or, or bring a referral in because we provide services maybe in domestic violence shelters or other areas. You know, again, we're happy to be just part of that larger community that's trying to serve these needs. So we see this as a, a good piece of policy just on the whole and wanted to communicate our support for it, so. Thank you very much for your time and happy to answer any questions.

HANSEN: All right. Thank you for your testimony. Senator Riepe.

RIEPE: Thank you, Chairman Hansen. Tom, I just want your opinion in terms, terms of some of the documentation here. You know, we closed the state regional hospitals with the promise that we were going to

establish community mental health centers. We failed to do that. And so we ended up with the county jails and prisons is where we incarcerated, if you will, or try to take care of the mentally ill. Is this, is this the new forum? Is this the second phase? Is this-- are these community mental health centers because you talked about across the state? I see a head shaking.

TOM VENZOR: Could you rephrase that question? I'm not sure if I totally understood it.

RIEPE: I don't know whether I can or not, but I will try. Are these-- I'm try to go to the-- cut to the chase here. Are the activities that we're doing going to create community mental health centers with cadre of services and, and how to, how to address those? I think community mental health centers, when they first came out, required inpatient, outpatient, partial hospitalization emergency care. I don't know whether-- I'm just trying to figure out is this the new generation--

TOM VENZOR: Yeah.

RIEPE: --of, of a system that attempted but never really got off the ground?

TOM VENZOR: Well, so I think if you go to the text of the legislation, you can see all-- like, you've heard about the core services that are going to be required to be provided by these CCBHCs. I'm learning how to say that word, so. But, yes, I think you've, you've got to, of course, have services that they're going to have to meet and provide just by nature of being one of these entities. And, and, again, those are outpatient services. I don't have-- forgot-- I don't the text of the legislation in front of me, but, yeah, I mean, I think they're going to provide those array of services and then, of course, that ability to be a hub, I think also find out, you know, if there's other needs that are going to be had by the client or the patient that there's going to be other places that they can also help to seek those services if that's helpful.

RIEPE: The question I might have for Senator Wishart in her closing if she does choose, is if they have catchment areas that this serves or not. I'll give you a heads up on that one.

TOM VENZOR: Yeah.

RIEPE: You can even say no. Anyway, I have--

TOM VENZOR: Sounds good.

RIEPE: --no more questions. Thank you, Chairman.

HANSEN: Any other questions? Seeing none,--

TOM VENZOR: All right. Appreciate it. Thank you.

HANSEN: --thank you for coming. We'll take our next testifier in support. Is there anybody else wishing to testify in support of LB276? Seeing none, is there anybody who wishes to testify in opposition to LB276? Seeing none, is there anybody who wishes to testify in a neutral capacity? All right. Seeing none, we will welcome back up Senator Wishart to close. And with that, we did have some letters for the record. I believe we had nine letters in support of LB276 and none in opposition.

WISHART: Well, thank you all for taking time today to hear this bill. When this was first-- when I was first approached with this legislation, it didn't take long for me to say yes to, to bringing this and, and the work that it entailed in, in getting this in front of you today. Because my husband was a police officer for five years in Lincoln, and every day when he'd come home, of course, I'd ask, you know, what went on? He did the night service. And a lot of the times the, the people that he was interfacing with were people who were either having a mental health crisis or a substance abuse issue. And there was not a lot of services or coordination with law enforcement and the providers and, and so to me, it just makes so much sense that there's sort of that missing link. And I think this legislation goes way beyond that, but I think that in itself will be a huge benefit to public safety. I'm happy to answer any of your questions. I, I do consider this a piece of legislation that I hope would be a priority. And so whether I look at prioritizing it or push for it to get some other priority designation, I think this is definitely the year for us to do it, especially since it takes a lot of work and organization for us to be able to submit that state plan amendment and, and get this plan adopted and moving forward. With that, I'll take any of your questions.

HANSEN: All right. Are there any questions from the committee? Yes, Senator Riepe.

RIEPE: Again, thank you for being here. Thank you for carrying the charge and, and probably working your staff pretty hard to get there. That's always good. Is this a statewide program to help me understand?

WISHART: Yes.

RIEPE: And so is it then divided up, much like we have regions, regions for mental health? Is it divided up that way? That's my reference to catchment areas, which is an old term that dealt with community mental health centers.

WISHART: So from my understanding, yes, this would-- part of the plan would be you'd submit through the catchment area. I'm, I'm not familiar with that term,--

RIEPE: You're too young.

WISHART: --but, but that it, it was referenced behind me that that, that would be the case. The way it would work is that you would have to qualify as a CCBHC and that is, that takes a, a certain level of qualification, it can either be sort of-- CenterPoint is a CCBHC in, in District 27, but it also applies to the tribes, for example, you have to be, you know, supporting behavioral health and substance abuse and mental health services--

RIEPE: OK.

WISHART: --and then you'd have to qualify. But it's statewide and so any center that's able to qualify, if the state grants them that permission, would be able to participate in this program.

RIEPE: Do they have something like a franchise so that you would say Scottsbluff, if, if they receive this, then they get a certain number of counties in western Nebraska, and, and you don't get competing-- you don't put one in Alliance right down the road from them or--

WISHART: Sure. That would be, that would be up to the department in the state plan amendment.

RIEPE: Oh, OK.

WISHART: But I anticipate that what you're going to see is a, is a statewide reach and a smart approach to where you have these centers across the state so it achieves the reach it needs without oversaturating.

RIEPE: I have one more question if I may, Chairman?

HANSEN: Yeah.

RIEPE: Yesterday, Senator Wayne introduced a bill requesting some traumatic stress for his particular community, and it had a fairly pricey price tag on. I'm trying to say it comes back to my maybe earlier question about how do we coordinate that with other service agencies so that we don't end up with a bunch of administrators? And, you know, I was a hospital administrator, you don't, you don't need to pay a bunch of those at the top just to kind of try to orchestrate it if you have something that can make it happen. And that's-- so are you or have you had a chance-- I know it's just--

WISHART: I have talked with Senator Wayne about that specific bill in the, in the appropriation for that. With this legislation, the department has been clear that because it's not creating anything new, it's just being smarter about the approach to behavioral health, that the dollars that we have already supported in our appropriations would be able to meet the needs of this program.

RIEPE: So if we were to move forward on his request, that would somewhere or another tuck into the process?

WISHART: It could.

RIEPE: OK. Thank you again. Thanks for being here.

HANSEN: Any other questions from the committee? Sorry for the noise.

RIEPE: Someone wants to come in.

HANSEN: It's either construction or someone is just doing ice sculptures. All right. Seeing no other questions from the committee, thank you.

WISHART: Thank you.

HANSEN: That will close the hearing on LB276. And we're going to switch up a couple bills here in the schedule per the request of the senators. So we will be hearing actually LB570 next, followed by LB605 and then LB657. Welcome, Senator Vargas.

VARGAS: Skeleton crew.

HANSEN: Yep.

VARGAS: Senator McDonnell and I were having a good laugh about your ice pick reference over there. If--

HANSEN: I don't know where it is, the noise somewhere.

VARGAS: Good afternoon, Chairman Hansen. Are you ready?

HANSEN: What?

VARGAS: We're good to go?

HANSEN: Yep.

VARGAS: OK. Good afternoon, Chairman Hansen and members of the Health and Services Committee. My name is Tony Vargas, T-o-n-y V-a-r-g-a-s. I represent District 7, which includes the communities of downtown and south Omaha. Today, I bring to you LB570. LB570 would adopt the Overdose Fatality Review Teams Act. Now, this proposal was brought to me by Douglas County Board of Commissioners. LB570 creates a framework for establishing county level multidisciplinary teams in Nebraska to collect data related to overdose deaths in Nebraska. As you all know, there is an opioid epidemic in this country. And tragically, too many Nebraskans are dying through overuse of certain substances. Now more than 100,000 Americans die each year from overdoses, mostly from opioids, according to CDC data released last week. That is higher than the toll from gun and car crash deaths combined. In 2020, Nebraska had an 11.3 death rate due to drug overdoses, 214 people. Now through LB570 and specifically the amendment that you have in front of me-- that you have in front of you, which includes a couple of different changes, the overdose fatality review teams, or OFR, bring together a variety of representatives from health sector, social services, and public safety to review overdose fatalities in their communities and identify missed opportunities and system gaps in hopes of preventing future deaths. One thing to clarify here, this is enabling legislation that would create-- a legislative framework would require any cities or counties or minister parties to do it, but would make sure that there's a legislative framework that allows any of these entities to be able to do this. The data collected would be summarized by the local health departments leading the OFR team and presented to the multidisciplinary team to discuss where the missed opportunities and the gaps that exist. After each case is reviewed, the team will be able to determine trends and factors related to overdoses in our

community. The team will then use the trends and factors they found to help develop prevention and response plans, as well as assist with implementation, assessment, and development of best practices prevention efforts. The OFR teams can discover system gaps and policy issues by applying a person-centered approach to the data provided by substance use service agencies. Now these local OFR teams are often earn a faster recommendation turnaround times than national agencies, allowing local authorities to quickly respond to emerging drug and overdose trends. Legislation-- this is very important-- legislation is needed to protect the team from subpoena and to keep all information confidential through a state statute. Currently, data is not allowed to be shared from DHHS and local departments and LB570 would eliminate the barrier. The ability for regional teams to collect and summarize data to determine where the gaps in our systems exist will prevent deaths, as well as helping those who have near-death experiences. Now, today, there is not a clear mechanism to collect and analyze this data and the circumstances related to overdose deaths. This is not a new concept, not especially and not for this committee, but there is a common way communities across the country are battling overdose deaths. Today, there are over 400 overdose fatality review teams across the country. Please note the amendment that I shared with you. Again, this amendment is to clarify this bill and narrow the scope to only pertain to overdose deaths and not include near-fatal deaths. There will be at least one testifier in the neutral position. We, we talked, this is CyncHealth, just to make sure that we, we are doing our due diligence on potential privacy concerns and so we'll be working on additional amendment language regarding that. But again, this is two things to clarify. This is creating a statutory legislative framework that enables these teams to be established at the local, city, or state level. It's needed also to protect the team from subpoena and keep all this information, information confidential through state statute. And those two things are really critical for allowing this to be in place in our state. And again, more than 400 of these types of teams exist across this country. And given all the good work that has been done in this arena, I think this is a worthwhile use of not only legislation but for us to pass. I'm happy to answer any questions. There'll be some people testifying behind me that will be able to answer some questions if I can't answer them.

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

RIEPE: Thank you, Chairman. Good to see you, Senator. My question is this, what current services or programs would this complement or

replace or have-- I'm sure there's something there that addresses this problem to some degree, but maybe not adequately enough, but--

VARGAS: So my understanding is there, there are some, there are some work that's done with different entities or agencies, but in some ways similar to the maternal and child health work. Now, that's already legislation that requires these teams to be in existence. One similar-- similarity between those-- these two problems is there are issues with privacy and subpoena concerns that we need statutory authority to protect information, and there's just more statutory framework that's needed to enable these teams to be secure and to exist at different levels. So it would solve that issue at large. And if we're able to create that framework-- and again, this is enabling legislation that would mandate any entity that would have to do it, it-- this will make sure that there's maintenance of some level of local control. That's what I believe.

RIEPE: OK. I, I would probably like it better if it said instead of a overdose fatality review, if it said an overdose fatality action, as opposed to just-- because I know there's a lot of fentanyl strip testings and all kinds of things that are now becoming more and more available in vending machines and out there for hopefully those that are users to be smart users, if you will. Also-- you also talked about framework for local communities, but is there-- is it simply the framework or is there funding that goes with that proposal?

VARGAS: So this is the funding that comes along with this. This is a legislative framework for the county level for review teams to be able to exist. There is an anticipated cost that would happen at the level of DHHS because we don't know what the anticipation in terms of how many municipalities or, or cities or counties that would take advantage of this. So there is anticipation of some new staff members that would be needed. There's still a review on whether or not some existing legislation in, in regards to overdose fatalities would be able to cover some of this programming that's noted in the fiscal note as well. But it's nice to know that you want to focus on as much of the prevention, which I do as well. I think sometimes reviewing these cases or having the ability for an entity or a county to review these cases will lead to prevention when we put that into effect.

RIEPE: OK. Thank you. Thank you for being here.

VARGAS: Thank you.

HANSEN: Any other questions from the committee? I have maybe a couple. And there's one that I think one of the letters addressed is who reviews the information? Like, who's a-- like, is it a certain member of a committee that's a part of this? Is, is it made up of like, like you have one person from this and one person that?

VARGAS: Yes.

HANSEN: OK. Is one of them from law enforcement?

VARGAS: I want to make sure-- yeah, we have pharmacists, healthcare providers. And bear in mind, these are allowable, that they may include-- not mandating that they include for many of these.

HANSEN: Well, I see, I see it right here.

VARGAS: Yeah.

HANSEN: Section 5.

VARGAS: You see the list? Yeah, [INAUDIBLE].

HANSEN: Because there's law enforcement [INAUDIBLE].

VARGAS: Yeah.

HANSEN: Is there, is there any concern or any conflict you see by having law enforcement review some-- somebody who's overdosed on something?

VARGAS: Well, there's two things that-- we want to make sure that their privacy concerns are taken into account. We haven't heard concerns with law enforcement necessarily being able to serve on the committees or serve on these review teams. But if there is, then we need to address some of that issues in, in, in an amendment. We'll, we'll work on that.

HANSEN: Yeah, that's cool. I was just kind of curious. And how about informed consent, because I know we-- there's still probably-- I'm assuming you still have to follow HIPAA law.

VARGAS: Yes. Yes.

HANSEN: And then is there, like, an informed consent that has to go along with this, like-- so the, the person is consenting for the information to go to this?

VARGAS: I'll have to check on that. The one thing that did come out in the fiscal note is there's still staff at the DHHS level are just making sure we're addressing all the HIPAA issues. Any of the information is de-identified in this, and that is stated in, in the legislation.

HANSEN: Cool. All right. Thanks. Any other questions? All right. Seeing none, we'll see you at the close.

VARGAS: Thank you.

HANSEN: We'll take our first testifier in support of LB570. Welcome.

PATTY FALCONE: Welcome. Thank you. My name is Patty Falcone. It's P-a-t-t-y F-a-l-c-o-n-e. I am the supervisor of health promotion at the Douglas County Health Department and thank you for this opportunity to speak today. Douglas County Health Department has over 15 years of addressing fetal and infant mortality through the FIMR process. Authority for the Douglas County FIMR comes through LB741, the Child and Maternal Death Review Act. The FIMR process involves data gathering and maternal interview that is brought before the case review team. Today, I am here to discuss our Overdose Fatality Review team, which is meant to mimic our FIMR team. Drug overdoses are a leading cause of death in the United States. Over 1 million people have died from an accidental overdose since 1999, with more than 90,000 deaths in 2020 alone. Provisional data from CDC suggests that overdose deaths accelerated during the COVID-19 pandemic, with almost 170,000 people who have died in 2021. A near 15 percent increase in 2020. Overdose deaths can be prevented with coordinated prevention strategies, timely implementation of evidence-based interventions, community mobilization, and support of family and friends. The shared understanding that overdose deaths are preventable guides the entire Overdose Fatality Review process. Federal agencies such as the Bureau of Justice Assistance and the Centers for Disease Control and Prevention are strategically coordinated to mobilize local communities to develop and implement OFRs. Overdose Fatality Review is a nationally recognized, locally based, multidisciplinary process for understanding the risk factors and circumstances leading to fatal overdoses and identifying opportunities to prevent future overdoses. The purpose of the OFR is to effectively identify system gaps and innovative community specific overdose prevention and intervention strategies. The Douglas County OFR team hopes to examine confidential de-identified cases of overdose, overdose deaths. The cases will be summarized by our OFR team abstractor and called a case review. These

case reviews examine the individual's drug use history, comorbidities, social emotional trauma, law enforcement encounters, and treatment history. This bill would provide protection of the team and its findings from subpoena to maintain confidentiality. By conducting a series of overdose case reviews, jurisdictions begin to see patterns of need and opportunity, not only within specific agencies but across systems. In 2020, 214 Nebraskans died due to overdose. Douglas County residents accounted for 37 percent of those deaths. Douglas County has seen a 14 percent increase in overdose deaths from 2020 to 2021, which mirrors the national provisional data. Currently, our team is able to calculate aggregate data such as this, but unable to examine individual case information. This individualized information is critical to respond to the rapidly changing environment. Local overdose teams are critical-- are crucial for a prompt prevention response. The New England Journal of Medicine states that every opioid-related death represents a missed opportunity for prevention. OFRs identify factors on multiple levels, spanning from individual to population based to assist in determining missed opportunities. This bill would allow the Douglas County OFR and future OFRs across Nebraska to be able to gather the necessary records to develop and implement data-driven prevention and intervention strategies which directly address those missed opportunities and prevent future overdoses and deaths in our community. Thank you.

HANSEN: Thank you. Are there any questions from the committee? All right. Seeing none, thank you. We'll take our next testifier in support. Welcome.

EDWARD DeSIMONE: Thank you for this opportunity, Chairman Hansen and, and the committee members. Edward DeSimone, E-d-w-a-r-d D-e-S-i-m-o-n-e. I've been a pharmacist for 51 years and licensed to practice pharmacy in Nebraska and have spent the last 46 years as a pharmacy educator. You have my written comments, so I'm not going to go-- my, my history and my involvement in this is, is spelled out in detail. I want to take time away from this. My area of specialization is addiction and substance use disorders. I've been speaking to student groups, parent groups, medical groups, and all sorts of groups since spring of 1970. I've been teaching a course on this topic at Creighton University School of Pharmacy for the last 30 years. As a matter of fact, I'm teaching it right now. In 2012, I was one of 24 pharmacists from around the country invited to the White House Office on National Drug [RECORDER MALFUNCTION]-- to have a day long that we spent the whole day discussing the role of pharmacists in dealing with this issue of illicit drugs and drug abuse. My intensive involvement

in this area was triggered first, as I watched my grandfather slowly suffocate to death from his addiction to tobacco and nicotine. Then I watched my father, a World War Two veteran, die at the age of 49 from the toxic effects of alcohol. And most recently, I watched-- and my 18-- my 24-year-old nephew who died from his addiction to heroin, although he tried very hard, to, to recover. And I can say with certainty that my comments are representative of pharmacists who believe that we are in a national crisis driven by the availability and use of illicit drugs, especially the opioids. Couple of statistics. This comes from a national survey on drug use and health, from 2021. Forty million people use illicit drugs regularly; that's 14.3 percent of our population over the age of 11. 9.2 million people misused opioids and that's 3.3 percent of our population. 7.5 million people suffer from an illicit drug use disorders. And there are ten different drug use disorders that are identified in the DSM-5 and the peak gauge for this is 18-25 years of age. And deaths, as you just heard, deaths are over 100,000 and more than two-thirds of those are related to the opioid-- use of opioids. Premature death and this is a very important factor, when someone dies, their, their cause of death goes into the database. And, and they look at, for example, someone who dies from a drug overdose, they look at their age, what was their life expectancy at the time of birth and calculate how many, how many years of person [SIC] life lost. Someone who becomes addicted to opioids will lose-- will die 37.8 years prematurely, based on their life expectancy at birth. I'd like to ask you to consider taking a look at a 12-minute video. I'm sorry. I didn't mention this earlier, but I'm speaking on behalf of Coalition Rx, of which I am the founding president. There's a 12-minute video that we made in conjunction with the Poison Control Center. And it's only 12 minutes and the link is on your handout. I would encourage you to, to take a look at that. In the middle is a 2.5 minute segment of local dads, all of whom have lost sons to these drugs. The increasing use of drugs of all types has caused our country great harm, especially to our young people. The rising death toll has stunned too many families with sorrow, grief and guilt and I've experienced that firsthand. In 2022, as you just heard, Coalition Rx teamed up with Douglas County Health Department to work on developing a local team. LB570 is intended to authorize and not mandate the creation of local overdose fatality review teams and provide the teams with responsibilities to examine and understand the circumstances-- excuse me-- leading to overdose, overdose deaths so that the local team can make recommendations on policy changes and resource allocation to prevent further overdoses. I ask you to vote in

favor of this, LB570, and put it in front of the Unicameral. Thank you.

HANSEN: Thank you for your testimony. Are there any questions from the committee? I remember seeing this. You handed out that--

EDWARD DeSIMONE: Oh, I'm sorry. I did--

HANSEN: --no. I remember, I remember seeing this story about how they seized, within four months, more fentanyl than they did within the whole entire year before that.

EDWARD DeSIMONE: The reason that that's not attached is it just came out the other day--

HANSEN: Yeah.

EDWARD DeSIMONE: --and so, I didn't even have a chance to staple it to the, to the handout. But that's a stunning statistic. And this way, it's, it's not-- it's right there in front of you. You can look at the, at the source, but it came from, you know, the Border Patrol.

HANSEN: Yeah. I thought that was-- they said, we, we seized as much fentanyl last year to kill every American.

EDWARD DeSIMONE: Yes.

HANSEN: And then, and then some.

EDWARD DeSIMONE: Yes. As a matter of fact, the most recent says-- the most recent data says this particular number is enough to kill one hundred million Americans and this goes on, on a regular basis around the country. We work with the State Patrol and-- Coalition Rx does-- and other law enforcement groups. And this is a constant, this is a constant problem coming through Nebraska, coming from the southern border, China and Mexico. So we really have-- we want to save the lives of our young people, in particular. But there are people of all ages who die from these drug overdoses and this legislation is absolutely essential to accomplish that.

HANSEN: Appreciate your work and thanks for coming to testify.

EDWARD DeSIMONE: Thank you, sir.

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

STEPHANIE SCHROEDER: Hi. Thanks for having me. To Chairperson Hansen and the rest of the committee. My name is Stephanie Schrader, and that's S-t-e-p-h-a-n-i-e S-c-h-r-o-e-d-e-r, and I'm here today as a grieving mom, urging you to pass this bill. I really don't want to be here today, but I am here because I'll do anything I can to make sure other families don't suffer like mine has. My only son, Andrew, was 18 years old and he had just finished his freshman year at UNO on a full ride academic scholarship. He was smart like his mom, is what I always told him. I wish you could have met him. He was a great kid. He was a lifeguard, a swimmer. He was a member of the Pi fraternity. He was just one of those kids that everybody loved being around. And I wish I could tell you that that day in May was a blur, but the details are forever ingrained in my memory. I walked up to his dorm that day knowing something was very wrong. We couldn't get a hold of him that morning. I saw police cars and an ambulance and many of Andrew's friends gathered outside. None of them would make eye contact with me. None of them smiled. Their faces were pale and their eyes were bloodshot, looking down at the ground. I approached the officer at the entrance of Andrew's dorm and told him who I was. I said, can you tell me what's going on? And he said, no, ma'am. And I said, is Andrew OK? And he hesitated and said, no, ma'am. And I said, can you just tell me, is my son alive? And he said, no, ma'am. Like so many other moms that you've heard the statistics about, at that moment, my whole entire world just-- not just crumbled, but it blew up entirely into a million pieces. My son had died of an accidental oxycodone overdose. My family and I have not been the same since that moment. And it's not just the holidays and special events. It's not just watching his friends graduate college, get married and have babies. It's, it's all of the moments, every single minute of every single day. Not a cell in my body has been the same since that day at the dorm. Every day I live with this life sentence. Do you know what it's like to not be able to take a full breath because your heart is so broken and your lungs just can't take in enough air to make up for all that pain? I hope you don't. It's a life of too much sadness, too much sorrow. It's a life of grief, despair, heartache, anger and questions. So many questions. So many what ifs. And now it's getting close to what I call my trifecta month, May. First, there's Mother's Day and then Andrew's death day and then, his birthday is the last day of the month. And this May, my daughter's getting married and her only sibling won't be there to give her fiance a hard time about, he better be treating his sister like a queen. He won't be there to make jokes and dance and entertain everyone, as often as he did in life. He won't be there. Never. And that's why we must pass this bill. I'm not here because I

want to be. I'm here because I must do everything in my power on Earth to make sure no other mom has to endure life without her child, due to an opioid overdose. So I'm here to ask you to please vote yes for LB570. Thank you.

HANSEN: Thank you for your testimony. You did good. Are there any questions from the committee? All right. Seeing none, thank you--

STEPHANIE SCHROEDER: Thank you.

HANSEN: --for sharing your story. Appreciate it. We'll take our next testifier in support, please.

JONI STREET: Good afternoon, Chairman Hansen, the Health and Human Services Committee. My name is Joni Street. I'm a pharmacist and board-certified pharma-- pharmacotherapy specialist and I'm here today, on behalf of CHI Health, to ask you for your support of LB570, the Overdose Fatality Review Teams Act. CHI Health is a regional healthcare network, with hospitals and behavioral health facilities in a variety of communities throughout Nebraska. Through our mission, we are committed to creating healthier communities. We seek to deliver exceptional patient care and ensure that every person has access to quality healthcare. I am also here today, speaking as the president of the Nebraska chapter of the National Association of Drug Diversion Investigators. NADDI is a national training organization dedicated to educating law enforcement, regulatory agencies and healthcare professionals about pharmaceutical drug diversion. By working together, we are able to identify additional opportunities we see in our communities, develop strategies and provide education to those investigating prescription drug diversion and treating substance use disorder. As a national organization, we see trends throughout the country. And while Nebraska numbers look better, comparatively, to most other states, it is our belief that those numbers are still underreported. Having greater access to data could help get those numbers more accurate and potentially, help us acquire additional resources. NADDI stands in support of LB570, because it supports the collaboration between all those trying to decrease the number of overdose deaths. While our country has been fighting the war on drugs since the early 1970s, I have been a pharmacist since 1993, which was two years before OxyContin was approved by the FDA. I have seen the emergence of pain as the fifth vital sign and the resulting steady increase of opioid prescriptions and subsequent overdose fatalities across our country. As a health system, CHI Health has followed CDC guidelines for prescribing opioids for pain. We have implemented

Alternatives to Opioids, also known as ALTO. I got to throw in my, my little acronyms, also-- and Enhanced Recovery After Surgery, ERAS protocols, which include multimodal pain therapy options in an attempt to decrease the amount of opioids in our homes' medicine cabinets. We see patients in our hospitals and clinics every day that need our help. All of us. All of our help. The stigma associated with substance use disorder is real. We need to get more access to medications for opioid use disorder. We need more patients and family members to have naloxone readily available if needed. We need referrals to treatment and recovery offered more frequently and by primary care providers, first responders, and upon release from incarceration. Overdose fatality review teams have the unique experience of getting a group of individuals with various backgrounds together, to help identify where there are gaps and to act upon those opportunities to help prevent additional overdose deaths. 214 families lost loved ones, in 2020, to drug poisoning deaths in Nebraska alone. The 2021 and 2022 numbers are expected to be higher. Whether those deaths were after a long history of drug use or from an accidental encounter with illicit fentanyl, we have the obligation to look at opportunities where we can intervene and provide assistance. Please join me in supporting LB570, the Overdose Fatality Review Teams Act.

HANSEN: Thank you for your testimony. Are there any questions from the committee? I have a couple. Is-- isn't there a new medication or drug coming on the market that's like naloxone? That-- naloxone, but better?

JONI STREET: There's-- there-- they've changed some of the concentration on naloxone. There's a little bit of concern with naloxone, what's currently available. We've upped the amount that you can get for our-- from our standing order, because the amount of naloxone it takes to reverse someone that is typically using heroin, versus somebody that accidentally is using fentanyl when they think they're using heroin, for example, it will take a, a larger dose, so it's more concentrated.

HANSEN: OK. Yeah, because I thought, I thought I just read like the FDA approved something that's-- for specifically, especially fentanyl overdose, that reacts a lot quicker, actually.

JONI STREET: I think it's-- I don't know. Maybe Dr. Small can speak to it, but I do know that they had-- they, they have come up with a more concentrated naloxone [INAUDIBLE].

HANSEN: I'll ask doctor Google later.

JONI STREET: OK.

HANSEN: He's always right.

JONI STREET: Right. And there's talk about making naloxone over the counter. That's one of the big, that's one of the big things right now with the FDA, is potentially making it over the counter.

HANSEN: OK. Yeah. One more quick question. You said there's two-- and Senator Vargas touched on this, too. There's 214 families-- or 214 deaths from drug poisoning? How was that comparatively-- comparative to other states?

JONI STREET: It is lower compared to other states. But that again, we think that the data doesn't necessarily show what we're-- what we're looking at is the data that we can collect, it's not all-- always that easy to get that information. So we're using different drug codes and, and how, how someone dies is not always determined or-- let's see. How do I explain this?

HANSEN: Cause of death?

JONI STREET: There are definitely times where we know someone may be impaired and in a car accident, but if they are-- if their death is caused by the result of a traumatic injury, we may not necessarily need to go for-- forward and determine whether or not there was drugs involved in the, in the process.

HANSEN: OK.

JONI STREET: So we think our numbers are, are actually lower than what they-- than what we're actually seeing in practice.

HANSEN: OK. All right. I know it's all trends, too. It's like--

JONI STREET: Yes.

HANSEN: --where we're going and how to react to it, I guess. That's what we're trying to accomplish here.

JONI STREET: Right. Right.

HANSEN: OK. Any other questions from the committee, just to make sure? All right. Seeing none, thank you.

JONI STREET: Thank you.

HANSEN: Is there anybody else wishing to testify in support of LB570? OK. Seeing none, is there anybody who wishes to testify in opposition to LB570? Seeing none, is there anybody who wishes to testify in a neutral capacity to LB570? Welcome.

FELICIA QUINTANA-ZINN: Hi. Good afternoon. Chairman Hansen and members of the Health and Human Services Committee. My name is Felicia Quintana-Zinn, F-e-l-i-c-i-a Q-u-i-n-t-a-n-a-Z-i-n-n, and I'm a deputy director of the Division of Public Health within the Department of Health and Human Services. And I'm here to testify in the neutral capacity on LB570, which would allow for the creation of county level multidisciplinary overdose fatality review teams. Although the intent of the bill appears to help identify gaps, make recommendations for policy and resource allocation to prevent future overdoses, there are technical issues that would make the, the bill difficult to implement. The bill conflicts with multiple current statutes. And additionally, LB570 is unclear on which drug overdoses are eligible for review and that requires a data turn-- turnaround time and committee membership that's not sustainable by the department resources right now. LB570 requires that data and information be provided to each of the review teams upon their request from the Nebraska Prescription Drug Monitoring Program, the PDMP, and the Division of Children and Family Services, regarding the individuals under investigation. However, this currently conflicts with the PDMP statute in multiple subsections and the Child Protection and Family Safety Act regarding obtaining child welfare records. So for example, in subsection 1(b) and 2(b), both this-- both state that the PDMP access eligibility would be for a credentialed prescriber, dispenser or the respective credentialed delegates with treatment relationship to the patients. However, many, if not all of the individuals listed by the local teams in the bill would not fall under the approved list of users or reasons for access. In subsection 9, it states that the department is allowed to release data collected pursuant to this section for statistical public policy or educational purposes, after removing information which identifies or could be reasonably used to identify the patient, prescriber, dispenser or other person who is subject to the information. The data needed by the local teams to conduct these reviews would require the release of identified information specific to the patient, which is just not allowable. Without addressing the direct conflicts within these statutes, the Department would be unable to comply with the request for the local fatality review teams. And in addition to the conflicts with the statutes, there are a number of references to the

reviews of near death and nonfatal overdoses. The bill is unclear whether it's intended for the fatality review teams to review nonfatal overdoses then gather the same information on living individuals, in addition to the decedents in question. If the intent is to include both the fatal and nonfatal overdoses in the eligible reviews by the teams, the number of possible requests for the data could pertain to over 5,000 events each year. And furthermore, DHHS is a covered entity under HIPAA and we could not release this information for living individuals outside the agency, unless it's in accordance with HIPAA. Finally, LB570 requires that all information requested by the local teams be provided within five business days after receipt of a written request. It's not feasible for the Department to provide this volume of information for overdose deaths under investigation, particularly if those d include nonfatal overdoses. For CFS to comply with the bill, the N-FOCUS system would need updates to extract the requested information. The division would need additional staffing to be able to pull and compile the information and to attend the meetings with the local team as a core member of each of the review teams. Similarly, the Division of Public Health would need additional staffing support to work with the local teams, respond to the requests and compile the data. The Department recognizes the current issues in Nebraska and nationally regarding substance misuse, abuse and overdoses and does take this situation seriously. DHHS has multiple programs across divisions that work with local jurisdictions to combat these critical issues, including encouraging providers to use the PDMP, increasing the availability of naloxone, provider education and support to a variety of medical providers and community groups, increase-- increasing access to treatment, among many other programs and activities. Divisions within DHHS regularly collaborates, as well as work with local, state and national groups to find new and evidence-based ways to prevent fatal and nonfatal overdoses. Thank you for the opportunity to testify today and I'd be happy to answer any questions.

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

RIEPE: Thank you, Chairman Hansen. Who could release HIPAA information after-- I know the individual could, but the individual's since lost, has, has passed away. Who-- who then, who then could release that HIPAA information?

FELICIA QUINTANA-ZINN: I, I think that depends on who you're asking for that information. But some of that would, would be-- a lawyer

would need to answer that question. I'm not a trained lawyer, so I'll have to defer and we can get back to you.

RIEPE: OK. So the question would have to be then, how strict and inclusive the release might be. But, you know, to solve the problem, we have to get to some understanding, it would be my opinion.

FELICIA QUINTANA-ZINN: So I can, can add that DHHS is a covered entity. And so, usually we have to have releases or approvals to be able to release that information.

RIEPE: OK. My other question would be in the second paragraph, there are concerns outlined and how, how redeemable are those? Do you think that you could sit down and resolve those concerns?

FELICIA QUINTANA-ZINN: I think that we'd definitely be willing to work with the Senator on that.

RIEPE: OK. Sounds like there's at least hope in the air. OK. Thank you very much. Thank you, Mr. Chairman.

HANSEN: Any other questions? I'm glad you brought the PDMP. I was going to ask you about that.

FELICIA QUINTANA-ZINN: Yeah.

HANSEN: So I was, kind of, concerned about, not confidentiality, but like compliance and how that fits under there, because I know that's used a certain way.

FELICIA QUINTANA-ZINN: It is.

HANSEN: I have another question about-- I'll ask it if Senator Vargas comes up here.

FELICIA QUINTANA-ZINN: OK.

HANSEN: All right. Thank you for your testimony. Appreciate it.

FELICIA QUINTANA-ZINN: Thank you.

HANSEN: Is there anybody else wishing to testify in the neutral capacity? Welcome.

JAIME BLAND: Good afternoon, Chairperson Hansen and committee members. My name is Jaime Bland, J-a-i-m-e B-l-a-n-d, and I am President and

CEO of CyncHealth, which is a statewide health information exchange and administrator of the PDMP, the Prescription Drug Monitoring Program, for the state of Nebraska. I'm here today to testify in a neutral capacity for LB570, and thank Senator Vargas for working with us on proposed amendments. We, of course, support efforts to reduce opioid related deaths and overdoses. The impactful work that has been supported across the past few years, in terms of data being able to provide for relevant research and functionality that has been built into the PDMP, helps providers and pharmacists identify potential opioid misuse and how-- it shows how dedicated individuals are, in Nebraska, of being part of the solution. We are very proud of the meaningful role we've been able to play in addressing the opioid crisis, improving patient care and supporting Nebraskans from-- suffering from substance use disorders. So while we obviously support efforts to reduce opioid related deaths in the state, we believe that amendments are needed to bring this bill into compliance with HIPAA and ensure an appropriate data governance for protected health information. As written in this bill, the process for the task force to obtain an individual's medical records is not HIPAA compliant. The bill contains confidentiality agreements for task members, but this does not address or necessarily create compliance with HIPAA. The appropriate approach would be to develop establishing-- or establishing data sharing agreements, ensuring HIPAA-compliant document, document destruction policies and develop necessary scoping for data that is needed and for what purpose, within the appropriate authority. Next, as the bill is written, the Prescription Drug Monitoring Program would be compelled to fulfill records requests from a task force that will likely include law enforcement representatives. The PDMP has always been a clinical tool, not a law enforcement tool, which is why it contains all dispensed medications, not opioids alone. Giving law enforcement access to the PDMP data may jeopardize the faith and trust placed in it. And if our providers and patients can't trust the data within the system and can't rely on necessary privacy protections afforded to protect health information, then the PDMP, PDMP's accuracy and robustness will be compromised and its value to Nebraskans diminished. In terms of data governance and access to the data within the PDMP, we believe the Health Information Technology Board is better positioned to review some of this work and has public transparency under the Open Meetings Act, a broad team of stakeholders and appropriate data governance structure in place. The HIT Board would have the necessary policies in place to release the identifiable information, as requested under the bill, for the PDMP data. It can also release for quality measures as approved and regulated by the

state or federal agency or for patient quality improvement or research initiatives approved by the Board. It also could report deidentified and limited data set information on the aggregate level, which would protect individuals' privacy, while providing value-- valuable information for addressing opioid related deaths in Nebraska. We wish to thank Senator Vargas for the chance to address privacy and governance considerations with him and we look forward to supporting this bill further. Thank you so much for your time. I will welcome any questions.

HANSEN: Thank you for your testimony. Are there any questions from the committee? So I had concern about the inability for, maybe, drug enforcement having access to the PDMP in some kind of limited fashion. They brought it to me before. Is that anything that's even feasible with, with their ability to, to access the PDMP with-- for investigation or if they go, you know, following--

JAIME BLAND: Sure.

HANSEN: --you know, a lead or something like that to find out if somebody's on something. I don't really know for sure. That's just something they've told me before. I didn't know if there's ever been any--

JAIME BLAND: If there's a warrant, we are compelled to supply data.

HANSEN: OK. All right.

JAIME BLAND: And we have many times in the past.

HANSEN: OK. Cool. Thank you.

JAIME BLAND: Yep.

HANSEN: All right. Thank you for your testimony

JAIME BLAND: Yep.

HANSEN: Anybody else wishing to testify in the neutral capacity? All right. Seeing none, we will welcome Senator Vargas back up to close. And before he does, we do have one neutral letter, one letter in opposition and 24 letters in support of LB570.

VARGAS: Thank you very much, Chairman Hansen and members of the Health and Human Services Committee. I just want to take a second and thank

you for listening to this testimony and for those that testified, we want to make sure that we're working on the privacy concerns. And as we heard from DHHS, which I appreciate, Senator Riepe said, there's always hope. There is hope. We can work on these technical issues. And I don't say technical as just technical and unimportant. Technical and important. We want to make sure those privacy issues are addressed as much as possible, that we are obviously in compliance with HIPAA and that we are also addressing some of these concerns with the PDMP that CyncHealth just brought up. So we'll be working on some amendments. And I think what you heard is there's an innate need for something like this. We need to be able to allow this to exist in this state. And we need to make sure there's a legislative framework that protects privacy, but also protects-- gives us the ability to do this kind of work and counties to do this kind of work. And as we've mentioned, we've been able to assure some privacy concerns, in other different avenues with types of review teams. So it's not a matter of whether or not we can do it, it's how do we make sure we address some of these issues. So I'll be working on this with my team and the other people that, that just testified. And I appreciate you and if there's other questions that I can answer, I will do my best.

HANSEN: Thank you. Are there any questions from the committee? I have one. Did, did the Attorney General's Office contact you at all?

VARGAS: No.

HANSEN: Or did you have any communication with them? Because I noticed this team would have the ability to request information from the attorney general and they would be compelled to and if not, then they would be held in contempt.

VARGAS: I'll text Hilgers.

HANSEN: I was just-- yeah, I was just kind of curious.I thought they'd--

VARGAS: I'll shoot, I'll shoot him a text.

HANSEN: Just tell him, this is what we're going to do. Don't worry about it.

VARGAS: Yeah, yeah, yeah.

HANSEN: And one more thing. Section 11, on page 11, a member of the local team may contact, interview or obtain information by request

from a family member or friend of an individual whose death is being reviewed. Does that mean, like a team member can go to their home or anything like that and then ask them questions? I, I, I was just--

VARGAS: I mean, that's the way I interpreted it, as well.

HANSEN: OK.

VARGAS: But, you know, we can flush that out a little bit.

HANSEN: OK. I didn't know if that was kind of a privacy thing or--

VARGAS: Yeah.

HANSEN: --that's all. Oh, and one more thing. If, if a case is currently under, like, investigation or if it's-- there's-- if it's in litigation, can they still request that information, like can the Attorney General or the county attorneys?

VARGAS: That I don't know.

HANSEN: OK.

VARGAS: So I'll find out. And, and for-- one thing to clarify before I forget, too. One-- some, some of the, the issues, in terms of the definition, were addressed in the amendment that were brought up by DHHS. So, again, we, we still need to work on some more of these technical issues.

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

VARGAS: Thank you very much.

HANSEN: All right. That'll end our hearing on LB570. And we will now open it for LB605, and welcome Senator Albrecht, to open. Welcome. Hopefully this hearing doesn't go till 9:30 at night.

ALBRECHT: I know. I have two people that are going to speak. So hopefully, we go quick. Good afternoon, Chairman Hansen, members of the Health and Human Services Committee. For the record, my name is Joni Albrecht, J-o-n-i A-l-b-r-e-c-h-t, and I represent District 17 in northeast Nebraska, which includes Dakota, Thurston, Wayne and a portion of Dixon Counties. I'd like to begin by thanking you for your time and critical consideration of LB605. I'm here today to share why

I offer background on and support of this bill. If this bill passes, LB605 would amend all relevant sections of the Uniform Credentialing Act and Mental Health Practice Act to qualified art therapists-- the title of the licensed mental health practitioner or licensed independent mental health practitioner with a credential as a certified art therapist. The bill you have before you today is the result of a five-year advocacy and review process. The 407 Credentialing Review, 407 process, for art therapy, began on October 9, 2018, with the Director's acceptance of the Nebraska Art Therapy Licensure Coalition letter of intent. The Coalition, compromised of Nebraskans for the Arts, Concordia University, the Brain Injury Alliance of Nebraska, Heartland Counseling and the Nebraska Arts Council, an individual art therapist proposed providing for credentialing of professional art therapists as licensed mental health practitioners under the Mental Health Practice Act, with associated certification as a professional art therapist. This decision was a pivot from the Coalition's original intent to create an independent licensure in art therapy and was adjusted in response to the feedback from the Platte Institute and lawmakers. In September 2019, the Coalition submitted the full 150-page 407 Credentialing and Review application for Art Therapy. Following this submission, the Department of Health and Human Services established Art Therapists' Technical Review Committee, which held six meetings between October of 2019 and March 2020, including a public hearing. Final reports in support of the proposal were issued by the Technical Review Committee, the Board of Health and the Director. The Director's report stated, "The Technical Review Committee members recommend in favor of the art therapy proposal. The Board of Health recommended in favor of the art therapy proposal and I concur with these recommendations." The report shares comments particular to the four criteria of 407 process and concludes, again, "The only way to address the shortcomings of the current practice situation of art therapy services in Nebraska is by passing the applicant's proposal." While the 4017 [SIC] process was underway, the Coalition's original bill sponsor, former state Senator Sara Howard, introduced LB422 as a shell bill, in 2019, to familiarize the Legislature of the process, while the 407 review was underway. During this time, the Coalition also worked with the American Art Therapy Association and the Nebraska's Mental Health Practice Board to ensure that the only amendment you have before you today, which is-- amend-- there is no amendment. There's not an amendment. That's all right. There is not an amendment. So the, so the American Art Therapy Association and the Nebraska Mental Health Practice Board incorporated not only feedback from the 407 process, but feedback from other

important stakeholders. So per the recommendations of the Department of Health and Human Services and other parties, this bill utilizes the legal framework that currently extends title protection to clinical social workers, professional counselors and marriage and family therapists. For each of these professions, title protection has ensured that the Nebraska practitioners are held to the highest standard of care and that the public have a clear understanding of what services their practitioner can provide them. Accordingly, I hope that you'll agree that offering this title protection to art therapists would be of value, not only to the art therapists, but also to the members of the public seeking mental healthcare. There are testifiers following me that would be happy to answer other questions. Thank you, again, for your time.

HANSEN: Thank you for your opening. Are there any questions from the committee? Seeing none, see you at the close. All right. We'll take our first testifier in support of LB605.

JESSIE STALLINGS: Good afternoon, Chairperson Hansen and members of the Health and Human Services Committee. My name is Jessie Stallings, J-e-s-s-i-e S-t-a-l-l-i-n-g-s, and I am testifying on behalf of Heartland Family Service in support of LB605 and we appreciate Senator Albrecht for bringing this bill forward. For more information on HFS, I refer you to my written testimony. I work at the Therapeutic School, which is currently located in north Omaha. In that setting, I serve as a full-time art therapist, providing services to children ages 5-19, all of whom have developmental and/or major mental health diagnoses. I also adjunct at the University of Nebraska, Omaha, in the Medical Humanities Program, teaching future doctors and other health professionals about the role of art therapy in medical and mental health settings, as well as opportunities for collaboration. Art therapy is a mental health profession that utilizes the healing properties of visual art making and the tools involved to facilitate psychotherapy, with specific master's level training that is approximately 50 percent different from the training, but parallel to that, that allied fields such as counseling and social work receive. I have worked with a wide variety of populations over the course of 18 years as an art therapist, including individuals of all ages with developmental disabilities, individuals with addictions, individuals who have experienced significant, significant trauma and more general psychiatric populations. I have utilized traditional talk therapy and art therapy with all of these populations. Over the course of my work, I have observed that art therapy reaches clients in a different way than traditional talk therapy. I have witnessed children, who are too

anxious to speak, communicate their anger and frustration with art. I've also witnessed adults have realizations in just one art therapy session that they hadn't come to and months or years of verbal counseling. To emphasize the need for the certification-- and I will briefly detail a documented case of harm that occurred in Connecticut and was documented in their licensing bed. A psychologist at a community mental health clinic was working with a five-year-old child with a history of complex trauma and a diagnosis of post-traumatic stress disorder. An art therapist was also assigned to work with the child in a school. And the psychologist described to the art therapist her experience of giving the child paint and her subsequent surprise and confusion when the child became overwhelmed and agitated and threw the paints all over the treatment room. It appears evident that emotional harm was caused to the child by the psychologist's choice of art materials, which caused emotional regression. In addition, the child's physical safety was put in danger when her emotional dysregulation created physical dysregulation, as evident by her increased impulsivity and physical agitation. Now, we are aware that this is not a case of harm in Nebraska. However, it illustrates concern regarding protection of the public. Art therapists have specific training in the psychological impact of art materials, knowing which are likely to trigger regression or provide calming, just to name a couple of examples. Other mental health professionals do not have such training. While we do not oppose these professionals using art materials in their practice, their use of art materials is distinctly different than the use of art materials by art therapists and it is important that this distinction be included in the regulation of the profession, to help to prevent and remedy incidences, incidences, such as that mentioned above. Passage of LB605 would ensure that Nebraskans receive quality care. This bill would benefit children, individuals with developmental disabilities, psychiatric populations, addictions populations, incarcerated populations, older adults, military personnel and medical patients, by increasing the availability of trained therapies across Nebraska. Additionally, this bill would increase the availability of art therapists as licensed mental health professionals, helping to fill open mental health positions across the state. Speaking on behalf of Heartland Family Service, we would welcome the opportunity to include more art therapy across our programs and specific regulation of the field allows us to ensure that our clients are receiving the best services possible. Please pass LB605 out of committee. And I will be happy to answer any questions.

HANSEN: Thank you for your testimony. Are there any questions from the committee? Seeing none-- one question I might ask you or if Senator Albrecht can ask-- answer later, would this now allow art therapy to be covered by Medicaid or is it already?

JESSIE STALLINGS: So because of this-- that is probably better for Senator Albrecht, but I can address that, partially. Because of the structure of licensing in Nebraska, where we all fall under an umbrella license and then have certifications, it would likely assist in that.

HANSEN: OK. Just curious. Thank you.

JESSIE STALLINGS: Um-hum.

HANSEN: Appreciate it. Thank you for your time.

JESSIE STALLINGS: Thank you.

HANSEN: We'll take the next testifier in support.

PETRA WAHLQVIST: Oh, yes. Sorry. Can you grab them?

HANSEN: Welcome.

PETRA WAHLQVIST: Thank you. Good afternoon, Chairman Hansen and esteemed members of the Health and Human Services Committee. My name is Petra Wahlqvist, P-e-t-r-a W-a-h-l-q-v-i-s-t. I'm the executive director of Nebraskans for the Arts, our state's arts advocacy organization and I want to thank Senator Albrecht for bringing this bill. I'm here to testify in support of LB605. I'm not an art therapist myself, but I want to bring some important points to your attention from the group of Nebraska art therapists that have been working with Senator Albrecht and Nebraskans for the Arts on this bill for several years. One of these art therapists grew up in south Omaha and then moved to Chicago for graduate school. She moved back to Nebraska, where she best felt she could serve her community, the community she views as her true home. Another waited 10 years to return to Nebraska, due to the lack of certification for art therapists in our state. Within their careers, they have witnessed the impact art therapy has, in clients of a wide range of ages, approximately ages 3-88, and levels of functioning. Art therapy provides numerous populations the ability to express and process countless impacts on their lives. Currently, anyone in Nebraska can call themselves an art therapist. LB605 would ensure that only those

with the specific training and experience will state that they are an art therapist, which will be helpful for our community members looking for art therapy services. Our art therapists have seen numerous times that clients have been thinking they were gaining arts therapy services, only to find out that they spent their money, time and energy towards a service their clinician was not trained to provide. Many clients our art therapists work with are nonverbal to moderately nonverbal. It's important that the clinicians working with them understand the impact of art materials that are chosen and that the materials are appropriate for specific needs and emotional processing for their safety and proper care. Advocating for those clients that may not be able to voice their distress is important and placing value on the training and understanding of arts therapy assessments, intervention and skill utilization is how we can do that, within this bill, by defining who can state they provide art therapy specific services. From our art therapists, I have learned that clients can be greatly impacted by art materials. Some examples include a client with sexual abuse trauma history being asked to use white glue, may be emotionally triggered by that experience or a child with autism spectrum disorder and nonverbal presentation being asked to paint about their feelings at certain times, can lead to overstimulation. Utilization of art within therapy will continue to occur as a tool and this bill will not present-- prevent that at all, but trained art therapy providers are significantly different from traditional talk therapy providers in the way those materials are chosen and provided to each individual. The clients our art therapists have worked with in Nebraska want to have a clear understanding of the services they are seeking out and utilizing for themselves or their children. Art therapists provide efficient treatment, particularly with patients who have difficulty communicating verbally, with children, survivors of traumatic events, those suffering from grief and individuals struggling with substance abuse. There are currently 33 states that are in the process of recognizing or developing professional art therapy certification and that includes Nebraska. We know that mental health needs are great in our state. LB605 will retain our current art therapists and put Nebraska in a place to recruit more mental health professionals. Thank you for the opportunity to testify. I ask that you vote to advance this bill to General File and I'm happy to answer any questions. Thank you.

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

RIEPE: Thank you, Chairman. My question would be this: in Health and Human Services when, when-- and I think in a paragraph, down under the problem on your handout--

PETRA WAHLQVIST: Um-hum.

RIEPE: --it says, art therapists treat individuals' emotional, physical and developmental disorders. So the question that I have is-- and is this subject to a 407 review?

PETRA WAHLQVIST: Yes.

RIEPE: And has it had that?

PETRA WAHLQVIST: Yes.

RIEPE: OK. That's good. Thank you.

PETRA WAHLQVIST: Thank you.

RIEPE: That's all I have, Mr. Chairman.

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

PETRA WAHLQVIST: Thank you.

HANSEN: Is there anybody else wishing to testify in support of LB605? Seeing none, is there anybody who wishes to testify in opposition to LB605? Seeing none, is there anybody who wishes to testify in a neutral capacity to LB605? Seeing none, welcome, Senator Albrecht back up to close. And I believe, for the record, we do have-- we did have three letters in support of LB605 and two in the neutral capacity.

ALBRECHT: Well, thank you for listening in here. I did send a letter from Jennifer Jackson PHONETIC]. She's from my district. That's why I carried this bill. And she wasn't able to come. Bad weather up north. OK. And this bill was introduced on January 27, of 2021 to Health and Human Service. Again, another that we ran out of time. Too many bills, not enough time to get it being corrected. So-- and as for your question on is it covered by insurance, I would certainly have to call and check with insurance companies. I would, certainly, think it would be if we're going to make them a practitioner in the field, but I would think-- I would probably call HHS. I don't know, but I'll figure it out and let you know.

HANSEN: OK. Thank you. You know, I was wondering, because since they're under mental health now, as opposed to their own field, though, that might make a difference in how they get covered, if it's medically necessary.

ALBRECHT: Um-hum.

HANSEN: So I was kind of wondering about that. And that might change the fiscal note, then.

ALBRECHT: Yeah.

HANSEN: Maybe. I don't know. If they are.

ALBRECHT: Yeah, because I looked at the fiscal note and I didn't see that.

HANSEN: Yeah, I noticed that. I didn't notice that either. I thought they would have put that in there. But

ALBRECHT: And I don't know what the protocol for that would be, so.

HANSEN: Any other questions from the committee? All right. Seeing none, thank you very much. And that will close the hearing on LB605 and we will open-- OK. Before we open for LB605-- LB657, we'll take a short five-minute break and see when Senator McDonnell gets here.

RIEPE: He comes here and the room's empty, he'll wonder.

HANSEN: And we can stretch your legs for, like, 2 seconds. Yeah, about 5 minutes.

[BREAK]

HANSEN: All right. We will now open the hearing for LB657 and welcome Senator McDonnell, to open.

McDONNELL: Thank you, Chairperson Hansen and one member of the committee. And so, we've got quality, not quantity.

HANSEN: That's right.

McDONNELL: Thank you. My name's Mike McDonnell. I represent Legislative District 5. M-i-k-e M-c-D-o-n-n-e-l-l. I'm here today to present LB657. This committee deals with a great many bills that directly impact life and death. LB657 is one of those bills. This bill

was brought to me by a very unique group of healthcare professionals associated with most, if not all, of our healthcare entities, hospitals and health systems, insurers, clinics and private practitioners, all of which have taken on the most horrendous disease human beings face: cancer. It's not, it's not that we haven't fought the cancer battle as a state on many fronts, some successfully and some not, but today I bring this bill because it is more important now than ever. Cancer deaths have increased dramatically in the last few years, in part because of COVID and the large disease of, of cancer screening and earlier treatment and partly because of the environmental factors, which includes identification of increases in pediatric cancer linked to groundwater contamination. LB657 was, was likely directed to this committee because of the funding source: the, the Health Care Cash Fund. Otherwise, the bill would be in Appropriations Committee. The bill directs $500,000, annually, to the University of Nebraska Medical Center, to provide grant funding to the statewide Comprehensive Cancer Program to link programs and services to Nebraska families facing a devastating cancer diagnosis. I believe there is no better use of the financial resources set aside in the Health Care Cash Fund than to fund these efforts, many of which are directly related to the use of tobacco products. The principal source of this cash fund is tobacco settlement dollars distributed to states into perpetuity. The Nebraska Legislature has unique back-- it-- unique-- back in 1998, because we were the only state that took tobacco settlement dollars and invested them in health for the long term. I appreciate the senators' sense in continuing to protect that defining decision and I can count myself as one of them. The most recent investment report shows the fund is sustainable, with decisions made by the Appropriations Committee on which I have served for the last six years. I also believe there is no better use of $500,000 annually than what this bill would fund. In recent years, cancer has suppressed heart-- surpassed heart disease as the leading cause of death of Nebraskans. This year, more than 11,500 Nebraskans will be diagnosed with cancer. And based upon past statistics, more than 3,500 Nebraskans will lose their battle and die in 2023. Lung cancer has become the number one killer of adults in Nebraska. Cancer has become the number one medical killer of kids in our state. I can't tell you all the reasons why these numbers are accelerating, but I can tell you that if Nebraskans get the necessary information and resources, lives can be saved. There is only one statewide entity that can implement a statewide collaborative effort and it's called the Nebraska Cancer Coalition. You will hear today from three cancer specialists who, in their limited free time, serve on the board of this coalition to

ensure continued outreach, so Nebraskans can learn the facts and make decisions that can serve their-- can save their lives. When this was brought to me and we started having the discussion and you put yourself in a position of someone that just was informed by their physician that they have cancer and the idea of what those resources are available to them and the idea of the services. And for us to have a statewide, wherever that person might be in our state, east, west, north, south, that has that terrible day with their physician that they're going to be, going to be battling for their life, I think that's the least we can do as citizens. We know that the services are out there and there's ways to, to help. And I think this is an opportunity for us to do that. The people that are here are the subject matter experts. They're going to be testifying today. And I'm here to try to answer your questions and I'll be here to close. I also appreciate the, the committee and, and my mistake today with the scheduling and also, the delay of getting here from Appropriations.

HANSEN: Thank you for that opening. Are there any questions from the committee? I might have one. Was this bill drafted with the intent to go to Appropriations?

McDONNELL: Yes. I, I draft every bill with the intent of going to Appropriations. So.

HANSEN: I just, I just didn't know if, like, the language was correct. It says, if it's here. I don't even know if it matters. You'd probably know more than I would. It says, there's-- the area is hereby appropriated $500,000-- Usually, I'm just used-- I'm used to seeing it said-- saying, it is the intent of the Legislature to you know, direct, appropriate-- and does that even matter?

McDONNELL: Well, and I understand why, also, if you look at the work you do in this committee and what we do in Appropriations, but I do believe it, it should be in, in Appropriations.

HANSEN: We have a few of those.

McDONNELL: I understand.

HANSEN: Thank you.

McDONNELL: Thank you.

HANSEN: We will take the first testifier in support of LB657. Welcome.

ALAN THORSON: Thank you. Senator Hansen, Senator Ballard, Senator Hardin, Senator Riepe, my name is Alan Thorson, it's A-l-a-n T-h-o-r-s-o-n. I'm here to testify as a proponent of LB657, on behalf of the Nebraska Cancer Coalition. NC-- also known as NC2, NC2 is the neutral voice of oncology in Nebraska, deliberately organized to include statewide engagement with multiple healthcare systems and clinics, doctors, advanced health professionals, nurses, mental health professionals, public health officials, extension offices, advocacy groups, industry and corporate partners, rural and urban associations and nonprofits, together with cancer patients, caregivers and survivors in all 93 Nebraska counties. Over 225 organizations access NC2's Webinars, educational materials and our social media. Historically, NC2's work goes far beyond any single grant. We require a strong, stable foundation to meet ongoing needs, without interruptions, to address the continuous needs of cancer patients, caregivers, families and at-risk individuals, which are all of us. NC2 provides the coordination that is required to intertwine oncology projects into an all inclusive plan, providing Nebraskans with the support needed to realize our mission, which is connecting people and resources to strengthen cancer prevention, detection and quality of life in Nebraska. By serving as a neutral coordinator, NC2's vision, Conquering Cancer Together, is actualized by bringing partners together for a common purpose and a sense of urgency with rural or urban-- whether rural or urban adults or children, no matter race, ethnicity, orientation or ideological diversity, cancer knows no borders and the Coalition recognizes no boundaries. The Coalition works to meet all Nebraskans where they are, as they are, who they are, in a voice they can hear and trust and respond to. In the handout you received, I provided some statistics along with some graphics. In the interest of time, I can summarize what they show. As we emerge from COVID, we are seeing an uptick in Nebraska cancer cases. Further, we anticipate that we will soon see an increase in the number of cancer deaths and death rates since, typically, death lags diagnosis. Nebraska's-- Nebraskans don't settle for second best. But in cancer management, we are not even average. Nebraska faces the seventh highest incidence of pediatric cancer in the nation and the highest incidence of pediatric lymphoma. We have the 27th highest cancer death rate in males and the 24th highest in females. Incidence rates are lower, suggesting that a higher percentage of cancer patients in Nebraska die of their disease. Except for cervical cancer screening where Nebraska is average, other screenings remain low. As of 2020, only 76 percent of Nebraska women are up to date with mammography, 35th in the nation. We are 32nd in colon cancer screening, with only

70 percent screened. Only 6 percent of Nebraskans have been screened for lung cancer. These dismal numbers serve as the basis for Senator McDonnell's declaration of a cancer emergency in Nebraska. Screening can prevent some cancers and detect others early where they are treatable and survivable. I have a friend with a history of colon polyps. COVID resulted in their missing their scheduled colonoscopy. By the time they were able to get that examination, they were diagnosed with a stage 3 cancer. Extensive education directed to all Nebraskans is key to increasing screening rates, clinical trial enrollment and increasing awareness of treatment alternatives. Funding a statewide cancer coalition able to reach the needs of all Nebraskans in all areas is critical to educational efforts. While serving as president of ACS CAN in the American Cancer Society, I had the privilege of working with many organizations, observing effective approaches to cancer management. I have seen what a neutral entity can accomplish when dedicated to reaching individuals where they are, as they are, with voices that they can trust. I can confidently echo Senator McDonnell's conclusion that, given the opportunity and appropriate funding, the Nebraska Cancer Coalition is the entity that can implement a statewide collaborative effort needed to bring Nebraska to the forefront, rather than the average of cancer management. LB657 addresses the foundational needs for a strong, sustainable, all inclusive approach to cancer management in Nebraska, while leveraging the strengths of our NCI-designated and COC-approved cancer centers across the state. For these reasons, we strongly urge all members to provide support for LB657, both here in the committee and on the Legislative floor. I'd be happy to answer any questions. Thank you.

HANSEN: Thank you. Are there any questions from the committee? Yes, Senator Riepe.

RIEPE: Thank you, Chairman. And thank you for being here. I'm somewhat familiar with the University of Nebraska's involvement with cancer research and they've, they've been at this issue for the last 15, maybe 20 years. And I'm just curious if this supplements this or is this a pick-up from where they're at, in terms of the funding side of it? And--

ALAN THORSON: So this is-- let me see if I can answer your question. This is not research related, only in the sense that, that the funding of this coalition provides an opportunity to ensure that all Nebraskans are educated and understand the availability of treatment options across the state, the availability of clinical trials which

can occur across the state, hopefully close to home, wherever they are, wherever the expertise may reside. But making that knowledge available so that we can do better with our statistics that place us below average, where I think most Nebraskans don't care to be.

RIEPE: So it's not paying for treatment, per se.

ALAN THORSON: It's not paying for treatment, per se. The Coalition is working to make information available to those-- to our, our citizens about the availability of options for screening, treatment and research in the sense there are clinical trials available in this state.

RIEPE: This bill seems to me to cry out for facts. I like, I like, I like, I like spreadsheets. I like-- I'm just, I'm just trying to figure out exactly what it is, just-- and some of that's my fault of-- so many bills that come our way.

ALAN THORSON: Sure.

RIEPE: So, anyway. I appreciate you.

ALAN THORSON: Is there, is there a specific fact that you'd like me to address?

RIEPE: No, I just-- I don't know what the availability-- where there are trend lines and facts and, and to really kind of clarify what the problem is, what's the degree of the problem and what's been accomplished there successfully in the past? You know, President Biden has pledged that he's going to cure cancer, so I'm kind of going off that, too.

ALAN THORSON: So, as you know, many different organizations are working on the cure, doing the research to approach the cancer issue. The purpose of our Coalition is to make sure that, that the citizens of Nebraska have an opportunity to take advantage of those issues.

RIEPE: Cancer is such a broad-- I mean, there's so many different cancers.

ALAN THORSON: Yes, sir.

RIEPE: And so, it's a very broad sweep. OK. I appreciate it. Find it intriguing. Thank you.

ALAN THORSON: Thank you.

HANSEN: Senator Hardin.

HARDIN: I apologize. I wasn't here for the beginning of Senator McDonnell's introductory remarks. Came in towards the end of that. But is there a spike, you're saying, in the cases we're seeing in Nebraska right now? And if there is a spike, is that related to proactive steps that people were not or could not take during the two years of the pandemic?

ALAN THORSON: So the, the data is suggesting that the, the number of missed screenings that were-- occurred during the pandemic are now contributing to diagnoses of cancers that may have been caught during screening, during that period of time. Some of those cancers are presenting in a more advanced stage, when they're not as treatable as they would have been prior to that, to the pandemic. So we are seeing-- right now, we're starting to pick up and you can see in my graphic, beginning from 2019 to 2023, we have this upward trend in the cases. We're not seeing so much of a trend yet in deaths. But as I said, deaths tend to follow.

HARDIN: Related to the game.

ALAN THORSON: --diagnosis if you-- it takes the, the time and we anticipate that's going to happen also. So it's critical that we get people back to screening and get back on that schedule. That's part of-- that's one small part of what we would do. You know, we are a very all-inclusive coalition, so we work not only on the screening side of things, but we work on other educational efforts, also, including making citizens aware of, of treatment, treatment alternatives, making Nebraskans aware of the availability of clinical trials, which is so important to our ultimate understanding and successful treatment of cancers in the future.

HARDIN: Just curious about the pediatric oncology needs in our state. Can you just speak broadly on that, in terms of how come we have such high cancer rates for kids?

ALAN THORSON: So those-- I think that's-- I would say that my understanding is that's not clear. I believe that there is a bill to look for appropriations to help study that problem more in the state, because we know there are some associations that may be important, but we don't have-- as I understand it. I'm not a pediatrician, so I'm

going a little bit on information that comes to me through other channels that you probably, actually, have access, also. So it is a problem. As I said, we have, I believe, the, the seventh highest rate of pediatric cancer and the highest of pediatric lymphoma in the nation. So those are two issues. We also have an issue with tumors of the brain-- brain tumors. But again, I'm not an expert in that area at all. So we can get more information to you from some of our experts if you'd like us to do that.

HARDIN: I would.

ALAN THORSON: OK. We'll work on that.

HARDIN: Thanks.

HANSEN: Any other questions? I would assume it's probably coming from pesticides, wouldn't you think? Because-- didn't they just lose, lose a big lawsuit because they have Hodgkin's and non-Hodgkin's lymphoma and glioblastoma they found in people from Roundup?

ALAN THORSON: I can, I can--

HANSEN: I'm going to, I'm going to have you speculate on the record. No, you don't have to say anything. I'm just--

ALAN THORSON: So, all I can say is association does not always equal causation. So until we can prove all those things and, and I would say that lawsuits don't always make the correct association. You just don't know. I mean, there's lots of data out there. And so I'm not an expert on that either. I'm sorry. I wish I was. I wish I could answer that for you.

HANSEN: That's just fine. I just--

ALAN THORSON: OK.

HANSEN: --you know, start talking when I'm--

ALAN THORSON: Sure.

HANSEN: --thinking of something.

ALAN THORSON: I love to talk.

HANSEN: Another thing with the, with the, with the graph that you shared. I thought that was kind of interesting, cause we're seeing

cancer in Nebraska almost-- on that-- you know, either trending even or going down [INAUDIBLE]. And in 2019, all of a sudden, it just starts going right back up there, which I think is kind of odd. And it's not like-- if it's missed screenings, I would think it would be kind of up and then, coming back down again. You know, back in 2021, when people were starting to get back in the hospital again, screenings would, then, come back in and things would start to go back down, but it's like a continuous trend upward.

ALAN THORSON: So.

HANSEN: Do you think that could also be from the fact that now, we have a lot more people working from home? You know, they're not moving, unhealthy lifestyle, do you think that might be a big part of it? Because we have a lot more people not going-- getting up, going to work and others have-- sit at home.

ALAN THORSON: I would only suggest that those types of activities probably take a longer term to have effect. I do think that if we can get people back to screening again, that we will see the, the, the case rates, hopefully, go-- start going back down. The case numbers, actually, because of the aging population and the increasing population, unless we can actually stop cancer, there's always a tendency for the case-- number of cases to keep going up.

HANSEN: OK.

ALAN THORSON: OK.

HANSEN: If I can ask one more question.

ALAN THORSON: Sure.

HANSEN: I'm going to put my, I'm going to put my tinfoil hat on for a second.

ALAN THORSON: OK.

HANSEN: Do you think it could be from COVID vaccines?

ALAN THORSON: So again, I--

HANSEN: I've had people ask me. I got, I got-- this is emails I get and so-- I got you in front of me.

ALAN THORSON: --I don't-- yeah. So all I can say is that I'm not the expert to be able to answer that question for you. I think-- I would only say that I think that's a question that should not be ignored. It should be studied and we could see if there is any association.

HANSEN: OK.

ALAN THORSON: That's, I think, where we should be at.

HANSEN: Appreciate that. Thank you for that. Any other questions from the committee? Thank you very much. Appreciate it. We'll take our next testifier in support of LB657. Welcome.

JOSHUA MAMMEN: Afternoon, Chairperson Hansen and other members of the committee. My name is Joshua Mammen, J-o-s-h-u-a M-a-m-m-e-n. I'm honored to testify in front of this committee in, in support of LB657. I think we're at-- really at an exciting juncture on our war against cancer that President Nixon declared, way back in 1971. I'm a surgical oncologist, a cancer surgeon, with nearly 20 years of experience in treating a variety of cancers. In addition to having the privilege of caring for patients with cancer, I've also been involved in the last decade in working on strategies to reduce the burden of cancer in the Midwest-- initially in Kansas for more than a decade and now, the last couple of years in Nebraska. Today, I'm speaking as an individual, not representing my employer. But I want to note that I recently joined the board of NC2, since I'm excited about its mission to address the problem of cancer in our state. Unfortunately, as you may know, 1.9 million fellow Americans were diagnosed with cancer in 2022 and almost 610,000 Americans succumbed to cancer last year. Incredibly, though, we've started to turn the tide. Between 1991 and 2020, the death rate from cancers declined 33 percent, which was quite remarkable. While much of this reduction can be attributed to the near miraculous new treatments that are more effective and less toxic, I think that the other key strategies to reducing the burden of cancer in our country have likely played a larger role, including techniques to detect cancer in an earlier, more treatable stage like low dose lung CT scans and stool DNA tests and measures to reduce exposure to carcinogens, like smoking cessation strategies. Unfortunately, in Nebraska, as you've heard, our incidence of cancer is higher than the national average, in particular, our incidence of melanoma and prostate cancer are dramatically higher than other parts of the country. Furthermore, while cancer mortality rates have declined nationally, our mortality rates in Nebraska, while improved, have not improved to the same extent as other part of, parts of the country. As you may surmise, our

attempts to address the scourge of cancer requires a multifaceted approach built on the foundation of strong partnerships. This proposed bill will provide much needed assistance to help strengthen that network of partner organizations across our state. LB657 leverages the strengths that we have in our state of an NCI designated cancer center with a dedicated group of other organizations, committed to reducing the burden of cancer in our state. The organizations have both the expertise and the passion and the reach to understand the needs of Nebraskans who are at risk of cancer or have cancer and a deep knowledge of the resources available and the ability to move the needle in our state. This bill is very different than bills that appropriate, perhaps, for research or for treatments per se. This bill really leverages outreach to the community and focuses on community organizations and partnerships. I'll provide you a small example. One is with colon cancer screening, which is one of the main ways, as Dr. Thorson had alluded to, to reduce the rate-- you know, not only diagnose cancer early, but also reducing the rate of cancer by removing polyps ahead of time. As you know, individuals above the age of 45 are supposed to get screened for colon cancer, either with a stool FIT test or with a colonoscopy. In Nebraska, our screening rate for individuals 50 and above who are eligible for colon cancer screening, the rate is only 66 percent. The American Cancer Society had aimed for 80 percent by 2018, and we're far behind the curve in that attempt. So organizations like NC2 or NC2 with other partner organizations work on those type of efforts, by educating Nebraskans about the importance of colon cancer screening. Their attempts, like sending postcards on the individual's 45th birthday and saying, hey, it's-- happy birthday, but it's time for your colonoscopy. Maybe not exactly the birthday card that you want to get, but, you know, it's those type of efforts that make a difference in public health and in colon cancer care. Similarly, there are programs that can be sponsored, like flu/FIT programs, where you get a flu shot and you get a FIT test, which is a colon cancer screening test, on the same day. Those type of programs are supported by partnership-type organizations like NC2. So in terms of tangible benefits, those are the benefits that happen. It's not necessarily more research. We honestly know a lot of great ways to treat and identify cancer early. Now it's really getting it out into the community, to the areas of the state that need that type of help and that type of information. Thank you, again, for the opportunity to testify on behalf of this bill and I'm happy to answer questions.

HANSEN: Thank you. I'm 43 years old, so I got two years. I'll be looking for that card and so. Senator Riepe.

RIEPE: I was going to say, serving on this committee may be tantamount to having had a colonoscopy. I have-- thank you, Mr. Chairman. Thank you for being here. I guess I look at this and say, well, on the melanoma being higher than others, you know, we are an ag state, so we have a lot more people out there that-- exposed every day. And also in colonoscopies, we're, we're a beef steak. We-- nutritionists would tell you we eat too much beef, if I can say that without getting run out of the state. My other, more serious question would be is, is this a match for many federal-- the $500,000? Is this a match with another-- some federal moneys or-- that you're aware of?

JOSHUA MAMMEN: It is not a match with any federal money, but it is a opportunity to leverage. The reality is this leverages the expertise that other organizations have which have their own funding, meaning that $500,000, by itself, actually has a multiplying effect, because the other organizations with their own funds are able to collaborate together and leverage the total amount of funds for running programs in a coordinated fashion throughout the state. So it's not a match with any-- I couldn't point to a line item from the federal, from the federal budget or from any specific other organizations. But I can say that organizations, like the American Cancer Society and many other cancer foundations, will partner together or have-- do partner together with NC2 to put on all of these programs to be able to reach out into all aspects of the community. And that's the real benefit of, of the funding of an organization like this. If I could also answer the question about melanoma is, I would say you're, you're exactly right, that because of the sun exposure of many of our, our farm-- farmers and ranchers, we do have a higher incidence of melanoma, but we do have an opportunity to reduce that rate despite that. And part of that's learning about sun protection strategies, which, admittedly, not everyone is necessarily open to, but it's also about allowing for skin cancer screening programs to exist throughout our state. Because like colon cancer, if you can shave off that mole before it becomes melanoma, then, perhaps, you can make a, a difference in that instance, as well. So those are the type of programs we're hoping to really disseminate throughout the state.

RIEPE: May I ask one [INAUDIBLE]? Are you familiar with-- there's a piece of equipment-- I'm doing consulting piece in Texas [INAUDIBLE]. But it-- it's screening for melanoma in rural areas where they don't have a, you know, dermatologist to or-- but you have to-- it has to be

under the supervision of a dermatologist. Do you have any experience with that kind of technology to maybe-- again, going after early identification?

JOSHUA MAMMEN: You know, I, I--

RIEPE: Maybe it's done by a clinical nurse practitioner, as opposed to a dermatologist.

JOSHUA MAMMEN: And you're exactly right. Those, those type of technologies are really exciting, because you may not have a specialist, a dermatologist, in every exact location. I've heard of those being used as trials. I haven't seen any of them actually being used in, in practice, but they're very intriguing because they may allow for, essentially, specialist expertise to get into places where it's harder to reach right now.

RIEPE: This is-- you know, my experience or my interim piece was within a rural community, but the firm would not sell it to the clinic. You had-- they would only sell it to a dermatologist.

JOSHUA MAMMEN: Oh.

RIEPE: And we didn't have a dermatologist right there and so, it was a catch 22, if you will. But yet, with a lot of cattle ranchers and stuff like that, we desperately needed better access to make people more likely to come in and do it or make it a part of their annual exam.

JOSHUA MAMMEN: And if I-- if you don't mind, I--

RIEPE: Sure.

JOSHUA MAMMEN: --if I could make another comment. One of the things we do do quite actively is go to where they are, right, to, to events where ranchers and farmers are attending anyway, to provide awareness and we do that on a regular fashion already. Awareness is part of the piece, but then you also have to provide the situations where screening could happen, as well.

RIEPE: If we're in a-- may I have one more?

HANSEN: Sure.

RIEPE: If we're in a restaurant together and you saw a mole on the, maybe, the side of my head, would you come up to me and tell me I need to see a--

JOSHUA MAMMEN: I certainly would hope to do that. Absolutely.

RIEPE: Oh, good. I'd appreciate it. Thank you.

JOSHUA MAMMEN: But I would also probably recommend seeing a dermatologist pretty soon thereafter.

RIEPE: OK. So you wouldn't take the steak, steak knife and--

JOSHUA MAMMEN: No.

RIEPE: --go after it.

HANSEN: Any other questions from the committee? So this is a joy we get from having experts in front of us in health all the time. We just like-- we get free medical advice, so. [LAUGHTER].

JOSHUA MAMMEN: That's what, that's what it's about.

HANSEN: The next time he's in a restaurant you can watch out for him. Senator Hardin.

HARDIN: This just-- more of an opportunity, I guess, to comment, but I just reflect on your autobiography here and-- contained in the first paragraph or so and you came here in the midst of the pandemic, it looks like, a couple of years ago.

JOSHUA MAMMEN: I did.

HARDIN: And you're an expert at what you do in oncology. I'm both honored and thankful that you're here, as well as a little alarmed that you looked around the country and said, there's a cancer spot that really needs a lot of help. I think I'll go there. Can you just comment on some of these big numbers that you're seeing in Nebraska, related to melanoma or related to prostate? Perhaps what we talked about before, with Dr. Thorson and children, what are we getting wrong here in our little state of 2 million people?

JOSHUA MAMMEN: You know, I completely agree with you that the numbers are, are alarming. But I, I, I would argue that-- I'll probably put a positive spin on this, that I would say the reason that I came here is

I saw that there-- we had organizations here that are remarkably committed to the health of the state. And that's really, actually, what drew me. The-- obviously, my employer, which I'm trying to avoid naming, is, you know, really committed to the care of, of Nebraskans. And I, and I saw that very early on. I, I have to admit, I came from a pretty, pretty nearly identical leadership position in my previous organization, because I saw the opportunity here to really be able to make a tremendous difference, because of the resources that were being committed to improving cancer care in the state. In addition to that, I'll also want to acknowledge that I've known Dr. Thorson for more than a decade. And, and I also knew of the work of NC2, prior to moving to Nebraska and I knew the tremendous efforts and work that NC2 was doing. I had no intention of joining the board. That wasn't the, the reason for moving here. But pretty quickly after I came to Nebraska, I asked to participate in their activities, because I realized how important it was to be able to reach out to other parts of the state.

HARDIN: Thank you.

HANSEN: Any other questions? Senator Ballard.

BALLARD: Yes. Thank you for being here, Doctor. Can you help me wrap my mind around this program? So what would it, what would it look like? So maybe I'm, maybe I'm getting at why does this have to be a reoccurring annual appropriation? Why isn't it just one, one appropriation for the program and then that's-- then we're done?

JOSHUA MAMMEN: Sure. Yeah. No, I think it's important that it be an-- annual. And the reason it's annual is because these needs are going to be annual, meaning that once we, for example, have a program about skin cancer awareness, let's say, or about colon cancer awareness, there, there's a need to be able to sustain those programs and repeat the, the programming, as well. Because, unfortunately, individuals tend to be committed to or learn from that messaging for a limited period of time. And then, unfortunately, in order to sustain that behavior of, you know, yes, you need to go to that colonoscopy five years from now, as well, there's a need for that reeducation afterwards, as well. So, unfortunately, I, I wish I, I could say that, you know, one event to say that you need to go for breast cancer screening would be enough, and then we'd be done and women would go get their mammograms, let's say, or that individuals would go get their colonoscopies regularly, afterwards. But unfortunately, there's an importance of that continuous messaging, as well. And then, also,

there are individuals that will become of that age, as well, meaning every year another group of individuals will become 45 and need colonoscopies or another group of women will become 40 and need to start mammography. And I think there's going to-- need for, for that type of education on a, on a continuous and sustaining basis.

BALLARD: OK. Thank you.

HANSEN: All right. Seeing no other questions, thank you for your testimony.

JOSHUA MAMMEN: Thank you.

HANSEN: Anybody else wishing to testify in support of LB657? Welcome.

JOEL MICHALSKI: All right. Thanks. Chair Hansen and members of the Health and Human Services Committee, my name is Joel Michalski, J-o-e-l M-i-c-h-a-l-s-k-i, M.D., Ph.D. I'm a medical oncologist and I practice here in Nebraska and I see and treat patients from all across this great state. Thanks for the opportunity to speak about two things that I find very, very passionate: caring for patients that have cancer and supporting the great state of Nebraska and the people that reside in it. Despite all the advances that we've had in cancer care, we know that these powerful tools are only helping the patients that are able to find them. We all know that barriers exist for many of our citizens, particularly if they live in rural communities or if they are from backgrounds that have traditional healthcare disparities. In rural Nebraska, our primary care providers are the first line of defense. The further from a large city somebody lives, the more a primary care provider has to take on in order to care for those patients, which is a testament to their abilities and their dedication to their patients in their communities. However, navigating the complicated landscape of oncologic care can be difficult. Lung cancer-- I'm sorry. Cancer screening guidelines are constantly changing and new tools, such as lung cancer screening, are being added. Despite these good screening tests being available, they are often underutilized. As we've discussed before, for example, for lung cancer, only 5-6 percent of Nebraskans are actually enrolled in those programs. To put things in example-- in perspective, Iowa is twice as good as we are. The best person to really educate and empower a patient regarding these screening tests as a trusted physician. We need to make sure that those providers have got the tools and the knowledge to make those screening tests actually happen. Effective screening will definitely save lives. Similarly, helping our

procedurally based specialties, such as gynecology, pulmonary and surgery, stay up to date on these recommendations will help any abnormal screening tests actually be evaluated, both efficiently and appropriately. As we all know, a good screening test is only as good as the follow through is going to be. Although many of these screening tests have been around for quite some time, the COVID pandemic has, unfortunately, hamstrung our efforts severely. This was an urgent issue before and because of this pandemic, we are now dealing with a population-based oncologic emergency. We need to get patients caught up. I'm not actually able to go many days in my clinic without seeing a patient that's been diagnosed late because of COVID-related delays. It's a real thing and we need everybody available to make sure that we're able to mitigate the so many countless missed opportunities. Oncology is a rapidly advancing field and ensuring Nebraskans have access to clinical trial opportunities is important. Many of Nebraskans, due to their geography, they're just unable to access these important clinical trials and we must do better than that. Cancer moves fast and the state of the art of cancer care is moving equally fast. Nebraskans deserve an agile entity that can bridge and partner with health systems, payers, private practices and state and local agencies, in order to support patients and providers when it is needed and importantly, where it is needed. With support from LB657, Nebraska Cancer Coalition is ready to be this entity. I proudly serve on this board for many reasons. I'm passionate about helping Nebraskans struggling with all stages of a terrible disease. But equally important, I am an Nebraskan. I've been supported by this great state my entire life. I was educated in Omaha through the public education system. I'm a graduate of a state college and I was supported, both academically and financially, as I pursued my dual doctorate program with the University of Nebraska Medical Center. I view my education and training as a true gift. And I really want to make sure I'm able to pay that gift forward many times over for the benefit of my community. And C2 is a worthy organization of countless people that are willing and dedicated and have support, in some degree, from a lot of their partnering health systems. And with support from this bill, I think we can do much better and get caught up. Thank you for your time. I'd be happy to answer any questions.

HANSEN: All right. Thank you for your testimony.

JOEL MICHALSKI: Yeah.

HANSEN: Are there any questions from the committee? Seeing none-- oh, maybe. Senator Hardin.

HARDIN: Well, I was going to pose the same question, I guess, that I asked a little bit earlier. And just to get another perspective on it--

JOEL MICHALSKI: Sure.

HARDIN: --talk about why we have some really high rates in our state.

JOEL MICHALSKI: Yeah. You know, I think underutilization of screening tests is a big part of it. And as we discussed before, COVID is not helping that. My two patients last week I saw, diagnosed with late stage breast cancer because of a missed mammogram and colon cancer, as well. So these are real things and, and real issues that I'm seeing frequently. And to kind of get back to some of the statistical questions that were posed previously, I think it's going to take several years for us to actually be able to prove, with some sort of number, what we're actually seeing, as far as missed opportunities from the COVID epidemic. So.

HARDIN: Do we have a guess, in terms of when we'll kind of work that wrinkle out of not having done screenings proactively for two years?

JOEL MICHALSKI: Yeah. That's a great question. So, you know, for example, for colon cancer, you know, the screening is also preventative. So if you find a polyp at an early stage, you're able to remove it and prevent that colon cancer. Colon cancer takes several years to develop. So the lag period could be several years for colon cancer. I don't think it's a good idea for us, unfortunately, to wait until we have the statistics before we move forward. I'm seeing this happening today. It would be nice to be able to get all hands on deck today. And the support of this bill will help us do that.

HARDIN: Thank you.

HANSEN: All right. Seeing no other questions, thank you very much.

JOEL MICHALSKI: I appreciate it, you guys. Thank you.

HANSEN: Good evening.

JERRY STILMOCK: Good afternoon, Mr. Chairperson, members of the committee. My name is Jerry Stilmock, J-e-r-r-y Stilmock, S-t-i-l-m-o-c-k, testifying on behalf of my clients, the Nebraska State Volunteer Firefighters Association, the Nebraska Fire Chiefs Association. Those organizations have over 9,000 members, men and

women volunteers serving throughout the state. One thing that is very clear from the associations, their directive to me, is to be involved in cancer legislation. It's very important to the volunteers and it's both for structure fires and for wildfires. And the statistics have shown that the incidence of cancer among firefighters is, is growing. It's a great concern. The, the membership-- one of the things that's happening in, in construction is the different types of products that are being used to build homes, to build furniture. Those items are carrying carcinogens. And the detail that the fire service is going through is so serious that they've developed a 11-step best practice of how to care for oneself after an incident of fire. It-- it's, it's a very big deal. And the more that the, the volunteer fire service members know and be able to prevent the whole idea of exposure to the skin and, and repetition of fires is of great concern. And that's why our associations are here this afternoon in support of what Senator McDonnell has introduced in LB657. Support the measure and I'd urge the committee to advance it to the full Legislature. Thank you.

HANSEN: Thank you.

JERRY STILMOCK: Yes, sir.

HANSEN: Are there any questions from the committee? Seeing none--

JERRY STILMOCK: Very well.

HANSEN: --thank you very much.

JERRY STILMOCK: Thank you, gentlemen, lady.

HANSEN: Is there anybody else who wishes to testify in support of LB657? Seeing none, is there anybody who wishes to testify in opposition to LB657? Is there anybody who wishes to testify in a neutral capacity to LB657? All right. Seeing none, we'll welcome Senator McDonnell back up. And before he starts, I believe, we did have four letters of support for LB657.

McDONNELL: Thank you, Chairperson Hansen. Thank you for everybody that, that came to testify today and again, the work they do on a daily basis for the citizens of Nebraska, trying to answer some of these questions and, and look at what we're doing here. If we look at a half a million dollar grant, a $500,000 grant, UNMC, you have an opportunity to have programming and services throughout the state and bring them together, have a comprehensive program, statewide, that links everything together. That's what we're trying to do. There's

things going on. And, and with the idea of-- again, knowledge is power. Knowledge is power, that if we can do this and make sure that everyone understands-- sometimes it takes a tragedy, where a family, friend, neighbor just went through a, a battle with cancer. And all of a sudden, you, you take a step back and say, what should I be doing differently? Or again, as I mentioned in my opening, that-- where that, that physician just sat you down and said, you're-- you now are going to have to battle for your life with, with-- against cancer. So the idea of having that one point in that comprehensive, where people can look and see those programs and services, it's-- the $500,000 isn't going to make the, the difference on its, on its own if it was just trying to, actually, do all this work. It's actually saying that throughout the state, all these different organizations that are working to prevent cancer and knowing that there's these programs out there and services, it's bringing them all together. And that's, that's the goal of this legislation.

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

McDONNELL: Thank you for your time. Again, I apologize for being late earlier and also, screwing up your schedule, which I will make sure I have plenty of donuts in the morning for everyone. Thank you.

HANSEN: That will conclude our hearing for LB657. And that will conclude our hearings for this evening.