

Transcript Prepared by Clerk of the Legislature Transcribers Office
Heath and Human Services Committee February 28, 2025

HARDIN: Hey, we're going to get rolling. Welcome to the Health and Human Services Committee. I'm Senator Brian Hardin representing Legislative District 48, and I serve as chair of the committee. The committee will take up the bills in the order posted. This public hearing today is your opportunity to be a part of the legislative process and to express your position on the proposed legislation before us. If you're planning to testify today, please fill out one of the green testifier sheets on the table at the back of the room. Be sure to print clearly, fill it out completely. Please move to the front row to be ready to testify. And when it's your turn to come forward, give the testifier sheet to the page. Can I ask how many of you are going to be testifying on 701? Awesome. Just as folks get done, kind of feel free to move up during those transitions to the front would be awesome. We'll do that on all the bills. If you do not wish to testify, but would like to indicate your position on a bill, there are also yellow sign-in sheets back on the table for each bill. These sheets will be included as an exhibit in the official hearing record. When you come up to testify, please speak clearly into the microphone, tell us your name-- and this is the part everybody forgets, spell your first and last name and ensure we get an accurate record. We'll begin each bill hearing today with the introducer's opening statement, followed by proponents of the bill, then opponents, and finally by anyone speaking in the neutral capacity. We will finish with a closing statement by the introducer if they wish to. We will be using a 3-minute light system for all testifiers. When you begin your testimony, the light on the table will be green. When the yellow light comes on, you have 1 minute remaining and the red light indicates you need to wrap up your final thought and stop. Questions from the committee may follow, which do not count against your time. Also, committee members will come and go during the hearing. That has nothing to do with the importance of the bill. It just means we're leaving to do what Senator Spivey is doing here. We're going to someone else's committee to do that some-- somewhere else. So a few final items. When you come up and you have copies of your testimony or any other handouts, please bring at least a dozen of those. Give those to the page. Props, charts, or other visual aids cannot be used simply because they cannot be transcribed. Please silence or turn off your cell phones. Verbal outbursts or applause are not permitted in the hearing room. Such behavior may be cause for you to be asked to leave the hearing. Finally, committee procedures for all committees state that written position comments on a bill to be included in the record must be submitted by 8 a.m. the day of the hearing. The only acceptable method of submission is via the legislature's website at

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nebraskalegislature.gov. Written position letters will be included in the official hearing record, but only those testifying in person before the committee will be included on the committee statement. I will now have the committee members with us today introduce themselves, starting with Senator Fredrickson.

FREDRICKSON: Oh, yeah, there's no one over there. John Fredrickson, I represent District 20, which is in central-west Omaha.

MEYER: Glen Meyer, District 17, northeast Nebraska, it would be Dakota, Thurston, Wayne, and the southern part of Dixon County.

QUICK: Dan Quick, District 35, Grand Island.

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

HARDIN: Also assisting the committee today, to my left is our legal counsel, John Duggar; to my far left is our committee clerk, Barb Dorn. Our pages for the committee are Sydney and Tate, and they were having a difficult philosophical discussion earlier, so keep them in your prayers. Today's agenda is posted outside the hearing room. And with that, we will begin today's hearing with LB701 and Senator Spivey.

SPIVEY: Thank you, Chair Hardin and members of the HHS Committee. It's good to be in front of you again. I am Ashley Spivey, A-s-h-l-e-y S-p-i-v-e-y, representing District 13 in northeast and northwest Omaha. Before I start, I just wanted to let you know that you have in front of you in a little blue folder some handouts that I think are going to be really important as I'm speaking, please follow along, but it has a one-page synopsis of what this bill does and also under the chart on the front it has information based on the counties that you all represent around maternal health vulnerability. There is a study from the Nebraska Perinatal Quality Improvement Collaborative around doula support. There's also an article that has an overview around nationally what we're seeing around doulas, as well as the bill language and an amendment that I will talk about later in my opening. So I am excited and proud to introduce LB701, a bill that defines full-spectrum doula services, and requires the Department of Health and Human Services to establish and work with a multidisciplinary stakeholder group to create a state amendment plan to reimburse doula services for pregnant people on Medicaid. So we are in a maternal health crisis in our state, 9.4% of people lack access to health insurance, 11% of the population live in poverty, 19-- or Nebraska

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ranks 19th in maternal death or mortality rates. Our preterm birth rate is 11%, and 93 of the deaths that we are seeing around maternal care are deemed preventable by the Maternal Mortality Review Committee that is ran by HHS. And so these statistics really paint a true reality that doesn't necessarily have to be this way. We are navigating unprecedented times around folks being, being able to access prenatal care, being able to have the resources that they need to be able to have and raise a family in the way in which they want to. And so this bill is important because doula care is one effective intervention to help improve these outcomes. And so for the purpose of this bill, a doula is defined as a trained professional who provides emotional, physical, and informational support for individuals during, before, and after labor and birth. This is-- includes, but is not limited to, attending prenatal visits, support during delivery, and providing resources during the postpartum period. I can say that there are lots of different types of doulas, so I want to be clear. The definition that we provided in the statute is related to what we are trying to accomplish with the bill. And so while there are other definitions that live there, doulas can really help you in different types of-- and navigate different types of health experiences. We're talking about the perinatal spectrum and course. As of January 2025, there are 13 states and Washington, D.C. that have opted to cover doula services under Medicaid. There are also nine additional states that are in the process of implementing coverage. And so to become a doula, there are lots of different types of certifications that you can take or learnings. There is no mandatory licensure, certification, or credentialing requirements because this is not a medical provider. So I want to underscore that, this is not an OB, this is not a nurse, this is a companion or a trained professional that is working to support and be an advocate. And so that's why there is not a broad managing or oversight committee or process, which we want to keep it that way. That person will go through whatever training is best for the practice that they want to have, and then they will then start to provide those services based on their training. Some states that have implemented Medicaid coverage, they specifically have requirements for what they want to see or competencies to be eligible to receive Medicaid reimbursement. So it really is specific to that geography, which I think is really important because it allows for that to be responsive to the field of what they're trying to achieve. Some states, for example, they will have a list of approved trainings or certifications that a doula could have. And then other states, they just say bring that, that certification, we'll review the competencies to say that you are an approved provider to receive Medicaid reimbursement. So with LB705 [SIC], this would require HHS to work

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with a diverse, interdisciplinary stakeholder group to develop and implement what are those competencies? What do we want to see in Nebraska? And then what is our state amendment plan? And I think that's really important. And why we didn't prescribe it in the bill is because we want people that are closest to the issue, that are closest to the work, to be able to work in partnership with HHS to create it. We don't want to over complicate the process. We don't want to over mandate and have that oversight. And so as you look at the bill and, and the, the verbiage, we outline some specific identities and skill sets that need to be present. But, again, HHS has autonomy to put that together. It's a statewide stakeholder group to then decide what does reimbursement look like under Medicaid. This model has been tested. There is a program in Nebraska called the Doula Passage Program that was a cross-sector collaboration with Charles Drew Health Center, the Nebraska Perinatal Quality Improvement Collaborative, Nebraska Medicine, CHI, and community-based doulas and organizations. And so they put together a training program around the competencies and what does it look like and the doulas that are trained in that-- in the program are currently being hired by direct service providers. They are currently participating in two doula pilots with MCOs, or Managed Care Organizations, that I'll talk about in a minute. So we have seen some proven track record here in the state. And so I bet you're wondering now, like, well, how does someone get a doula? Right? And so doulas operate their own practices. They are 1099 employees. They are business owners. They are operating the services that they want to provide. And so that person that is pregnant and that family, they decide, OK, this is, this is what I want in a doula. I want someone that has experience in infant feeding or I really want someone to support us postpartum. And so they would interview this person like they would do any other contractor or service provider. They usually engage in some sort of written contractual agreement that outlines what that person is providing for that fee. Currently, because there is not a reimbursement mechanism, private pay or with insurance then they would have to pay out of pocket. And so we know that a majority of births are on Medicaid, and so the reimbursement mechanism will allow for people that need perinatal support through their birth journey to get that without the fee or that cost to be a barrier. I am-- in, in community, there are conversations with private pay providers being able to offer this for their members. But, again, I think this is what we're seeing nationally is because of the majority of births that are on Medicaid, that this service should be offered to those members. And then a lot of people use word of mouth as those doulas are marketing. So, like, as people are pregnant, they talk. And so who have you used? What does that look like? And they're able to

make recommendations. And so most commonly the services that you see a doula provide are around birth planning and preparation. So this could be a birth plan. What do I want my birthing experience to look like? I actually had a doula for my youngest son, who is now almost 2.5, and so we made the birth plan that my husband was going to catch the baby, which he did, and then my doula was going to hold my hand. And so I had someone to scream up, up here, and somebody is handling the stuff with the baby. And so we, we worked on that plan and that doula made sure that I was able to communicate that in an effective way to my OB, so that everyone else on my care team understood what I wanted and was able to honor that. Doulas also provide a network of resources related to pregnancy and postpartum period. So that pregnant person has a question about something or they're, they're not sure about something, they help to pull together the information so that person can make the best decision. They are not giving medical advice but making sure that that person has the resources and all pertinent, relevant context and make the best decision for them, their pregnancy, and their family. They can attend the actual birth so that person decides. And so as like-- as I mentioned, my doula attended the birth and they act as a support for that family and that pregnant person. And then, again, they also can support postpartum. So it really is where you're able to work with that, that advocate and that companion directly to say this is what I need in my pregnancy and this is how you support. I can say during a pregnancy everyone is concerned about the baby and this-- which is valid, right-- but this person is really concerned about that pregnant person to make sure that they're honoring their mental health, their physical well-being to ensure that, again, they are in a, a good space so that they can, again, ensure that their children are as well. So studies have shown that doula support during pregnancy, birth, and postpartum are linked to improved maternal and infant health outcomes. So, for example, doula-assisted mothers were four times less likely to have a baby with low birth weight, two times less likely to experience a birth complication for the mother or the baby, significantly more likely to initiate breastfeeding, and receiving care from a doula is also associated with reports of positive birth experience. Like, they just actually enjoyed their experience and it wasn't traumatic. Additionally, and very importantly, doulas can help address the health-related social needs of a mother, including referrals to social services to community health workers, transportation, housing, and food assistance. They know this person and this family intimately, and they are there as an advocate and support. One study modeling the cost effectiveness of doulas concluded that payment for doula services would likely be cost saving for that state Medicaid program by offsetting costs associated

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with preterm birth and cesarean deliveries. So, as I mentioned, Nebraska's preterm birth rate is at 11%. So imagine if that dropped to 5%, the cost savings that we would have by investing in this advocate. So a couple of things that I want to address are the fiscal note associated with this bill. I do think that investment for long-term cost savings is minimal. I have been working with Fiscal and as this is a new space for them, and they're projecting, we actually have a lower fiscal note for the first year at \$16,000 and the second \$120,000 versus what's projected. And we also have written in a cash fund pay source. So this would be the same cash fund pay source that the prenatal-- perinatal plus program is using that Senator Dungan just passed. And then, of course, if there's no funds in there, then it would have to revert back to general funds or HHS has that discretion. So that amendment is with the Drafters. I don't have that in front of you now, so I apologize. They have a lot of amendments they're working on. But that fiscal note is adjusted and the pay source for that. And so, again, I think for what we're-- are going to see from that outsized impact, having that investment in maternal care is going to make a difference. And I think, lastly, that I wanted to go over is that this bill is not new. So this bill has been brought before this body before I was here by different senators. I have advocated for this bill as a policy advocate before. I am now sitting in this chair, and I think it's because we know that, again, as I mentioned, we're in a maternal health crisis and we can really create change. People that are choosing to be pregnant and parent deserve resources, dignity in their birth experience, and to really enjoy bringing new life into the world. And so doulas are transformative in creating that experience. They are members of the care team. They are working side by side with OBs and nurses, phlebotomists, like everyone is taking care of that pregnant person and that family to ensure that it's a successful and healthy birth. And then, again, continued as that child begins to grow. And so I'm really excited to be able to bring forth LB701, excited for the impacts that it'll have on Nebraska's moms and babies. And I will be happy to answer any questions that you all may have around doulas.

HARDIN: Thank you. Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Senator, Senator Spivey, for being here, for bringing this bill. So one question I had. So this is-- I heard your testimony. I think it sounds like this could be a really helpful component of the birthing process for folks. Can you-- we've heard a handful of bills this session about birth and birthing and one of the bills or a couple of the bills, I should say,

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we've heard about, a bit about midwives, can you maybe sort of share with the committee a little bit midwife versus doula?

SPIVEY: Yeah, absolutely. So the difference is midwives are trained medical professionals. And so their scope of work is different. And that's why you see the conversations around licensure. What is their role? How do they fit into the care team in that way? The bills that are in front of you are around two different types of midwives, nurse midwives, and then certified-practicing midwives. And so, for example, I'll, I'll kind of tie them together if that's OK in an example. So I mentioned that there are a couple doula pilots that are happening in the state. So Nebraska Total Care has two doula pilots with CHI hospitals and then Olson Center, which is at UNMC in Omaha. And so they have midwives that can deliver babies. And so when we talk about the care team, the, the pilot is around how doulas are impacting those birth outcomes. They work with the OB or that midwife, whomever is supporting that family, and they are actually tracking things like birth weight, NICU days, there's lots of data on the claims side with the MCO and what they're looking at, and then the community-based organization that is running that pilot is looking at the overall experience. And so there is going to be more data for Nebraska specific around how do all of these factors work together. But in that packet that I gave you, March of Dimes has some policy initiatives that talk about how do you impact birth outcomes and midwifery support and doula services are their top policy priorities that they are saying states need to implement in order to change and create better birth and maternal health outcomes. And so I think, in this body, what you're seeing, because we are in a crisis is like how do we figure that out? This is accessible. We can create the, the difference. And so I think that's why you see what Senator Hansen has brought and why I'm bringing this. Because I do think that they work together. And he and I have talked about what would it look like as a package for these to kind of come together around birth support as they move through this committee and then, hopefully, to the floor.

FREDRICKSON: All right. Thank you.

SPIVEY: Thank you, Senator Fredrickson.

HARDIN: Senator Meyer.

MEYER: Thank you, Mr. Chair. This is strictly for my own educational purposes, do you use a midwife and a doula at the same time?

SPIVEY: Absolutely, Senator Meyer.

MEYER: At peripheral vision, I'm seeing--

SPIVEY: Yes. So-- because remember, doulas are not medical professionals. They are a member of your care team. And so, like, I'll use myself for example. So I had an OB that I used at Olson in-- at UNMC in Omaha. So she was my practitioner. That's who gave me medical advice. She didn't deliver my baby because it wasn't her rotation when, when my water broke, but that was my doctor. And then there were nurses that are a part of her team that supported me. And then my doula was also a part of that care team. And so my doula attended some of my prenatal visits, and we talked about my birth plan all together. My doula was at my birth. And so as I was navigating that experience, my doula was helping the folks that were in the room to be reminded of, like, what I needed. And she was really my support. So she was helping me breathe because my husband could not do that. I was not talking to him. They did not get my epidural right, and so she was trying to comfort me during that time like-- so she was there as my advocate to ensure that I was heard, which I think is really important because we have seen in the maternal health space that there are a lot of deaths that are preventable because a medical mistrust or doctors not listening. I think Serena Williams, her story, she's telling people what's wrong with her. Someone is not listening to her. That doula is in the room as an advocate. Their goal is to ensure a successful birth from the baby's standpoint and that parent standpoint. And so they don't replace anyone on the care team that's a medical provider, they are in, in addition to, and they complement that, that group of people.

MEYER: May I--

HARDIN: Sure.

MEYER: --continue? And I am aware of patient advocates in surgery and things of that nature so it sounds like that, very similar to that. And at, at risk of--

SPIVEY: Absolutely, Senator.

MEYER: --exposing another level of my ignorance, is that an acronym for something, doula, or is that just a--

SPIVEY: Doula? No. It's a Greek word. It, it has, like, a, a different history, but think of it as a, as a birth companion instead of doula. Yeah. So this person is an advocate. And as I mentioned, there are lots of different types of, like, health advocates. So there are some

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folks that are doulas that help people transition where they're at the end of life. Like, they are in these different, very specific medical and health experiences people have. This bill is defining full-spectrum doula to focus on that perinatal journey. So the prenatal delivery and postpartum period is what we want to focus on because of the maternal and health outcomes. But there are doulas and the definition can be broader for other types of health experience. Kind of like what you mentioned as a patient advocate.

MEYER: Thank you, Senator. I appreciate that.

SPIVEY: Yes, of course, Senator Meyer. Thank you for those questions.

HARDIN: Senator Quick.

QUICK: Yeah, thank you, Chairman. And so like right now, doulas are practicing now, right?

SPIVEY: Absolutely.

QUICK: So what would-- and you probably described that in the bill, but, you know, maybe I didn't get, you know--

SPIVEY: Yeah, absolutely.

QUICK: So what would this do based on what they can do now?

SPIVEY: Yeah, so doulas can practice because they are not regulated because they're not a medical practitioner. And so if I was pregnant and I wanted a doula and my insurance doesn't cover it, I can private pay, I can, I can do-- whatever that looks like, I can still retain their services. And so what this bill is saying is, one, we're putting a definition to doulas in Nebraska. And then we're saying HHS-- really Medicaid of, you know, within the department would work to put together this stakeholder group to determine how do we want doulas to be reimbursed under Medicaid. And so, as I mentioned, there are already two MCO pilots, Nebraska Total Care and UnitedHealthcare have doula services as a pilot right now. So they are not unfamiliar with the model. And Molina is also paying for doula services that are virtual but is within out of state like a virtual group. And so MCOs are very familiar, but this interdisciplinary stakeholder group will say these are the competencies that we want, or this is what we mean by certification, or we want to have the approved list like some of the other states, like whatever that looks like, they will decide as a group and then they will put for their state plan amendment to go to CMS to approve those services to be reimbursed under Medicaid. And so

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the first step, it has a timeline on when that group would meet and come with those recommendations. And then it has a timeline for then when they would implement that state plan amendment.

QUICK: OK. All right. Thank you.

SPIVEY: Thank you, Senator Quick.

HARDIN: Do you know, is the doula practice under the Uniform Credentialing Act?

SPIVEY: No, it is not, because it's not a, a medical provider.

HARDIN: How would things have to change in terms of training or anything else if Medicaid dollars started flowing in that direction?

SPIVEY: It wouldn't. So other states are already doing reimbursement for doula services under Medicaid, and that's where it comes in for that state plan amendment. So HHS would have to say these are the things that we would accept in order for that scope of work to be approved and reimbursed under Medicaid. We get to decide that, and we would submit that to CMS, and then CMS would kick that back and say, yes, or this is what you need to change. So we have autonomy in creating that. It doesn't have to go under the, the Uniform Credentialing Act.

HARDIN: Other questions? Will you stick around?

SPIVEY: Of course. And, Senator Hansen, you missed all the good midwifery talk.

HANSEN: I know. Right? Show up now.

SPIVEY: Yes, but I will be here to close, Chair Hardin, and thank you so much for the questions.

HARDIN: Proponents, LB701? Don't be shy. Welcome.

SHANIKA KING: Hello. Hello. All right. Good afternoon, my name is-- oh, do I wait till you guys get that? I'm OK?

BARB DORN: No, you're good.

SHANIKA KING: OK. My name is Shanika King, S-h-a-n-i-k-a, last name King, K-i-n-g. I am a full-spectrum doula, the cofounder of a maternal support agency and, most importantly, a mother. As a doula, my role is so much more than just supporting women during labor. I'm there to

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offer emotional, physical, and informational care throughout the entire journey of the pregnancy, childbirth, and beyond. I specifically work with mothers who face barriers to getting quality maternal health care and community resources. Studies have shown that the care doulas provide leads to better birth outcomes. However, here in Nebraska, doulas aren't compensated fairly for the essential services that we provide, services that make a real difference in people's lives and definitely feel like it's time for a change. When doulas are fairly compensated, we can continue to offer this much-needed support without worrying about financial strain. For the past 22 years, I've worked in OB/GYN or different factors of community health work and just advocacy. I've dedicated myself and business to improving maternal health in Nebraska and advocating for those who need it most in our community. In closing, doulas are more than just a service, they're an investment in public health. By integrating Medicaid-funded doula programs into Nebraska's health system, we together can definitely lower maternal and infant mortality rates, reduce racial disparities in birth outcomes, save health care costs, and provide emotional, physical, and community support to all at-risk families. I'd like to thank Senator Spivey for introducing this important bill, and I truly appreciate the DHHS board [SIC] for taking the time to listen to my testimony today.

HARDIN: Thank you.

SHANIKA KING: Yes.

HARDIN: Questions? So walk us through--

SHANIKA KING: Yes.

HARDIN: --what happens if a mom says help me?

SHANIKA KING: Yes.

HARDIN: Start to finish, can you give us-- give me the--

SHANIKA KING: Yeah, definitely.

HARDIN: --120 to 240-second version.

SHANIKA KING: So they reach out or we either get a referral or our community partner reaches out to us, let us know that a mom needs our support. We get them set up, we gather information, get them set up with a doula. Like Senator Spivey said, there's an interview process.

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They can pick whatever doula that they would like, whatever they would on their family that fits them. From there--

HARDIN: And so where are they finding doulas right now?

SHANIKA KING: Yep. In the community, we do a lot of community outreach. There's a lot of different other agencies that have doulas here in the community in Lincoln and Omaha, and just really being there when we go to the doctor visits, word of mouth. A lot of people just share the service that they've had from different doulas.

HARDIN: OK.

SHANIKA KING: And so from there, the doula is there to meet with them. They talk about a birth plan. They go to the different doctor's appointments with them. We like to get the first, in that first and second trimester to really make a big impact to be able to give them the resources and the things that they need. And it might not be all medical resources, it could be housing, it could be food support, it could be finding things to help with therapy or mental health. So just different things. And so from there, we support them. About three to four visits, depending on what they need. If they're high risk, we go to their doctor's appointments, they let us know when they are in labor. We're kind of showing them different things prior to-- we do different education with them and showing, teaching them about their body and their births and what's going to happen so they're prepared and know what is to be expected. And from there, they let us know when they are ready for us to come when they're in labor. Either they-- during this time, we've met with their family, we've integrated, you know, maybe came to their baby shower. Just building that relationship with them. And then from there, we're there for the entire birth, from the time they call, where they're supporting them, helping them with different comfort measures, getting them ice, water, rubbing their feet, rubbing their back, helping dad or their partner be able to support them and show them the things that they need during that time. And from there, we're there supporting the doctors if they need us to do anything, or helping the moms explained certain things that maybe the doctors need, you know, for them to be able to understand. So from there, we are there an hour or two after the birth, to be able to help them with breastfeeding or getting the things that they need after that time. And then once they are moved to another room, the doula is either discharged or let, you know, go from-- to be able to go home. And then from there, checked on within 24 hours, back up at the hospital checking on mom, seeing if there's anything that they need, and then from when they're home a schedule is set for whatever that

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mom might need for the doula to be able to come support them at home for those weeks after.

HARDIN: I would imagine the answer is the earlier the better.

SHANIKA KING: Yes.

HARDIN: But when in a 9-month process, would you say that most moms reach out? When, when-- if they haven't reached out by such and such time do you go [INAUDIBLE]? So [INAUDIBLE].

SHANIKA KING: Yeah, between, I would say, 3 to 4 months--

HARDIN: OK.

SHANIKA KING: --depending on when that mom--

HARDIN: First trimester-ish?

SHANIKA KING: Yep, when that mom-- depends-- and if they're in a crisis, sometimes it's a little bit later. And those are the ones that really need those-- a lot of support just finding those resources.

HARDIN: OK. Other questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here--

SHANIKA KING: Yes.

FREDRICKSON: --and taking the time to share your testimony with us. What, what's the typical cost of doula services currently?

SHANIKA KING: Yep. So it's up to \$2,000, sometimes \$2,500, depending on what the services that the mom has and how long you are working with that client.

FREDRICKSON: OK. OK. And I know Senator Spivey spoke about this a little bit in her opening, but can, can you maybe elaborate a little bit more on if, if a person would want to become a doula, what type of training or requirements are required for that?

SHANIKA KING: Yep. So there's a lot of different trainings. I've done the DPP program through-- the program in Omaha, Nebraska, and then I've also done DONA, and I've also got certified through ProDula. And those are outlets that are outside of Nebraska that train doulas all over the world. And so being able to do the training and they come here to Nebraska and train different doulas and they have different

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sessions. So being trained through all those different ones, just really being able to bring it all in perspective in here. But I've been through all the different trainings that we have.

FREDRICKSON: And my last question if I may? Do you find that when you're working with, with a mother, like, are, are most OB/GYNs, physicians, are they really-- are they mostly open to working with doulas? Is that--

SHANIKA KING: Yep.

FREDRICKSON: --have you ever had any challenges or [INAUDIBLE]?

SHANIKA KING: I have had different challenges, but for the most part, we have had really just a good environment of doctors that support the doulas and incorporate us in the care and make us feel included.

FREDRICKSON: Thank you.

SHANIKA KING: Um-hum.

HARDIN: Senator Meyer.

MEYER: Thank you, Chairman Hardin. Just, just out of curiosity, how many clients can you handle at a time?

SHANIKA KING: Yep. So for mental healthwise, I mean, two to three clients a month.

MEYER: Your mental health or theirs?

SHANIKA KING: Yep. Both. But two to three clients a month, just so you won't get overwhelmed or burned out. Because you do-- they pull a lot from you because you're helping them and supporting them and going and being kind of where they need you to at that time. So not to overwhelm, but for me, it's two to three a month. And that's births.

MEYER: And it, it, it indicated about 30 hours a week roughly. So you're, you're engaged pretty much.

SHANIKA KING: And community outreach and really just the different events and being able to get the, you know, show the clients that we're here and that we're building those relationships and that we're here to support them in their maternal health.

MEYER: Thank you. Appreciate it.

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SHANIKA KING: Yes. No problem.

HARDIN: Other questions? Seeing none, thank you.

SHANIKA KING: Thank you.

HARDIN: Next proponent, LB701? Welcome.

TOYA BROADWAY: Hi. Thank you. All right. Good afternoon, Chairperson Hardin and members of the Health and Human Services Committee. My name is Toya Broadway, T-o-y-a B-r-o-a-d-w-a-y. I'm a women's health registered nurse and full-spectrum doula with over 3 years of experience. I strongly support LB701, which would allow Medicaid reimbursement for doula services. Doulas complement medical professionals by addressing emotional, social, and physical needs, helping families make informed decisions before and after birth. This support ensures that parents aren't overwhelmed in the hospital setting, and helps bridge the gap in care that medical providers may not have time to cover. Research has shown that doula care leads to significant cost savings. Studies indicate that doula support can reduce cesarean rates by 39%, shorten labor by 25%, and decrease the need for pain medication by 60%. The overall savings can amount to over \$3,000 per birth by lowering the need for interventions and reducing maternal and infant complications. As a doula, I advocate for positive birth outcomes. For example, I recently supported a teenage client who had many questions about childbirth. We met several times to discuss her concerns, desires, and ways that I can support. Also, I attended a prenatal appointment with her provider. During labor, I provided nonmedical support, which both my client and her mother found invaluable. I envision a future where doulas are recognized as vital members of the health care team, and clients with Medicaid don't have to worry about payment. In my work as a postpartum nurse, I provide clinical care, but my role as a doula allows me to offer personalized, holistic support, attending baby showers, prenatal appointments, and offering continued care postdelivery to reduce postpartum depression and other complications. I also support the bill's provision for creating a work group to develop reimbursement rates and implementation plans, ensuring that all voices are heard. I would like to thank Senator Spivey for introducing this important legislation and the committee for your time and consideration. In conclusion, I urge you to support LB701. Doula care provides compassionate support, reduces health care costs, and improves outcomes for families. This bill is an important step toward more positive birth outcomes. Thank you for your time and consideration. Toya Broadway. Love, doula sista.

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HARDIN: Questions? Full spectrum. What's that mean?

TOYA BROADWAY: Yes. So a full-spectrum doula, I provide care prenatally, I provide care during the delivery and postpartum, but there are doulas who mainly provide care during birth or maybe just postpartum. So I'm a full spectrum.

HARDIN: Before, during, and after.

TOYA BROADWAY: Yes.

HARDIN: Gotcha. OK. Very good. Any other questions? Yes, Senator Quick.

QUICK: Thank you, Chairman. So, like-- so you're a registered nurse, so how does that-- do-- you also provide some services as being a registered nurse as well, right? So how does that work?

TOYA BROADWAY: Yeah. So I keep the two separate. When I'm working as a registered nurse, I am with my clients for 12 hours a day in the hospital versus as a doula, I know that I can't overstep that boundary. There's some education I can't provide as a doula because I'm not licensed to do so. I can't tell them, oh, you should take this medication. You should take Tylenol and Motrin this time and this time. That's not my job. Unless their provider has gave them that education, I can enhance it or I can, like, encourage them that, hey, your provider suggested this. So the two, I have to be careful not to overstep while I'm in my doula role.

QUICK: OK. And as a registered nurse, are you with a clinic or hospital or--

TOYA BROADWAY: Yes. So I've worked in the hospital, I also work in OPS as a substitute nurse, and I'm also going back to school to get my doctorate in women's health.

QUICK: All right. Thank you.

TOYA BROADWAY: Um-hum.

HARDIN: Other questions? Seeing none, thank you.

TOYA BROADWAY: Yes. Thank you.

HARDIN: Proponents, LB701? Welcome.

SAMI ZEINEDDINE: Good afternoon, everyone. Thank you, Chairperson Hardin, members of the Health and Human Services Committee. My name is Sami Zeineddine. It is spelled S-a-m-i Z-e-i-n-e-d-d-i-n-e, and I'm an OB/GYN and physician and a chairman of the CHI Health Immanuel Women's Health Clinic in Omaha. I'm also the residency Program Director at Creighton University for the Department of OB/GYN. I'd like to thank you, Senator Spivey, for introducing this bill. Many of the mothers I see in my practice are experiencing barriers to a healthy birth. They may lack family or other social support. They may have low health literacy. They might be experiencing stress from previous negative health care experiences, which may make the prospect of their impending birth not something they are excited about, but something that makes them very fearful and anxious. Each of these are things a doula may address in a coordinated way with the clinical care team. CHI Health launched a grant-- grant-funded pilot to offer free doula care to patients at heightened risk for poor birth outcomes in 2023. To date, we have enrolled around 50 patients. We have patients as young as 15 years old that have been paired with a doula. Doulas may attend prenatal visits with a patient, reinforcing the importance of and resolving barriers to routine perinatal care. They often gather information about a patient, such as signs of depression and anxiety, and can help the clinical care team tailor the patient's care plan. They help patients create their birth plans so they feel empowered in their health care. They offer social support and comfort. At times, they may be the only other person with the patient during the delivery. After a baby is born or, sadly, when a baby is lost, doulas continue to provide nonclinical care, which may include grief and/or breastfeeding support, education and safe sleep, and resolving barriers like transportation to well-child and postpartum visits. Doulas may help patients obtain items, too, like diapers because they are knowledgeable about the availability of community resources. One patient said having a doula was really great, especially without support from the child's father. She helped with the breastfeeding when the nurses couldn't get my baby to latch. She checked up on me even when I didn't text her. While my primary goal as a health care provider is a healthy mom and healthy baby. Expanding access to doula care may result in cost savings due to, many has been listed before, to a fewer, fewer low birth, preterm birth, NICU admissions, fewer C-section deliveries and their complications, and certainly increased breastfeeding initiation. Yet, one major impediment to the proliferation of doula is reimbursement. Doulas in Nebraska cannot currently bill Medicaid, despite evidence of their positive impact on patient and health care costs. CHI Health would be happy to participate in the work group LB701 would establish. We

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expect to enroll 150 patients over the next 3 years in a study assessing the impact of doula care on patient experience, birth outcomes, and health care utilization that may give important insights to the work group tasked with assessing optimal doula training and reimbursement. Once again, thank you to the Health and Human Services Committee for your interest in this important issue, and definitely to Senator Spivey for introducing this bill. I'm really happy to answer any questions and I'm honored to be here.

HARDIN: Thank you.

SAMI ZEINEDDINE: Thank you.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Doctor, for taking the time to be here and share your testimony.

SAMI ZEINEDDINE: My pleasure.

FREDRICKSON: So you, you had mentioned that-- so we're looking at a potential to have a plan for Medicaid reimbursement for, for doulas. Just out of curiosity, how many patients that you see at the Women's Clinic you work at, how, how many of those are enrolled in Medicaid, approximately?

SAMI ZEINEDDINE: So I, I deliver between 15 and almost 20 patients a month. I would say maybe 60% of them are on Medicaid.

FREDRICKSON: 6-0, 60?

SAMI ZEINEDDINE: Um-hum.

FREDRICKSON: OK. OK. And with the pilot program that you, that you currently have been working through or working on, have you noticed, have there been any cost savings to the hospital or, or to the taxpayer with that with the doulas?

SAMI ZEINEDDINE: It's hard to answer, maybe too early to answer. But I can, as a provider and all of us and advocates for my patients, we care about the journey for the 20 years of my practice and whatnot. The doulas helped and many that I haven't heard yet. I've seen them have the patients come to the clinic, actually the access, especially if the patients need to be there. They help them to come to establish this care. So my clinic becomes their source of their care, not the emergency room. Because these patients when, when they don't come to

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my clinic to have proper care, they're going to show up at the emergency room and that, that creates a lot of costs. So that's besides all the positive things that I've heard from the doulas and from the senator. This is a big factor for them to come see me in the clinic to prevent the complications, to prevent the preterm delivery, to prevent that C-section that happened at 34 weeks. I want it to happen at full term if I have to do it or not. So I cannot answer you exact the number, Senator, but I think we'd get to that down, down the road. Sorry.

FREDRICKSON: Thank you.

HARDIN: Other questions? Your sense is that when a doula is involved, it creates proactivity instead of reactivity.

SAMI ZEINEDDINE: Absolutely. It's a, it's a team.

HARDIN: OK.

SAMI ZEINEDDINE: We treat it like a family, another extra family member who knows the lingo, the language, and another care team.

HARDIN: Very well. Thank you. Appreciate you being here.

SAMI ZEINEDDINE: Thank you, all. Appreciate it. Thanks.

HARDIN: Yes. LB701, proponents? Welcome.

TESHA WILLIAMS: Thank you. Good afternoon. And first and foremost, thank you, Senator Spivey, for introducing LB701. My name is Tesha, T-e-s-h-a, last name is Williams, W-i-l-l-i-a-m-s, and I am a certified doula serving families across Nebraska. I am here today as a BIPOC woman and birth worker to strongly support LB701 because I have seen firsthand how doula care transforms birth experiences, they improve maternal health outcomes and also saves the lives, especially for black, Indigenous, and other birthing persons of color. As a new doula, I will provide continuous emotional, physical, and informational support to birthing individuals, ensuring that they are heard and they're respected and, more importantly, empowered. Too often, I witnessed BIPOC birthing people ignored in medical settings, their pain is dismissed, as well as their concerns being overlooked. So this reality is reflected in the alarming maternal health statistics. Black women are three to four times more likely to die from pregnancy-related complications than white women and Indigenous, Indigenous-- excuse me-- women also face significantly higher risk. So these disparities are not due to biological differences, but to system

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inequities, and implicit bias and gaps in culturally competent care. So doulas, we bridge the gap. Studies show that having a trained doula present during pregnancy, labor, and postpartum, that leads to lower C-sections, also reduce preterm births, and improve mental health for new mothers. By providing advocacy, comfort measures, and evidence-based education, doulas empower families to make informed decisions and navigate a complex health care system with confidence. However, doula services remain inaccessible to many of the families who need the, need the support most. And with that, BIPOC birthing persons must choose paying for doula services or covering necessities. So with LB701, it's an opportunity to change this ensuring that the Medicaid reimbursement for doula care will make lifesaving services available to all families, regardless of income. So this bill is about equity, access, and justice. It's about recognizing that every mother deserves compassionate, culturally respon-- culturally-- excuse me-- responsive care and that no one should face pregnancy alone simply because of financial barriers. I urge this committee to support LB701 and invest in a healthier future of Nebraska's birthing people and babies. And I'd like to thank you all for your time and consideration.

HARDIN: Thank you.

TESHA WILLIAMS: Yes.

HARDIN: Questions? Can you help me understand something?

TESHA WILLIAMS: Certainly.

HARDIN: How does a doula's involvement improve C-section numbers?

TESHA WILLIAMS: So a lot of times, and I, I actually had a C-section and had I had a doula 21 years ago, I may not have some of the complications that I've had after. And the way that we have an impact is because we're there to support the birthing person. And a lot of times they don't know what their options are. The doctor may come in and say, hey, we need to have a C-section. They don't understand why. They don't understand that it's because the baby's heart rate is dropping or the baby's heart rate is increasing, whatever that looks like, it could be for the safety of the, the, the mother. It could be the safety of the baby. But there are instances, and not all the time, where a doctor-- they have a life outside of delivering babies, right, so let's say that this birthing person has been in labor for 2 days. We want to get it down the road. Doesn't necessarily mean that they are rushing it, but when you hear C-section, they don't know what their options are. I didn't know what my options were. I wasn't in

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labor for 2 days. I was only in labor for 16 hours, and I really don't think that I needed to have a C-section. But I did. But I didn't know any better either. So it's really about the education, understanding what your options are. And so that's, I think, the, the biggest thing.

HARDIN: Thank you.

TESHA WILLIAMS: You're welcome.

HARDIN: Other questions? Senator Riepe.

RIEPE: Thank you. I apologize, I, I had another hearing, so I came in late for the introduction.

TESHA WILLIAMS: That's OK.

RIEPE: Is there an association of doulas?

TESHA WILLIAMS: There are. There is several.

RIEPE: Is this kind of an urban issue more than it is rural? I mean, we have a shortage of rural, just of anyone in maternal and infant care.

TESHA WILLIAMS: Correct. So--

RIEPE: I don't know.

TESHA WILLIAMS: --it would be rural--

RIEPE: Do you have any-- anyone out there?

TESHA WILLIAMS: It would be both.

RIEPE: It could be, but--

TESHA WILLIAMS: It could be.

RIEPE: --I don't know whether it is or not.

TESHA WILLIAMS: Yeah. I mean, because as a doula, you can offer your services anywhere. So it doesn't necessarily have to be in the urban area. You can provide your services in the rural area. There's a list, there's a directory. And so the birthing person has the right to look for their birthing doula or their doula. So um-hum.

RIEPE: OK. Thank you. Thank you for [INAUDIBLE].

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TESHA WILLIAMS: Yeah, you're very welcome.

HARDIN: Other questions? Seeing none, thank you.

TESHA WILLIAMS: OK. Thank you so much for your time.

HARDIN: LB701 proponents? We're getting a strange whistle here through the windows we've never heard before so it's something-- it's a new feature. Welcome.

KAYLA KOHL: Hi. Good afternoon, Chairperson Hardin and members of the Health and Human Services Committee. My name is Kayla Kohl, and that's K-a-y-l-a K-o-h-l, and I am a certified labor and postpartum doula. I am here today in strong support of LB701, which I believe will have a profound positive impact on the birthing community in Nebraska. As the only doula in Nebraska currently accepting health insurance through TRICARE, the military health insurance provider, I have witnessed firsthand the transformative effect of financial support of doula services. The Secretary of Defense has initiated a 5-year demonstration project under TRICARE to evaluate the cost, quality of care, and maternal and fetal outcomes associated with covering doula services. Early results nationally are showing that financial support for doulas is breaking down the financial barriers many families face while simultaneously lowering the cost of births, reducing caesarean section rates, and improving overall birth experiences. Since participating in this program since its inception in 2022, I have seen firsthand the incredible impact that having a doula can have on the birthing process. Not only does it reduce the financial burden for families, but it also leads to improved birth outcomes. Research, including a 2019 study, has shown that doula support can reduce health care costs by an average of \$884 per birth due to fewer medical interventions, and it can lower the risk of cesarean deliveries by up to 39%. In addition to the physical health benefits, families who have access to doulas report higher levels of satisfaction with their birth experience and greater confidence in their ability to care for their newborn. This level of support is particularly crucial for families facing socioeconomic barriers, where access to resources like doulas can be limited. Expanding Medicaid coverage to include doulas would ensure that more Nebraska families, regardless of income, can access this valuable support, ultimately leading to better health outcomes for both mothers and babies across our state. I'd like to express my sincere gratitude to Senator Spivey for introducing this critical legislation, and to the committee for your time and consideration. I strongly urge you to support LB701 so that more families across

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Nebraska can benefit from the invaluable support of a doula. Thank you.

HARDIN: Questions? Can I ask a question? How did you get the military gig?

KAYLA KOHL: So I'm actually a military spouse, and so I know a lot about the TRICARE health insurance process. The Federal Register published this pilot program, so it was announced nationally. And there are several qualifications you need to meet to become a doula through this program. So I obtained what I needed to, to do that. And I've been working with TRICARE ever since.

HARDIN: OK. All right. Thank you.

KAYLA KOHL: Um-hum.

HARDIN: Seeing no other questions,--

KAYLA KOHL: Thank you.

HARDIN: --thank you. Proponent, LB701? Welcome.

JOYCE DYKEMA: Thank you. Hello, Chairman Hardin, members of the committee. My name is Joyce Dykema, J-o-y-c-e D-y-k-e-m-a. I have been a birth doula since 2009, serving over 200 families, certified with DONA International and Hypnobabies. I'm an evidence-based birth instructor and the doula mentor with Malone Center's Maternal Wellness Program. I'm a DONA International birth doula trainer candidate, and I sit on the Board of Directors for DONA as Director of Communications, and I'm testifying today on behalf of the DONA Board of Directors. DONA International is the only nonprofit, member-owned doula organization delivering evidence-based training, education, and certification worldwide. Founded in 1992, our organization and its network of doulas first professionalized the doula role. We've certified over 16,000 doulas and support over 5,000 members in over 54 countries. DONA supports LB701 and encourages the committee to advance this bill. DONA supports the expansion of Medicaid to cover doula services. As the doula community has found in other states, a process that integrates the perspectives of doulas across the state to develop doula eligibility for Medicaid reimbursement, the reimbursement amount, and the billing process are necessary to ensure long-term sustainability of doula engagement, and increases the likelihood that doulas will enroll as providers and be able to serve the Medicaid community. One of the reasons that Kayla is one of the-- or is the only TRICARE-approved provider for doula services in the state is

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because TRICARE's process is very, very time consuming. I've been waiting for 5 weeks to hear back and they said it would take 2, so we'll see. I did include in there a calculation of TRICARE's reimbursement rates. Starting tomorrow, it comes to a maximum of \$1,627.88. That rate is in alignment with Nebraska's market rates for doula services. Personally, I charge \$2,000 for my services, and I also, I do a, a sliding scale. And I budget for 2 half-price services per calendar year. DONA hopes that the Department of Health and Human, Health and Human Services and CMS center the diverse doula community in the development of this Medicaid benefit throughout Nebraska, and the development of training, certification, and experience standards for Medicaid eligibility, determining the reimbursement rate commensurate with market rates and costs of living, and formation of a paid doula committee to evaluate, approve, and deny the eligibility, as well as to evaluate the program's implementation, investigate, and discipline any professional and ethical violations that might arise within Nebraska doula Medicaid providers. Thank you.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. I see that on your letterhead you're international. Where's your corporate headquarters?

JOYCE DYKEMA: Chicago.

RIEPE: Chicago. And do you have, then, state organizations or how do you-- how are you structured after then?

JOYCE DYKEMA: Yeah, so our headquarters are in Chicago, incorporated as a 501(c)(6) business league in the state of Illinois. We have members in multiple countries. It-- we don't have chapters like some organizations do. We're kind of just one big organization that communicates.

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

HARDIN: Do you know what TRICARE is looking at measuring, observing? Are they basically collecting data? I appreciate your charts that you included in this. Do you know the kinds of things that they're looking at? And, and I'm guessing this will be done in 2026 sometime?

JOYCE DYKEMA: I believe--

HARDIN: It started in 2022?

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JOYCE DYKEMA: --so-- yes-- I believe so. I, I couldn't tell you exactly what they're looking at, obviously. You know, that's going to be something to ask TRICARE. I believe that they're looking at the cost-benefit analysis and seeing if it's worthwhile continuing.

HARDIN: I see. All right. Any other questions? Seeing none, thank you.

JOYCE DYKEMA: Thank you very much.

HARDIN: Proponents, LB701? Welcome.

BECKY SHERMAN: Hello, Chairperson Hardin and committee members. My name is Becky Sherman, B-e-c-k-y S-h-e-r-m-a-n, and I have been a birth doula in Nebraska for 18 years. I have served at births from Red Cloud and Kearney to, to Omaha, Beatrice, and Lincoln. I'm primarily centered in Lincoln. I know that all of the other doulas are going to tell you amazing statistics, and I'm super happy about that. So that saves me time. But when a doula has comprehensive doula training filled with knowledge of the anatomy and physiology of birth, comfort measures and birthing techniques, a doula will decrease interventions such as C-sections, as you were asking, and I can totally go into detail about how we would prevent a C-section. In the movies, my profession is portrayed as like a wacky, eccentric lady. And in reality, I have years of training. And even more years of birth wisdom. I am the witness and in 18 years I have witnessed patient abuse in many forms. Some would shock you. I could tell you stories for days, but I'll just wait for you to read it in my book. The short story is that birthing people are mentally, psychologically, and physically abused every day in the maternity system. Medical professionals use coercion, manipulation, and physical means to get what they want from their patients. When there is not a precarious position of life or death, this is not necessary. More and more, I am being hired because of my strong professional advocacy skills. I will also talk to you about how I get paid privately, if you'd like to get-- to know all that. We know based on national numbers that women who are disadvantaged, mothers who are minorities, and people who are-- people more likely to die in childbirth and through the year following. Making doulas more accessible will strengthen Nebraska's birth numbers and perhaps save more and more lives. On the back, I gave you guys information that I do not publish. It's how much I charge and all of the services that I do. The reason that I do not publish this information is because of private pay situations, and I want a client to be able to say, actually, I can only pay this much and then I will accept that. The only reason I am a professional doula, I take two to three a month, is because I have supplemental pay

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from another-- from a partner, so that's how I can offer help. So that's my--

HARDIN: Questions? Is your, your book going to become a text book?

BECKY SHERMAN: It is-- I am writing a book called Mouth, and I am just not going to not talk about what I've seen.

HARDIN: OK. It's more of a tell-all on the medical world?

BECKY SHERMAN: Yes.

HARDIN: I see.

BECKY SHERMAN: And how--

HARDIN: And it's out when?

BECKY SHERMAN: It's on my laptop right now.

HARDIN: Oh, I see. And you have it backed up?

BECKY SHERMAN: Yes, of course.

HARDIN: OK, good.

BECKY SHERMAN: Yes, of course.

HARDIN: Laptops fail.

BECKY SHERMAN: Yes, of course.

HARDIN: All right.

BECKY SHERMAN: Of course.

HARDIN: If there are no other questions, we thank you.

BECKY SHERMAN: All right.

HARDIN: Appreciate it. Proponents, LB701? Welcome.

JoANNA LeFLORE-EJIKE: Hello. Thank you for presenting an opportunity for us to speak with you today. My name is JoAnna LeFlore-Ejike, J-o-A-n-n-a L-e-F-l-o-r-e-E-j-i-k-e. I am a proponent of this LB701, and you've heard from many people in different roles or primarily doulas. I am positioning myself as a recipient of doula services. And so while I represent many hats in the Omaha community, I'm here today

as a mother, and I've benefited from the doula prenatal services and then labor and pregnancy. So I'm really grateful that this bill is being presented, because it allows many other women and birthing folks to have the opportunity to have that support. And I think that this is necessary for us to hear all sides of the story. The last person that testified talked about the advocacy. A lot of people have mentioned the advocacy. And for me personally, I had a very high-risk pregnancy and I was very confident that with having a doula I would have a successful pregnancy. And so for that reason, I did not have a C-section. And my doctor was not able to make it on time because my labor was short. And that was primarily because I had a doula. And so I really want to advocate for other potential patients in Nebraska having this support. Yes, it is very necessary to have a midwife, to have the OB, to have the clinical care support, but the doula is definitely necessary for the care of the mother as well. And so I think that that's something that somebody should also write a book about, the care that's offered for the birthing mother. And so I just wanted to highlight a couple of things. This is an opportunity for us to not necessarily hone in on an expansion of government health care, nor does it replace doctors or nurses, but instead it helps reduce expensive medical interventions and that saves taxpayer dollars in the long run. And, again, I just want to emphasize that because I had a doula in the room with me, the opportunity for the pushing of unnecessary medications was avoided. And because I was only there with-- I had a COVID birth, so there wasn't a lot of people allowed in the birthing room. But my doctor was an advocate for me having a doula as well. And so I think that's important to note, especially when you consider potential patients who might have high-risk pregnancies or they don't have a support system. When your doctor is an advocate, that makes a big difference, too. And, again, there was the opportunity for postpartum care, which is very important as well if you're birthing for the first time, like I was. And I think that if we consider more opportunities for doulas to be reimbursed, we can have a better success rate as a state. So thank you.

HARDIN: Questions? Seeing none, thank you. Proponent, LB701? Welcome.

LaTEYA BROADWAY: Thank you. Good afternoon, Chairperson Hardin and members of the Health and Human Services Committee. My name is LaTeya Broadway, L-a-T-e-y-a B-r-o-a-d-w-a-y, and I am here today in support of LB701 because research demonstrates that doula support leads to healthier pregnancies and fewer complications. LB701 represents an essential investment in maternal health. As someone, as someone who benefit-- who benefited from having a doula-- excuse me-- I can speak firsthand to its impact. I was diagnosed with alpha thalassemia as a

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preteen. This is a blood disorder that prevents my red blood cells from receiving enough oxygen. I didn't fully understand how this condition would affect my pregnancy, and I often went into doctor's appointments worried about my baby's health. Having my doula by my side meant I didn't have to face these challenges alone. She provided comfort during such a stressful time and gave me the confidence to speak up and ask questions. Due to my blood disorder, I had to attend weekly doctor's appointments for nonstress tests to ensure my baby was growing properly and receiving enough oxygen. Every week, my doula made it a priority to be there, and when I felt anxious, my doula was there to explain what was happening. Throughout my pregnancy, my alpha thalassemia caused a significant decline in my energy levels. To help restore my strength and provide the right nutrients, my doula carefully created a personalized plan including meals and my exercises tailored to my needs. This level of support should be a privilege-- shouldn't be a privilege-- excuse me-- it should be a right. As my pregnancy progressed, I had committed to having an unmedicated birth. However, when labor began, I found myself overwhelmed by the pain and requested an epidural. As my doula walked in and the anesthesiologist walked out, I had just consented to whatever terms were required to relieve the agony. Luckily, my doula and midwife were aligned in their approach to a natural delivery. When my doula entered the room, my midwife seemed energized. Knowing that with my doula support and positive reinforcement, I could still summon the strength to give birth naturally as I had intended. Throughout the remainder of my labor, my doula provided counter pressure and words of encouragement, and I was able to deliver a healthy baby boy without medication. Having a doula was truly lifechanging for me. Every birthing person deserves to feel informed, supported, and empowered throughout their pregnancy and childbirth. I was fortunate to have that experience, but many others do not. Passing LB701 will ensure that more Nebraskans have access to this vital support. I would like to thank Senator Spivey for introducing this important legislation, and to the committee for your time and consideration. LB701 is a crucial policy that aims to improve birth outcomes in Nebraska, and I strongly urge you to support it. Thank you.

HARDIN: Thank you. Let's pretend they're not here.

LaTEYA BROADWAY: OK.

HARDIN: How do you find a good one?

LaTEYA BROADWAY: How do I--

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HARDIN: Because, frankly-- well, let's be honest, there's good doctors and there's not good doctors.

LaTEYA BROADWAY: Yes.

HARDIN: Right?

LaTEYA BROADWAY: Yes.

HARDIN: Whatever, there's good politicians and not good politicians just to level the playing field.

LaTEYA BROADWAY: Yes.

HARDIN: How do you find a good doula?

LaTEYA BROADWAY: I think the interview process is the best way to go.

HARDIN: And so what do you ask?

LaTEYA BROADWAY: What is your experience? I think that's the first-- the, the main question here. What-- do you have experience? How would you comfort me in such a stressful time where I am not able to think straight when I'm in so much pain that I don't know what's going on? How-- luckily I had-- I have a friend who was my doula, so she was, she was great. She was able to comfort me. She was able to comfort my boyfriend who needed the comforting, of course. And, yeah, it, it was great.

HARDIN: OK. Thanks.

LaTEYA BROADWAY: Yeah.

HARDIN: Appreciate that. Any other questions? Senator Quick.

QUICK: Yeah, thank you, Chairman. So as-- and I'm sure this probably happens, happens from time to time. But would-- you know, maybe you start out with a client that you're working with and maybe that personality difference becomes something that neither is comfortable with or do you help them find another doula or how does that work?

LaTEYA BROADWAY: So I think you would just communicate with the agency--

QUICK: OK.

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LaTEYA BROADWAY: --and say, hey, this isn't-- I don't think this is a good fit and go through another interview.

QUICK: OK. All right. Thank you.

LaTEYA BROADWAY: Um-hum.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. I'm trying to get my head around-- I think you described in your own personal experience that your doula was able to sit beside you and [INAUDIBLE]. How long-- how many months did-- I, I know it would vary case by case and need by need, but in your personal case, how long did you have a doula with you? And that was on a full- or part-time basis? I know they didn't stay over, I'm assuming so.

LaTEYA BROADWAY: Yes. I would say I contacted my doula when I was about 2 months pregnant and she stayed the full course. Things started-- I, I guess it was a little bit more lenient at the beginning of my pregnancy, because I'm just going through the motions, I guess, of just having the baby growing and figuring out what doctor's appointments look like and-- yeah.

RIEPE: So the doula came to your house or apartment, whatever, every day during that period of time?

LaTEYA BROADWAY: No, no, no, she would meet me at doctor's appointments.

RIEPE: Oh, OK. OK. OK.

LaTEYA BROADWAY: After I had the baby, she would then come to the house and then help me with whatever needs.

RIEPE: OK. Thanks for the clarification.

LaTEYA BROADWAY: Of course.

RIEPE: Thank you, Chairman.

HARDIN: Other questions? Seeing none, thank you.

LaTEYA BROADWAY: Um-hum. Thank you. Have a good day.

HARDIN: Proponent, LB701? Any more proponents? Opponent? Oh, we got one more. Don't be shy.

JOY KATHURIMA: [INAUDIBLE]

HARDIN: Welcome.

JOY KATHURIMA: Good afternoon, Senator Hardin and members of the Health and Human Services Committee. My name is Joy Kathurima, J-o-y K-a-t-h-u-r-i-m-a, and I am policy counsel at ACLU of Nebraska, and I'm testifying on behalf of the ACLU of Nebraska in support of LB701. The ACLU works to ensure that Nebraskans can make the best decisions for themselves with regards to whether and when to have children. According to the National Institute of Health, continuous labor support confers measurable clinical benefits to both mother and baby. Continuous labor support is the care, guidance, and encouragement provided by those who are with a pregnant woman in labor that aims to support labor physiology and mothers' feelings of control and participation in decision-making during childbirth. Doulas are trained professionals who provide continuous one-on-one emotional and informational support, and the core function of their work is to provide continuous labor support. In 2024, the Bixby Center for Global Reproductive Health estimated the average cost of a doula to range from \$1,500 to upwards of \$2,000. Providing for reimbursement of doula services will make care more accessible for pregnant and birthing Nebraskans. For these reasons, we urge the committee to advance LB701 to General File. Thank you, and I'd be happy to answer any questions.

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

JOY KATHURIMA: Thank you.

HARDIN: Proponent, LB701? Opponent, LB701? Neutral testifiers, LB701? Senator Spivey, come on back. Proponents online, 25; opponents, 1; those in the neutral, zero.

SPIVEY: Thank you, Chair Hardin and the rest of the HHS Committee. I just want to thank all of the testifiers today for their beautiful stories and personal experience and, and spending the afternoon with us. A couple of things that I just wanted to address as we were talking, and so I wanted to pull your attention to that blue packet that has the amendment language. We did work with Fiscal because right now it's a-- it's just a technical change. How it's written is that doula services, like that all would be covered. And what we are saying is doula coverage-- doula services under Medicaid. So I just wanted to pull your attention to that amendment and also just mention the other cash fund amendment that will be coming. The second thing that you have is from NPQIC, the Nebraska Perinatal Quality Improvement

Collaborative. So that is the organization that was created in statute that is like the best practice agency for continuity of care around maternal and child health. And they created a, a memo or like information for policymakers, other stakeholders that talk about the importance of doulas. And on page 22, it talks about implementation, what they see to be the best practice for implementation. They ran the doula pilot with UnitedHealthcare and the Olson Center. And so what we have outlined in the bill does align with NPQIC in terms of implementation, having the cross-functional multidisciplinary stakeholder group doing the state plan amendment. And so I just want to uplift that. We are aligned with our state providers and people that are leading in this work. One thing that I, I would be remiss if I didn't talk about, and I, I did not mention in my opening, is that this is like an actual job and it's a workforce initiative, too. The folks that are in these spaces are operating businesses and practices. They're providing essential support. And so like, yes, that birthing person has a benefit, but there's also a benefit to our economy. And so one of the things that you have in the synopsis that I gave you is a list of the current reimbursement rates by state, and what we will advocate for. Again, that is with the, the work of that HHS Department and that cross-functional committee is that the reimbursement rate has to align with the work. So we can't expect folks to come into this, and we have a reimbursement rate of \$400. And so I wanted you all to see what the current reimbursement rate-- I know there were, there were some questions to the practicing doulas around what they charge and what they give their clients. And I think, you know, the floor needs to be \$2,000. Again, that's not my decision, but I want to uplift that this is also a workforce initiative. So when we talk about people being able to provide support, this is a job. This is not just they're doing this because they just enjoy it. They probably do, but they need to be paid. Senator Riepe, to your point, so 80% of our counties, as you probably know, are maternal care deserts. And so when we look at around access to care, there's a movement across our state around community health workers and now doulas. And so while some of the doulas practicing are representing urban core areas, the care and what they can provide will make a difference, especially in rural counties when you, when you're having issues trying to travel to get to a primary provider, whatever that looks like. And so I do think that we would see impacts in rural areas which make a difference. And in the synopsis I shared with each of you, your counties and the maternal vulnerability that you have. And so I think like, Senator Meyer, yours is at, like, 48%.

MEYER: 68.

SPIVEY: 68. Yeah. So I mean, when you-- again, we're in a crisis. And so when you think about-- and you heard the testimony from people that are actually practicing, you heard the testimony from the OB, this makes a difference. And so we can see accessible change across our state because this is not an urban-rural issue. It does further maternal health disparities impact communities of color. But this is for any person that can give birth, right, like they're seeing maternal disparities. And so this can have impacts and truly change what we're seeing in Nebraska. So I just wanted to uplift that as well. And then to the question around, like, organizations and, like, how they function. So, again, they-- doulas now, practice can be independent. You can have your own practice. You get your clients. And then there's organizations here that employ doulas like A Mother's Love, Shanika spoke first. You have federally qualified health centers that are hiring doulas. In Lincoln, you have the Malone Center. And so there are agencies that are trying to find funding now through private philanthropy and other revenue streams to be able to support people that would benefit from a doula. And so, again, we have the case study here. So the, the pilots are starting to wrap up, but we have the national data to show the impact. And so as those pilots wrap up, you'll see more data coming from NPQIC around those Nebraska numbers. The MCOs, again, are looking at claims data and the difference. But we do have a framework here. So even though, like, it's not already-- doula services are already reimbursed. It's not like we're starting from scratch and, like, what does this mean for our geography? What does it mean for Nebraska? People have been and are going to continue doing this work. We are just setting them up for success and I think the state needs to make-- and take a big swing at this to say that we care about moms and babies, right? Like, we're in a crisis. It does not have to be this way. What does policy look like for us to pass to ensure that people can have healthy pregnancies and children and families after? And this is a step in that direction as well. And then, lastly, I wanted to just uplift that the Medicaid care organizations are reviewing what does this look like? And so why they didn't testify, they are at the table with these pilots and working. We have two of the three that have pilots on the ground, one that does not, and a lot of community-based organizations-- to your questions, Chair Hardin-- are working around, like, what does it mean to be a doula friendly hospital? There's people that put out toolkits around how do you interview? This is a service contract. So if there is a discrepancy or a grievance, you can end that contract. And I think it would be on HHS and that, that multi-- multidisciplinary committee to come up with if there's a grievance because we know that there could be bad actors, what does that look like, so that we can ensure safety

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for all parties. And so I think, absolutely, the framework is here for what we're doing. I think this is an important step for maternal and child health in our state. I would love for you to consider moving this out of committee so that we can work this on the floor with other policies that align to creating better birth outcomes for our Nebraska mommas and babies. And I will be happy to answer any additional questions that you all have.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you again, Senator Spivey, for bringing the bill. You mentioned in your closing that there's a couple of amendments and that you've been working with Fiscal. Do you anticipate what the amendments you spoke to-- how do you anticipate that will impact the fiscal note? Without a limited fiscal note or--

SPIVEY: No. So what will happen is the fiscal note will go to \$16,000 for the first 2 years and then 120 for the next 2. And then the funding source will not be general funds, it's a cash fund. So the same as Senator Dungan's prenatal plus. And then, of course, if the fund is exasperated, then HHS will have to make the decision to either close that reimbursement or to make an appropriations request for general funds. And so, as we know that we are in tight fiscal times, I talk about that every day on committee, but I think this is an investment long term. So when we talk about what is a good ROI for our residents and what does that look like, there is a cash-funding source and we will see the difference made in terms of claims paid out in the costs for insurance under Medicaid for caesareans, preterm birth, and what comes with that. And I do-- I won't bore you now, but there are some data points in that synopsis document that you have. So you can kind of compare some numbers so that you have that grounding as well.

FREDRICKSON: OK. Thank you.

SPIVEY: Thank you, Senator Fredrickson.

HARDIN: Senator Hansen.

HANSEN: Thank you, Chair Hardin. Thank you for bringing this bill. Now, I know we're just a bunch of guys up here.

SPIVEY: I didn't notice, Senator Hansen.

HANSEN: But I appreciate not just you bringing, bringing this bill, but the people who testified. I think we as not just a committee, but as a Legislature, I think needs a little, needs a little education, I

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think, sometimes on the different types of options I think mothers have when it comes to either doula services or mid-- midwifery. And so just some of the stories and what some of the testifiers have mentioned when they're, when they're talking, whether it's about, you know, actually coming to your home for guidance and comfort or having births without medication or decreased cesarean sections or turning a baby, you know, and readjusting the mother to turn the baby, you know, etcetera. I think we're used to, like, whatever they show on a movie. Somebody brought that up earlier. Both parents freak out, they run to the hospital, you know, the white gown and their legs are up in the air and everyone is staring at them, you know. And so it's, it's kind of-- it's, it's-- becomes a medical event, like an emergency. Right? And that's not how the birthing process is. And I think a lot of us kind of have this in our head and I think it's time we change that.

SPIVEY: I think you're absolutely right, Senator Hansen. And we talked about it a little bit before you got in, but I also have for you the March of Dimes policy measures. And we talked about the midwifery and doula care is top priorities for March of Dimes as we've been rated as a state and what they're looking at nationally around to create and change some of the outcomes that you just named. A birth should not be traumatic in that way. One of the testifiers talked about some of the medical harm that, that you see. And so this is a time to be innovative, right? Like, this is literally life or death. It, it can make the difference. And so we want to create care teams that are multidisciplinary, that has an OB or a midwife or maybe both. Right? Like, that has doulas, that has community health workers, that has that support system because we want that person to be successful. We want them to have an amazing, beautiful experience, and then we want them to have strong-- especially that first year of life when the majority of maternal or infant deaths are happening. And so I think this is a, a great opportunity and a, a stand in perspective that this body in the state needs to take to say we care about moms and babies, and this is what we're doing to ensure that that happens. We're not just saying it in theory, but we're proving it with the policy and the investment that we're doing. And so I appreciate that and appreciate you lifting that up.

HANSEN: Yeah, and I-- we tend to be a little behind the times in Nebraska--

SPIVEY: No?

HANSEN: --when it comes to certain things.

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SPIVEY: Yeah. Well, no time like the present, right, Senator Hansen?

HANSEN: Yeah, that's right. And so it sometimes takes-- we're, we're, we're stubborn to change I think. And so even the federal government and the VA are ahead of us--

SPIVEY: Absolutely.

HANSEN: --on many of these issues, whether it's midwives or whether it's doulas. Right?

SPIVEY: Absolutely.

HANSEN: And so they're starting to recognize the importance of alternative types of care or options, I guess, whether it's physical therapy, whether it's chiropractic care, whether it's OT, whether it's doulas or it's midwives, they're starting to find out, geez, if more people are covered, you know, with, with these types of services, we spend less taxpayer money and we have better outcomes with better patient experiences.

SPIVEY: Absolutely.

HANSEN: And so not all birthing processes are-- is a, is a medical event, but some are.

SPIVEY: Absolutely.

HANSEN: They really are. And then we have, you know, a medical doctor here to testify to that. And, you know, we're blessed to have people like that.

SPIVEY: Right. And it's not a competition, right, like--

HANSEN: No, it's a, it's a team effort.

SPIVEY: Absolutely.

HANSEN: And I think that's one of the common themes, I think, we've heard here with the testifiers, it's, it's a team effort. I think the more we have team effort, the, the better the, the mother feels, I think, psychologically and physically and the better outcomes received for the baby, so.

SPIVEY: Absolutely.

HANSEN: Yeah.

SPIVEY: Thank you, Senator Hansen.

HANSEN: Appreciate you bringing this and so, hopefully, we can kind of get some things moving here.

SPIVEY: Absolutely.

HARDIN: Senator Riepe.

RIEPE: Thank you. I have a question. How many doulas have delivered-- actually delivered a baby?

SPIVEY: So doulas do not deliver babies because they're not medical practitioners.

RIEPE: Well, they might find themselves in a situation where they're-- they would have to deliver. You know, we don't-- baby decides when he or she wants to come sometimes.

SPIVEY: Yeah, I would say that's an anomaly because you could say, like, how many dads have, right? Like, if you're driving in the car and the baby comes. And so I think the--

RIEPE: Could happen.

SPIVEY: Yeah. I mean, so I think the, the-- what I don't want to get misconstrued are that doulas are medical practitioners. They are delivering babies. Right? Like, we've talked about the different practitioners that can like midwif-- midwives in OBs and so these are advocates and support. They're highly trained. They have lots of knowledge, they're helping that birthing person make the best decisions, but they are really providing that support. They are not positioned to be in medical spaces in that way unless I would assume that it's a medical emergency.

RIEPE: OK. I think I, I also-- I think I heard you say postdelivery and so on. Do they have a postdelivery role?

SPIVEY: Yeah, so postpartum, and, and for me, I think is the most important of how they support that birthing person. And I've been really kind of transparent about my experience. I suffered from severe postpartum depression and anxiety after my second son. And, and it was terrible. I-- I'm-- I am blessed to be here today. That's how bad it was. And I, I had a strong village, but it didn't make a difference. I have all the accessibility. I know the doctors. I do this work every day and it didn't make a difference. And my doula called and checked

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on me. My doula knew something was wrong and she's pinging my husband. She helped ping my village and they got me the support and medical intervention that I needed to be able to get out of the place that I was in. And so outside of that, though, they're helping with-- because having a new baby is hard, cleaning, light chores, one of my doulas helped to make food because I was trying to breastfeed so to insure that I, I had the capacity and I'm having the nutrients. I mean, they're really taking care of that person to ensure that they have a healthy experience and that, again, you just don't feel alone. And so I think the role that they play is vitally important. And, again, creating that comprehensive care team. And so for me, just in my personal experience, I think the postpartum support is so integral. And I think one of the key roles that they play, but it does not minimize their, their role and support throughout that full spectrum prenatal labor and delivery and postpartum.

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

HARDIN: Other questions?

SPIVEY: Thank you, Senator Riepe.

HANSEN: I have more.

HARDIN: Yeah. Senator Hansen.

HANSEN: You brought up maternal deserts earlier. And so this is, this is kind of a constant topic that we always have to struggle with as a committee, but it seems like we're, we're always kind of viewing it from a different-- like the same lens all the time. Like, how can we pay providers more? How can we do incentive programs for colleges and scholarships? To me, this is a no-brainer.

SPIVEY: Absolutely.

HANSEN: I mean, giving, you know, different options from others I think is a no-brainer, I think. And so in your opinion, this, this would help out western Nebraska just as much as Omaha.

SPIVEY: Absolutely. Because with the, the doula support, usually folks are in the geography that they're in. And so as this would open up and provide a reimbursement rate, because that's the barrier, right, who can do this and, and not get paid? And so if there is a, a revenue stream, then we-- there can be folks that are trained in their areas and providing support. And, and doulas don't also just help with the prenatal labor, delivery, and postpartum, they're helping connect to

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resources. So if you're in western Nebraska and you're having issues with food access, they're gathering that information to make sure that, again, you have what you need. And so I think this is a part of that comprehensive approach. Again, I think the midwif-- midwifery information that is coming in front of your committee that you all are grappling with, like that's all a part of this comprehensive plan around how do we give power and choice to moms and their families? And then how do we ensure that people have the access to the care that they need in order to be well? And so, yes, I think this is a no-brainer. And I think that, again, we've tried to really work through all of the fiscal implications because we understand what that, what that looks like in the state. And I think we have a strong response to ensuring that this does not add more to our debt, but we have the funding stream. We have the right folks in the next steps for implementation that is outlined by NPQIC that we included in the bill and really try to do our due diligence so that this can be pushed through this committee into the body, and then we can start really supporting moms and babies like that. That is the goal with this. And so, yes, I, I agree with you, Senator Hansen. I think this will make a, a big statement for maternal and child health in our state.

HANSEN: Thank you.

SPIVEY: Thank you, Senator.

HARDIN: Questions? Thank you.

SPIVEY: Thank you, Chair Hardin. And, again, thank you, committee members. And I encourage you and your support to move this out of committee. Thank you.

HARDIN: This concludes LB701. We'll transition the room and prepare for LB454 with Senator Quick.

FREDRICKSON: All right, Senator Quick-- oh. All right, Senator Quick, you are welcome to open on LB454.

QUICK: All right. Thank you, Vice Chair Fredrickson and members of the committee. My name is Dan Quick, D-a-n Q-u-i-c-k, and I represent District 35. And today I'm here to introduce LB5-- LB454. This bill was brought to me by the regional behavioral health authorities, and is, and is aimed at providing flexibility to behavioral health regions and reducing barriers to mental health care in Nebraska. LB454 makes two overarching changes, both targeted at increasing access to services. First, LB454 updates the procedural requirements for the

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regional behavioral health authorities to secure mental health care provide-- health care services. The current statutory framework says that regional, regional behavioral health authority must contact-- must contract for their services through a competitive bidding process. This bill changes that requirement to allow the regional behavioral health authorities to expand and add services to, to current, to current providers without going through the typical bidding process. This would also include pilot projects approved by the Department of Health and Human Services to avoid that typical bidding process. Pilot projects approved, approved must be limited to one year, apply only to existing services, and have preapproved outcome measures established by the Regional Behavioral Health Authority. Allowing more flexibility for pilot projects to get off the ground, ensures the regions can respond and adapt to mental health care needs in their communities. Allowing for more flexibility and securing service, service offerings will result in increased innovation, better care-- better quality of care, and a greater access to services. This will all lead to stronger mental health outcomes. Second, LB454 clarifies the definition of individuals who have access to funding for housing needs. Under current law, some funds used by regional behavioral health authorities are restricted and may only provide rental assistance to those with serious mental health-- mental illness. This bill expands the scope of housing assistance to include low-income adults and substance use disorders. This aligns with the reality of individuals who need access to assistance with housing, and aligns with Nebraska's comprehensive approach to behavioral health care by recognizing that secure housing is crucial-- is a crucial factor in, in recovery and long-term stability. In developing, in developing this measure, we're engaged with key stakeholders, including mental health providers and a division of behavioral health. There will be testifiers after meetings that can speak in further detail to these issues. But I believe that LB454 will strengthen Nebraska's behavioral health system to be more efficient and flexible. With that, I respectfully ask the committee to advance LB454, and I'm happy to answer any questions you may have.

FREDRICKSON: Thank you. Any questions from the committee? Senator Riepe.

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

QUICK: Yeah, thank you.

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RIEPE: In one of your notes here it says, and expand housing assistance. But what if there is no housing for them to be assisted to?

QUICK: Yeah, I think they're talking about being able to have like-- so in Grand Island you might have a Mid-Plains or, you know, a, a facility, I'm using Mid-Plains, for example, but a, but a facility that has maybe housing or maybe I'm not sure if it's includes halfway houses and things like that where they, then they're not currently receiving those, you know, that assistance through those type of, of programs.

RIEPE: OK. So it's a, it's a different concept--

QUICK: Yeah.

RIEPE: --for the use of housing.

QUICK: Yeah, and, and it could be that they'll-- maybe I'm getting that wrong, but that's my interpretation of it. And maybe they would be able to address that.

RIEPE: They can make some sense, so thank you.

QUICK: Yeah.

RIEPE: Thank you, Chairman.

FREDRICKSON: Thank you. Other questions? Seeing none, we'll see you at close?

QUICK: Yeah.

FREDRICKSON: All right. We'll now hear from proponents for LB454. Welcome.

THOMAS JANOUSEK: Thank you. Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Dr. Thomas Janousek, T-h-o-m-a-s J-a-n-o-u-s-e-k, and I am the Director of the Division of Behavioral Health in the Department of Health and Human Services. I am here to testify in support of LB454. LB454 would remove the requirement for the regional behavioral health authorities, or regions, to complete a public bidding process to subcontract services, and it would allow the regions to continuously contract with providers who currently render DBH services. In addition, the bill would allow the regions to fund housing supports for individuals with

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a primary diagnosis of substance use. Currently, the regions are required to release a public bid for services to enroll a new provider into their network or expand the number of services rendered by an existing provider. The proposal requests consume large amounts of valuable time and disincentivize small behavioral health providers from responding due to lengthy documentation requirements. The process is similar to applying for a grant. Removal of the public bid requirement would simplify the process by allowing the regions to directly contract with providers with the department's oversight and approval. Further, this change would enable the regions to target smaller providers who would utilize funding to provide services, but who would lack the resources to respond to these lengthy requests. In addition, the bill would allow the regions to open their housing dollars to provide housing supports for individuals with a primary substance abuse disorder diagnosis. Currently, these dollars are reserved for individuals with a primary serious mental illness diagnosis. Given the clinical overlap of the two conditions, this change would allow the regions with oversight to expand to the population of individuals who could be served within community housing. While the division is in support of this bill, we do recommend a minor technical change. We respectfully request that the committee advance this bill to the General file with these changes. Thank you for your time. I would be happy to answer any questions on the bill.

FREDRICKSON: Thank you, Director. What is your minor technical change?

THOMAS JANOUSEK: So the technical change that we are requesting is that the pilot project language is stricken from page 4. So just essentially lines 2 through 6 on page 4. And this isn't because we oppose the idea, but the fact remains is that the regions can already put out pilot projects. It's just in the past, they would have to go through that RFP process to initiate a pilot project, right? So if this bill were to pass, they could directly contract to do pilot projects. And just having this language would be unnecessary to be put into statute. Similarly, the language says a pilot project shall have outcomes approved by the RBHA. There's a portion that says it shall not be used for existing services, and then says no more for than one year. Say there was a pilot project where we get a year into it and we go, let's give it another 6 months. This language would potentially preclude us from extending a pilot project to further evaluate it. So removal of that section would actually kind of lend to more freedom for the regions.

FREDRICKSON: Got it. Thank you. Other questions? Senator Meyer.

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MEYER: Thank you, Vice Chair. Full disclosure, I was involved with Region 4 Behavioral Health in Norfolk, and one of the struggles that I found that we had is sufficient funding. And we are currently, as of the end of December, up until the end of December, I was still involved with Region 4, and we struggled, quite frankly, with our housing budget. I think there's been some relief in that regard. I hear we're expanding a, a program, a housing program where we struggled previously to provide sufficient resources. As the Department of Health and Human Services, are you committed to providing sufficient resources to adequately fund this program?

THOMAS JANOUSEK: Absolutely. And I think we've evidenced that by making adjustments with amounts of money that we've had that has been in our Documentary Stamp Tax Service Fund and giving those additional funds out to the regions, as we've had gains within that cash fund to distribute.

MEYER: I know in the past, certainly COVID affected our budgets. And for those that don't know, it's a, it's a drawdown process. Funds-- budgets are made available and, and funds are drawn down on a monthly basis as billing is, is presented. And given COVID and expanded Medicaid, we were in a position over a number of years whereby we did not full-- draw down our full allocation of funds. I think the unfortunate result of that is just very recently, this, this last fiscal year, we had a substantial cut in our funds. To some extent, based on historical, recent historical evidence, we weren't having full draw down. From my personal experience, I know that we had a full commitment of the resources that we would have had available had we not had the cut. And so I think it's imperative that we have an adequate, adequate supply of funds to provide the services that's expected of our regions and, and also the commitment and, and realization and assessment of just if there is some discrepancy there, let's have that discussion so that we can justify there-- why there may be a, a, a discrepancy in how the funds are drawn down, so.

THOMAS JANOUSEK: We'd certainly be open to that. Yes.

MEYER: I appreciate that very much. Thank you.

FREDRICKSON: Thank you, Senator Meyer. Other questions? Seeing none, thank you for being here.

THOMAS JANOUSEK: Thank you.

FREDRICKSON: Next proponent for LB454? Welcome.

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TIFFANY GRESSLEY: Thank you. Got to put these on, unfortunately. Good afternoon, members of Health and Human Services Committee. My name is Tiffany Gressley, T-i-f-f-a-n-y G-r-e-s-s-l-e-y, and I'm the Regional Administrator for Region 3 Behavioral Health Services. Region 3 serves 22 counties in central and south central Nebraska. I appear before you today on behalf of the Nebraska Association of Regional Administrators and the Region 3 Governing Board in support of LB454. As the committee is aware, the regional behavioral health authorities, or regions, have been the structure for public behavioral health services across Nebraska since 1974. For 50 years, we've served as a safety net for Nebraskans who are uninsured, underinsured, and experience complex mental health and substance use disorders. Our networks of community-based providers and coalitions provide a comprehensive array of treatment, rehabilitation, support, and prevention services touching all 93 counties in Nebraska. LB454 is intended to increase access to services and support the flexible nature of the regional system and its ability to meet local needs. Within the current statutory framework, regions are required to complete a competitive bidding process to expand or add services within our network of providers. This requirement often creates barriers to responding to identified community needs in a timely and efficient manner by adding months of additional wait time while the request for proposals, or RFP, process is completed. LB454 changes that requirement to allow the regional behavioral health authorities to expand or add services with current legal network providers on a per service basis without that RFP process. This would also include pilot projects approved by the Department of Health and Human Services. Approved pilot projects, projects must be limited to one year and have preapproved outcome measures established by the regional behavioral health authority. We believe that allowing these narrowly tailored exceptions to the RFP process will provide more flexibility for the start-up of pilot projects, ensuring that regions can respond to locally identified behavioral health care needs and meet our responsibility of planning, developing, funding, and monitoring of our adult and children's publicly funded behavioral health services. I greatly appreciate the time that you've committed to hear this important bill and urge its advancement. And thank you to Senator Quick as well. I'm happy to answer questions.

FREDRICKSON: Any questions from the committee? Seeing none, thanks for being here. Next proponent? Welcome.

CHASE FRANCL: Thank you. Good afternoon, Chairman Hardin, members of the Health and Human Services Committee. My name is Chase Francl, C-h-a-s-e F-r-a-n-c-l. I serve as the President and CEO for Mid-Plains

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Center for Behavioral Health Care Services, which is headquartered in Grand Island. Mid-Plains Center has served our communities for more than 50 years. We provide an array of services, and we're funded primarily through Medicaid and contracts with the regional behavioral health system, along with funding from probation and private insurance. I'm testifying today in strong support of LB454, which would allow the behavioral health regions the flexibility to expand services among their existing provider network, as well as offer 1-year pilot programs without undergoing the lengthy and administratively burdensome RFP proposal process. In contrast to the Medicaid system, which employs a rigid, often federally restricted definition of basic services, the behavioral health regions were established to meet local needs as they exist and as they evolve. What should have been attached to your testimony today is a side-by-side comparison of the types of services that are able to be funded by the regions in which Medicaid and other insurers do not cover. Those are left on my printer at home, so I'll get those to you. Always leave them wanting more. The unique freedom and flexibility this creates is absolutely critical within the behavioral health system. And I want to share with you an example of how that responsiveness is impacting my community today. So through funding by Region 3, my organization conducts crisis assessments to youth in our communities. They can come to us either as walk-ins or more commonly referred by school counselors. Sadly, this has proved to be a popular service. We've assessed more than 50 youth over the past 4 months, but in the past, I've seen as many as 25 youth in a single month. Several months ago, I began receiving feedback from my therapists who were conducting these assessments and learned that they hated the fact that they had so little to offer the families in crisis besides a referral and a safety plan. Most commonly, youth who don't require hospitalization are being referred back home with a recommendation to begin seeing a therapist, but this regularly entails as much as a 2 to 3 month wait due to workforce shortages in our sector. Yet, the parents at that time wanted and needed support in that critical period to help them safely manage the behaviors, learn and practice new parenting skills, or refine and follow the safety plan. But, unfortunately, no such service existed. So I approached our region with the idea of creating an emergency family support program, and over the next 2 months, they helped us identify other system partners and funding. In this case, they had some ARPA funds still available, and as soon as the service was defined and we were ready, we had approval to begin supporting families in crisis. Had an RFP process been necessary, the program would not be serving families as it is now, but instead be stalled in multiple month waiting period, undergoing additional reviews and

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carrying additional administrative and personnel costs, all while benefiting absolutely no one. Instead, we were able to quickly launch as a pilot project and will have a much better understanding of whether the service effectively meets the needs we set out together to fill in the months to come. The last thing I'll just share is, as region network providers, we undergo a really lengthy process that includes submitting policies, processes, submitting to programmatic and financial audits, and really get to know our regions well, they get to know us well, and so it only makes sense that when needs exist, utilizing that, that knowledge that they have of us to, to meet those needs can really be expedited and give a lot of confidence that, that these services can be met. So thank you. Happy to answer any questions.

FREDRICKSON: Thank you for your testimony. Any questions from the committee? Seeing none, thanks for being here.

CHASE FRANCL: Thank you.

FREDRICKSON: Next proponent? Welcome.

PATRICK KREIFELS: Thank you. Good afternoon, Vice Chair Fredrickson and members of the Health and Human Services Committee. My name is Patrick Kreifels, P-a-t-r-i-c-k K-r-e-i-f-e-l-s, and I am the Administrator for Region 5 Systems, Behavioral Health Authority. Today, I'm here on behalf of the Nebraska Association of Regional Administrators and Region 5 Systems Governing Board. Region 5 is comprised of 16 counties in southeast Nebraska, and those are outlined in your handout. I want to begin by offering my profound appreciation to the senators and governor for your contributions to the state. Thank you for your service and leadership. The six regional behavioral health authorities were established in 1974 by LB302 with the duties and responsibilities of delivering publicly funded mental health services. In 1977, LB204 extended public policy to include substance use services. In 2004, LB1083 reconfirmed and replaced legislative bills with an emphasis and transition from institutional care to community-based care and advocacy for people with lived experiences of mental health and substance use challenges. The regional behavioral health authorities aid individuals by providing the Supported Housing Program, which affords people an opportunity to achieve or remain in permanent, affordable, and community-integrated housing while receiving behavioral health services supporting recovery. This program provides funding by way of a voucher for housing to serve as a bridge to other housing resources, such as a federal public subsidized housing, or living independently in housing without rental assistance.

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LB454 looks to clarify the definition of individuals who have access to funding for housing needs. Originally, the Housing Related Assistance Program was created in 2005 and utilizes Nebraska state documentary stamp tax dollars to provide housing assistance to individuals with serious and mental health illnesses. LB454 would allow the regions to serve individuals with substance use challenges and remove restrictions of only allowing regions to serve individuals with serious mental health illness, therefore, increasing access to care and adding flexibility on who may be served. This aligns with the original statutes of the public policy to change from initial substance use and going-- expanding-- or initial mental health and expanding to substance use, and aligns with SAMSHA's priority, which is to prevent substance use and overdose. At this point through the fiscal year, the regions have housed 734 people. We have 64 people on the waitlist that would meet the criteria for our housing programs. People do recover with mental health and substance use challenges and become productive citizens. I respectfully request you advance LB454 as it supports the wellness and recovery of Nebraskans with mental health and substance use challenges with very low income, a vulnerable population in our community. Thank you for the time to allow me to articulate how this bill supports wellness and recovery of the people we serve. I'm available to answer questions.

FREDRICKSON: Thank you for your testimony. Questions from the committee? Seeing none, thank you.

PATRICK KREIFELS: Thank you.

FREDRICKSON: Next proponent? Welcome.

ANNETTE DUBAS: Good afternoon, Vice Chair Fredrickson 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'm the executive director of the Nebraska Association of Behavioral Health Organizations. NABHO is a statewide organization representing community mental health and substance use disorder providers, hospitals, the regional behavioral health authorities, and consumer groups. We thank Senator Quick for introducing LB454 and his dedicated support for behavioral health in general. Sometimes I feel like the regional system is one of our best kept secrets, and not always easy to understand. It's easy to explain how Medicaid works. It's very much like an insurance. It's a payer, but not so with the regions. They are a system. The original legislation that established the Regional Behavioral Health System was to enhance local control and to be able to contract with vetted community providers for services that meet the needs of the citizens

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in that particular region. They're made up with boards of county officials that help with the planning and service implementation. The regions have the ability to tailor services within the service definitions and regulation guidelines to address mental health and substance use disorder treatment needs. LB454 is intended to support the flexibility built into our regional system. It will remove some of the red tape that slows down implementation of services, and gets money and services into the communities in a timely manner. Over the past several years, we have heard concerns about the regions not spending their money. And one of the reasons we repeatedly gave was the time it took to get projects or services approved. This legislation, while putting some parameters around pilot programs, will definitely streamline the process. My members will tell you they appreciate working with the regions. They believe the system fosters the ability to be innovative and truly meet the needs of their clients, as well as getting paid in a timely manner. This is a collaborative approach to providing treatment. The contracted providers really want to work together. We also support expanding the use of housing assistance to include those with substance use disorders. Access to affordable housing is one of the top challenges those going through treatment face, and it's so important to support their recovery journey. If they're not able to afford a safe and comfortable shelter, they're going to compromise their treatment plan. We believe LB454 goes a long way to meet the behavioral health needs of Nebraskans and urges this community, excuse me, this committee to advance LB454. Thank you so much for your attention, and I'd be happy to answer any questions if I'm able.

FREDRICKSON: Thank you. Questions from the committee? It seems like this is a pretty commonsense bill.

ANNETTE DUBAS: Yes.

FREDRICKSON: Thank you.

ANNETTE DUBAS: Thank you.

FREDRICKSON: Any other proponents? Seeing none, is there anyone here to testify in opposition to LB454? Seeing none, neutral capacity? Seeing none, Senator Quick, you're welcome to close. While you come up, we had one online comment in the-- as a proponent, zero opponents, and zero in the neutral capacity.

QUICK: All right. Thank you, Vice Chair. And thank you, committee members. And, Senator Riepe, evidently, I didn't know about the

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housing part very well, so I'm glad they answered some of that, so. But I think this is a, is an important bill that would help maybe speed up the process of, of, you know, getting that care that people need. I know even though when I was not in the Legislature, I also worked with, with our community to make sure that we were trying to provide mental health and, and help with addiction in our community. And worked a lot with the juvenile justice side to just trying to make sure we can help families and, and our kids. And I think one of the things that when people are in crisis, whether it's mental health or drug addictions, I think what we find there's barriers in place. And so at that, at that time, if they are needing that type of care, just trying to get into some facility sometimes is, is-- it's, it's, it's-- they just can't get in. So they can't get the treatment at that time that they really need it. And by the time that that facility is open or, or available, then they're already back into their addiction cycle. And it just becomes more difficult for them to, to do this. But I think with this type of loosening up a little bit so that they can provide more housing needs, be able to help people, maybe, get into a, a facility or care sooner, I think that's going to be really important for people all across Nebraska. And I don't think this is not just an urban, but it's also a rural thing so I think it would help the regions cover the whole state. So I think it's going to make that process a lot easier. So-- and also with the DHHS on their amendment, you know, we're willing to try to, to work with that to make that so that's an easier process as well. So thank you.

FREDRICKSON: Questions from the committee? Senator Meyer.

MEYER: Thank you, Vice Chair. I think Dr. Janousek had mentioned maybe removing some language. You're cool with that? You're, you're-- you've, you've had that conversation and--

QUICK: We haven't actually talked to him about it.

MEYER: OK.

QUICK: But, you know, I'd, I'd like to sit down and, and visit with him about it and make sure, you know, because they said it would make the process more, more helpful.

MEYER: It appears that it would conform more easily into what the intent of the bill is, so.

QUICK: Yeah. Yeah.

MEYER: Certainly. Appreciate that. Thank you.

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FREDRICKSON: Other questions? Senator Riepe.

RIEPE: Thank you, Chairman. I had a quick one here, I noticed that in the, in the fiscal note it says remove the public bidding, which is pretty much an inherent part of transparency and good, clean government. So I don't know. My point is I come from a perspective of 1 will get you 10. If we make an exception in 1 case, we're going to have 10 more in here next year.

QUICK: Yeah, I think that's just in essence, you know, it's trying to help with that process because when, when, when they have to go to that-- through that bidding process, then the care isn't, isn't always there when it's needed. So, I mean, it allows the behavioral health districts to, to really work with maybe a provider in the area or with the housing and that, and that process, so.

RIEPE: Could they have multiple sources that if (a) can't respond to it, they can go to (b) and go to (c), but they've all bid to get a certain-- if not a guaranteed price or guaranteed volume, at least some would be standby or you get what you get, but at least you're-- the providers would have alternatives so that they could be responsive.

QUICK: Yeah. Well-- and really out in rural Nebraska, I don't think there are that many providers. So it's-- so, you know, that-- the one you have there might be the one that you're going to have to, to talk with to see what-- but I understand your concern.

RIEPE: I was just thinking. I don't know. I'd like to think about it and look at it and talk to you.

QUICK: Yeah. Yeah. I appreciate it. Thank you.

RIEPE: Thank you, Chairman.

FREDRICKSON: You're welcome. Senator Meyer.

MEYER: If I may? And, and I want to address what Senator Riepe was saying. You're, you're very accurate, Senator Quick, with your assessment of the opportunity to find sufficient number of providers, and certainly in our rural communities. And I would, I would venture to guess even in the urban communities. And so the process is such that you have a fairly finite list of providers and you contract-- and, and please correct me, Doctor, if I'm, I'm wrong on this, but-- and I, I know there are some other regional professionals that could clarify this, but you contract with them and it's a monthly drawdown.

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And it's not like if (a) can't do it, (b) has to. We really don't have that option. And, and so we are not overcompensating them for the services that are provided I can assure you. So that's always a challenge. And then finding sufficient staff to provide those services in, in our communities is also a major problem. So while good government is, is-- really depends on competitive bidding processes. In all probability, we don't have that luxury in our rural communities. Perhaps, you do in your urban communities. So there's plenty oversight regarding our cost and abuse of any programs. There's audits, yearly audits. And so from the standpoint of no-bid contracts, which can be a problem, and I certainly appreciate your viewpoint on that. I believe perhaps in this setting it would be less of a problem than what it would be and some other, some other government activities, government projects. So I, I understand your concern though, but-- and it's certainly well within your purview to bring that up. But I think given the situation we have the services that are required and the services that are be rendered-- being rendered, I'm, I'm-- personally I'm very comfortable with, with that process right now, so, the no-bid process.

FREDRICKSON: Thank you. Other questions from the committee? Seeing none, thank you, Senator Quick. That will close our hearing for LB454.

HARDIN: Senator Quick, can we get you to stand up, turn around, and sit back down again in order to reset, reshuffle the cards for us?

QUICK: I could, but I think my legs are numb.

HARDIN: OK, gotcha. I think we're ready.

QUICK: All right. Thank you, Chairman Hardin and members of the Health and Human Services Committee. I'm Dan Quick, D-a-n Q-u-i-c-k, and I represent District 35. And today I'm here to intro-- intro-- to introduce LB255. LB255, which would appropriate \$1 million from the Opioid Treatment Infrastructure Cash Fund to problem-solving courts in order to provide medications, medication-assisted treatment for qualified-- qualifying individuals, and the problem-solving courts. Medication-assisted treatment, referred to as MAT, is the, is the use of medication approved by the federal drug-- Food and Drug Administration in combination with counseling and behavioral health therapies for the treatment of substance use disorders. For individuals with opioid use disorder, MAT addresses the physical, physical difficulties a person might experience when they stop taking, taking opioids. For individuals struggling with addiction, the use of these assistive medications in combination with behavioral health

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services can help sustain recovery better than just medication or psychological or social-- psychosocial treatment on their own. MAT for opioid use disorder includes three U.S. Food and Drug Administration approved medications. At the outset, I would like to address one common misperception about MAT. MAT is not the same as substituting one addictive, addictive drug for another. The dosage of drugs used does not produce the high associated with opioid misuse. These medications restore balance to the, to the brain circuits affected by addiction, allowing the brain to heal while working toward recovery. While every person has a unique path to, to recovery, the scientific evidence shows that MAT is a highly effective tool in the treatment of opioid use disorder that works well for many patients. Increasing-- increasingly-- increasing access to MAT will play a critical role in addressing the current opioid epidemic. Individuals with opioid use disorder are at risk-- are, are at the greatest risk of, of death and over-- overdose immediately following release from incarceration, specifically in the first 2 weeks following release. While Medicaid may not cover MAT for individuals who qualify, it can take 30 days after release for individuals to qualify. Reducing this barrier to receive MAT can ensure people have the treatment they need when they need it. And that is-- and that they aren't stopping and starting the treatment. MAT has been shown to reduce the risk of overdose by up to 75%-- or excuse me. MAT has been shown to reduce the risk of overdose deaths by up to 75%. Other benefits of MAT include decreased illicit opioid use, increases in social functioning and retention and treatment, reducing criminal activity, and reducing the transmission of infectious diseases. We decided to use the Opioid Treatment Infrastructure Fund for this bill, because this is an approved use of the opioid settlement funds in Exhibit E. This is ensuring that the opioid settlement funds are state-- that our state receives, are being utilized for an appropriate use. Additionally, problem-solving courts could be a good avenue to provide MAT. Currently, funding MAT is one of the biggest challenges for the problem-solving courts. Including funding for MAT in, in problem-solving courts will increase success rates statewide for those clients. Finally, I see this as an avenue for property tax relief. Medication-- medication-assisted treatment helps to reduce the recidivism, which is-- which, in turn, saves taxpayer dollars that would otherwise be spent on our-- on county corrections. There are testifiers behind me who can elaborate on MAT, but I think this is an important tool to fight the opioid epidemic, reduce recidivism, save property tax dollars, and give our problem-solving courts more tools to help individuals they serve. And, more importantly, I think this is going to help people who struggle with addiction. I think that's probably the most important part of

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that. I will say we have looked at-- we haven't talked with DHHS. They did come and talk to me a little bit about the infrastructure fund and maybe they want to use it more for infrastructure. I would like to see maybe, you know, if we can have the opportunity to use it for, for-- used for treatment. And so we are looking at maybe bringing an amendment. We'll see, you know, if the DHHS is OK with using the infrastructure funds. But there was maybe another avenue, and we're working on an amendment if, if that's what we need to do to try to find the funds, maybe through the Opioid Recovery Trust Fund. I would like to thank the committee and hopefully we can get this bill advanced out of-- out, and I'm happy to answer any questions you might have.

HARDIN: Thank you. Questions? I think I have lots of questions, but I might have more for you at the end.

QUICK: OK. All right. Thank you.

HARDIN: Proponents, LB255? Welcome.

JEFF KILPATRICK: Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Jeff Kilpatrick, J-e-f-f, second name K-i-l-p-a-t-r-i-c-k. I serve as the Director of the Lancaster County Department of Community Corrections, and I'm here to testify on behalf of Lancaster County in support of LB255. Lancaster County Community Corrections provides an alternative to incarceration for justice-involved individuals, including the Lancaster County Adult Drug Court. The mission of the Lancaster County Adult Drug Court is to increase public safety by providing a program that facilitates access to treatment, implements intensive case management, decreases substance abuse, and returns law-abiding, productive, and responsible citizens to their family and the community. While Nebraska's opioid prescribing rates are lower than the national average, the state still faces challenges related to the opioid crisis and overdose deaths. In Nebraska, 213 deaths were attributed to drug overdose between January 2020 and January 2021. A 49-- a 47.9% increase in overdose deaths were reported between January 2019 and January 2021. During 2018, 50.6 opioid prescriptions were written for every 100 persons in Nebraska. LB255 provides funding for medication-assisted treatment, a treatment strategy that combines FDA-approved medications, counseling, and therapy to help opioid dependent patients recover and maintain healthy lives. Studies have shown that the MAT treatment greatly increases a patient's chance to recover completely from opioid dependency. The evidence shows that the best outcomes and the greatest challenge for ongoing recovery from

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opioid use disorder comes from combining medication and patient-specific therapies in a holistic approach to treatment, producing a better outcome than either medication or therapy-based treatment alone can achieve. It is an essential element of comprehensive opioid treatment programs, including drug courts, DUI courts, veterans courts, and other treatment problem-solving courts. LB255 will take money from Nebraska Opioid Treatment Infrastructure Case [SIC] Fund and make this money available to the Nebraska problem-solving courts, where it is the greatest need. A substantial proportion of adults in adult-- in the adult drug court present a moderate to severe opioid use disorder. Opioids were ranked as a primary substance of abuse in approximately 20% of urban adult drug courts, and just over 30% of rural and suburban adult drug courts. Thank you for your time this afternoon, and thank you to Senator Quick for introducing LB25 [SIC]. I ask that you advance LB255 and use the Nebraska Opioid Treatment Infrastructure Case [SIC] Fund money to help fix the problem. Thank you.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you. Thank you for being here. I see that you're the Director of Community Corrections.

JEFF KILPATRICK: Yes, sir.

RIEPE: And my-- is this-- are these programs limited to those that are incarcerated or soon to be released?

JEFF KILPATRICK: These programs refer individuals that have been released and are on a probationary status.

RIEPE: OK.

JEFF KILPATRICK: So it's, it's in conjunction with state probation.

RIEPE: OK. The other question I have, it's a broader one. I'm from Douglas County so I look at this and say, is this a Douglas County, Lancaster County, McPherson County, a county issue as opposed to a statewide where the statewide is paying for the programs, but the focus-- and it might be more in Douglas County than in Lancaster. So I'm saying, I, I, I see programs as having merit, so is the question of who's paying the bill, because it's not going to be free?

JEFF KILPATRICK: No, but the, the number of participants are-- you know, 20% of the participants in each one of the county drug courts have these, these opioid addictions.

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RIEPE: Yes, but it would be different for McPherson County than it would be for [INAUDIBLE].

JEFF KILPATRICK: Right, the number of participants. Yes, sir.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. This is-- with our opioid settlement dollars, do, do you know how many we are sitting on currently?

JEFF KILPATRICK: How many? No, sir, no I don't.

FREDRICKSON: No? OK. I'll, I'll, I'll maybe ask some-- another [INAUDIBLE]. Thank you.

HARDIN: OK. You did cite some statistics related to 2021 and earlier. Do you know what things are looking like now closer to 2024, '25?

JEFF KILPATRICK: I'm afraid I wasn't able to find anything more current than what the data that I selected.

HARDIN: OK. The, the CDC is not usually terribly helpful on those kinds of keeping up to speed. That's for the record. So anyway, thank you, sir. Appreciate you being here.

JEFF KILPATRICK: Thank you.

HARDIN: Proponents, LB255? Welcome.

BOB DENTON: Thank you. Chairman Hardin and members of the Health and Human Services Committee, my name is Bob Denton, B-o-b D-e-n-t-o-n. I am the Deputy Administrator for the Adult Probation Services Division with the Administrative Office of the Courts and Probation. I testify today in support of LB255. Nationally and in Nebraska, the use of medication-assisted treatment in problem-solving courts is supported by best practice standards. Studies on treatment courts have reported significantly lower completion rates and higher recidivism rates for participants with opioid use disorders and higher rates of overdose deaths. When treatment courts adopt the use of medications for opioid use disorders, they have significantly better outcomes, including improvement in treatment retention, completion rates, employment, and long-term recovery. Administrative Office of the Courts and Probation currently offers financial assistance towards psychological evaluations, initial diagnostic interviews, and ongoing medication management appointments for qualified justice-involved problem-solving

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court participants. However, we do not offer financial assistance towards the cost of medication-assisted treatment. LB255 would enhance the Administrative Office of the Courts and Probation's ability to support participants with medication-assisted treatment needs by allowing for financial assistance towards prescribed medications for qualified participants. Therefore, we support LB255 and view it as a critical resource to assist individuals in being successful within Nebraska problem-solving courts. And I want to thank you for your time today and would be happy to answer any questions.

HARDIN: Thank you. When you say allowing for financial assistance towards prescribed medications for qualified participants, tell me a little bit about the prescribed medications. We're trying to get away from opioids. We know what a blight they have been in people's lives. Tell me about the prescribed medications and, and just kind of comment on all of that.

BOB DENTON: Sure. Well, I'm not an expert in medications,--

HARDIN: Sure.

BOB DENTON: --I want to clarify that. But making--

HARDIN: The courts are saying good, not so good. And so can you just kind of talk about that for me?

BOB DENTON: So the use of medication-assisted treatment, again, is a best practice standard in Nebraska. So if you have an individual who is an opioid addict and requires medication, problem-solving courts cannot prohibit them from entering a problem-solving court. Actually, encourage it. However, we don't have funds to pay for those medications right now. By giving us this funding, we would now be able to pay for the medication. So right now, if we have an individual that needs these, and Mr. Kilpatrick mentioned or, I'm sorry, Senator Quick mentioned the three different-- there's three different kinds of medications that are approved. If they're prescribed those medications, they have to find funding on their own. And a lot of times, you know, they don't get it.

HARDIN: OK.

BOB DENTON: Yeah.

HARDIN: We're looking at \$1 million a year. Do we have any sense how many people that might serve? How far does that \$1 million stretch? Any idea?

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BOB DENTON: I, I don't. I don't have any idea to that. As to Senator Riepe's question about the need in, in, you know, the western part of the state, unfortunately, opioid addiction is statewide and not-- the majority are probably in the metro area, but there's a need across the state.

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

BOB DENTON: Thank you.

HARDIN: Proponents, LB255? Welcome.

ANNETTE DUBAS: Good afternoon, Chairman Hardin 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'm the Executive Director for the Nebraska Association of Behavioral Health Organizations. NABHO is a statewide organization representing community mental health and substance use disorder providers, hospitals, regional behavioral health authorities, and consumers. And we thank Senator Quick for introducing LB255 and his support for behavioral health in Nebraska. NABHO is a very strong proponent of problem-solving courts. We've seen the benefits, especially the drug and mental health courts. We know these courts help to reduce and address recidivism, and moves us away from a punitive response to those with a substance use disorder to one of evidence-based treatments and rehabilitation, which provides help and hope for individuals and their families. It costs approximately \$11.94 a day for an individual to participate in a problem-solving court versus \$36.67 a day for incarceration. And I just might add, if you've never been to a problem-solving court graduation, I would strongly encourage you to do so. It does instill a great deal of hope as you see these individuals successfully complete their programs. The more tools and resources we can provide for problem-solving courts and the people that are involved with, the more we can anticipate better outcomes for these individuals and their families, and hopefully less expense for the state. MAT services are an evidence-based practice that allows behavioral health professionals to use a combination of medications and/or therapies to provide a whole-person approach to treat substance use disorders, especially those dealing with opioids, heroin, and fentanyl. Withdrawal and abstinence from these drugs is extremely difficult. Individuals are assessed by professionals and monitored closely, and these medications are used to help curb cravings and lessen the symptoms. By blocking these receptors, it decreases the effects of the substance and helps to prevent overdoses. For those who are going through a drug court, having access to behavioral health professionals who can assess the individual's drug

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use and then include medication-assisted treatment as part of the overall treatment protocol, just gives another valuable, proven treatment option to the courts to help individuals successfully complete their treatment and graduate. We believe directing some of these opioid settlement dollars towards providing this, this important treatment is an appropriate and beneficial use. I thank you for your time and attention and urge you to advance LB255 to General File. Thank you for your time.

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

ANNETTE DUBAS: Thank you.

HARDIN: LB255 proponents? Welcome.

JASON WITMER: Good afternoon, Chair Hardin and committee. My name is Jason Witmer, J-a-s-o-n W-i-t-m-e-r. I am here representing the ACLU in favor of LB255, which enhances the role of problem-solving, problem-solving courts here in Nebraska. Nebraska faces a critical contradiction in our criminal legal system. As Chief Justice Funk has recently stated, even though our state's crime rate has decreased, the rate of incarceration has increased. We continue to have one of the most overcrowded prisons in the United States. LB255's investment in problem-solving courts reduces recidivism, saves taxpayer dollars, and helps individuals rebuild their lives. Prison does none of these. And, personally, I'd like to say that probation is a great support in diverting people from this costly system. Nebraska's problem-solving courts are tested and effective alternatives to an overcrowding prison system. According to the Nebraska Judicial Branch 2024 Annual Report, 76-- 76% of all adults in problem-solving courts do not recidivate-- re-- re-offend, which I'm sure you guys know, but. To demonstrate the effectiveness of specialized courts for targeted populations, the Veterans Treatment Court impressively has an 87% completion rate. LB255 ensures that more Nebraskans receive support they need to expand access to medication-assistance treatment, an evidence-based method address-- addressing the opioid disorders. I put my notes because I've been learning about this, and so they are very much layman's notes and I thought, I know there's going to be professionals out here, I definitely did not want to come in here talking all about this-- the medication-assistance treatment, but everything I've read about it says it helps in so many ways. And some of that's in there. Incarceration is not just an ineffective-- not just ineffective for many, it is also fiscally irresponsible, and Chief justice pointed out in his recent address that for prison, it's \$41,000 for each person every year. For, for probation, it's \$3,500. Diverting only 100 people

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annually into problem-solving courts could save Nebraska nearly 3.75, three and a quarter, three-quarter million dollars. And that's money that could be reinvested in rehabilitation, public safety, or the cost that we might have to put up front for this. Again, as Chief Justice stated that even though our state's crime rate has decreased, the rate of incarceration has increased. We suffer from outdated policies, including the belief that the solution lies in more prison beds. However, I submit we side with the Chief Justice. We need more problem-solving courts and funding to sustain them. LB255 ensures, ensures that Nebraskans struggling with addiction receive treatment, not just punishment. So with that, we'd ask you to advance LB255.

HARDIN: Thank you. Questions?

JASON WITMER: Thank you.

HARDIN: Seeing none, thank you.

JASON WITMER: Thank you.

HARDIN: LB255 proponents? LB255 opponents? Welcome.

THOMAS JANOUSEK: Hello. Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Dr. Thomas Janousek, T-h-o-m-a-s J-a-n-o-u-s-e-k, and I am the Director of the Division of Behavioral Health in the Department of Health and Human Services. I am here today to testify in opposition to LB255. LB255 appropriates \$2 million over the next 2 years from the Opioid Treatment Infrastructure Cash Fund to support problem-solving courts ordering medication-assisted treatment for substance use disorders. Right now, the Division of Behavioral Health is required by statutes to distribute money in this cash fund. The Legislature has previously decided that the Opioid Treatment Infrastructure Cash Fund shall be used for public and private partnerships for opioid use prevention and opioid treatment infrastructure projects, which can include both capital construction and renovation projects. Nebraska is currently prioritizing capital expenditure projects with Opioid Treatment Infrastructure Cash Fund dollars, as this is a rare opportunity to physically build structures that will render behavioral health services. We are currently in talks with multiple providers regarding the development of crisis stabilization and withdrawal management programs. We are also in the process of finalizing a process for additional providers to apply for this funding in partnership, in partnership with the behavioral health regions. The project proposed in LB255, would appropriate funds to problem-solving courts to order

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FDA-approved medication-assisted treatment services in combination with counseling and behavioral health therapies for the treatment of substance use disorders. The activities in this bill are treatment-oriented rather than funding infrastructure, which is not aligned with the purpose of the Opioid Treatment Infrastructure Cash Fund. Nebraska has existing resources such as the Behavioral Health Services Fund administered through DBH, the State Opioid Response Grant, which is also administered through DBH, and these are designated to cover a broad spectrum of behavioral health services, including supportive medication-assisted treatment described in LB255. I'm also going to add that Medicaid also covers medication-assisted treatment. And as a part of every substance use service in Medicaid, it requires that they provide access to medication-assisted treatment. The funds I previously mentioned have the flexibility to address the growing demand for services without compromising infrastructure and development. Additionally, community organizations such as behavioral health providers can request funds from the behavioral health regions as a part of their appropriations under Nebraska statute 71-2491 to the Opioid Prevention and Treatment Fund. Utilizing these sources ensures that the ability to maintain and expand MAT access without diverting funds for critical capital projects. We respectfully request that the committee not advance the bill to General File. Thank you for your time and I would be happy to answer any questions about the bill.

HARDIN: Thank you. Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Director, for being here and for your testimony.

THOMAS JANOUSEK: Yep.

FREDRICKSON: So do, do you know approximately how much, what, what the funding status is currently of this, of this fund? How much money we have?

THOMAS JANOUSEK: In the treatment infrastructure fund, there's about \$9 million.

FREDRICKSON: OK. OK. And for the projects you referenced that-- and it sounds like DHHS has plans for those, those, those funds. Do you have a sense of timeline on that?

THOMAS JANOUSEK: Yeah. So we've had some conversation with some providers, and we're trying to work out details to get plans and contracts in place. We are looking to get our application process here

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out within the next couple of months, so that we can start getting applications for more of these projects here, hopefully, started this year.

FREDRICKSON: OK. And when you say infrastructure, I'm not going to hold you to this, but do you have a sense of how many separate sites that the department is envisioning with these funds?

THOMAS JANOUSEK: I've at least got three on the top of my mind. We're trying to really target crisis stabilization and withdrawal centers so that we can aid with law enforcement as alternatives to incarceration, because those types of centers are the things that we need the funding to stand up. And those can go a long way in really serving the purpose of what I think we're all trying to do, which is divert unnecessary legal involvement.

FREDRICKSON: OK. And then last question, do you know geographically where in the state those were located?

THOMAS JANOUSEK: We're looking at the central part of the state, the northeastern part of the state, and then we're also in some talks with some providers on the far western end of the state in the Panhandle area.

FREDRICKSON: Great. Thank you.

THOMAS JANOUSEK: Yep.

HARDIN: Are you saying good idea, wrong fund from which the moneys flow?

THOMAS JANOUSEK: Essentially, what I'm trying to say is that the, the, the whole thing with this Opioid Treatment Infrastructure Fund, we have never had a funding source, to my knowledge, that has allowed us to actually build buildings and create that kind of necessary infrastructure by capital expenditure. Right? So our behavioral health services fund through DBH, we can pay for services with that. The portion that was sectioned off from LB1355 last year, that can go to funding services. We have a State Opioid Response Grant that is-- comes from federal dollars that can go towards funding services. And then on top of that, Medicaid already pays for this level of treatment for medication-assisted treatment. So, again, more money to fund the service. We're really trying to capture and keep this infrastructure fund to build buildings, which we can't use with any other funding source.

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HARDIN: OK. Senator Riepe.

RIEPE: Thank you. Thank you for being here. Will the fund allow you to lease buildings so you don't have to have such a high capital investment?

THOMAS JANOUSEK: Potentially, but since the nature of these, these settlement funds are kind of finite, we're only getting so many from these settlements. We're trying to invest in things where we can make a big impact with a one-time expenditure. So, yes, we could potentially lease buildings, but the better investment is to actually buy something that could stand over time.

RIEPE: Not if you can't come up with the capital.

THOMAS JANOUSEK: Well, and that's where this fund would come in, so.

RIEPE: OK. Thank you.

THOMAS JANOUSEK: Yep.

RIEPE: Thanks, Chair.

HARDIN: Any other questions? Thanks for being here.

THOMAS JANOUSEK: Thank you.

HARDIN: LB255. No more opponents? Neutral testifiers, LB255? Seeing none of those, while Senator Quick comes up, we have four proponents, zero opponents, and one neutral testifier online.

QUICK: Thank you, Chairman Hardin. I think I'll start off with one thing I do want to maybe correct that was just talked about. Of the people who go to problem-solving courts or on probation, they cannot receive Medicaid. So those dollars-- that's not-- they're not-- they can't access those dollars. So, you know, and, and we're willing to talk to DHHS. I understand the need to have that infrastructure in place, too. So I understand that they want to use those dollars for that. But I think we do need to find some place where we can find those dollars that's going to help with that MAT treatment to keep people from-- they go through-- they're, they're in-- spend some jail time. There's-- they're-- they-- they're off the drug. But then when they come back out, if they're not getting that MAT services, they start using again. And, actually, sometimes when they use-- after they haven't used for a while, they start using at the same levels that they're at, it can cause death. So I think it's really important. I

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think this bill is important for that treatment. And I think it is happening in every county across the state. It's happening in Hall County. I think through the, the problem-solving courts, they're trying to address that and trying to help these people in, in our rural areas of, of the state. I'm sure it's, it's probably happening out in Scotts Bluff as well. Opioid addiction, it's-- it doesn't care what county you live in. It's happening everywhere. So I'm going to talk a little bit about just from a personal level, if you haven't lived it or experienced that, it's very devastating to a family. Personally, on a personal note, it's happened to my family and you can see-- sorry--

HARDIN: That's OK, Dan.

QUICK: --you can see not only how it affects the individual, but also the family. Although, this wouldn't directly help my son, it could help many others. I see with my son how opioids have affected him. It changes your brain, brain chemistry. As hard as he tries to quit, he can't get off the drug and we're trying to help him as best we can. You know, as parents, you try to do the best you can for your kids. And did we do everything the right way? But he struggled with this since he was 15 years old. He's going to be 40 this year. He's had a whole lifetime of drug use. And we've experienced it firsthand. We went through treatment with him every single time. Four times he's been through treatment. He knows treatment like the back of your hand. I've told him that God must have a plan for him or he'd be dead already. So I figure at some point, since God has been protecting him, he's going to find that, that help he needs. And he's gonna be able to help other people because of his experience. So, you know, I know this is through the problem-solving courts, it won't affect my son. We're trying to do the best we can for him. But a lot of these people that go through these court systems, they don't have that support, that, that family support. When he went through treatment, when he was, when he was 15 or 16 years old, we saw a lot of children. Actually, their parents were probably drug users, and that's why they ended up-- they were in that cycle of drug use in that home. And so we witnessed it firsthand of children going through treatment along with our son. It doesn't care who you are. It doesn't care what class you come from. It doesn't care if you come from poverty. It doesn't care if you're, if you're a doctor's son. When, when the drug gets a hold of you, it's devastating. And so I think treatment is really important and we're trying to work and get our son into some type of MAT treatment so he can get his, his brain back in order, and so that those drugs would, would be a way for him to get out of that, to help that brain

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chemistry correct itself. And then he can go through treatment again and actually get the help he needs. So with that, thank you.

HARDIN: A pastor friend of mine wrote a book a number of years ago and its title is: Everybody's Normal Until You Get to Know Them. And it's true for all of us. And so thank you for sharing your story. Questions? Seeing none, thank you. LB255's hearing comes to an end. We're going to transition to LB553 and Senator Riepe. In just a moment or two, Senator Riepe, we'll get going. I think, Senator Riepe, we are dangerously close to ready.

RIEPE: I hope so, if I can get my voice going. Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Merv Riepe. It's M-e-r-v R-i-e-p-e, a senator representing District 12, which is the south-central Omaha and the fine town of Ralston. I would like to go on record and express my sincere and pressed-- being impressed by Senator Swift's or Quick's ability and willingness to share that kind of a story. That has to be very challenging and I simply want to be on record as hoping that God will help them. Today, I am presenting LB553, which expands student loan and loan repayment eligibility under the Rural Health Systems and Professional Incentive Act to include dietitian nutritionists. Dietitian or dietetic nutritionists are essential health care providers, particularly in rural areas where food deserts limit access to healthy food and contribute to higher rates of obesity, diabetes, and heart disease. Their expertise helps patients manage chronic conditions, improve dietary habits, and reduce reliance on costly medical interventions. Since I carried a bill to address this topic last year, I'd like to note that although GLP-1, medications like Ozempic, have shown promise in treating obesity and diabetes, they are not a cure-all. These drugs are most effective when combined with proper nutrition and lifestyle changes where dietitians play an essential role ensuring rural communities have access to these professionals, strengthen prevention-- preventive care, and improves long-term health care outcomes. LB553 allows dietitian nutritionists to qualify for loan repayment incentives. Helping recruit and retain dietitians in underserved areas by expanding this program, we take a proactive step in addressing health care disparities and improving patient care access across Nebraska. I appreciate your time on this Friday afternoon and for your consideration, and I urge you to support LB553. Experts and-- will be testifying after me. Thank you. And I appreciate and will try to answer any questions you may have.

HARDIN: Thank you. Senator Fredrickson.

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FREDRICKSON: Thank you, Chair Hardin. Thank you, Senator Riepe, for bringing the bill. Is this, is this the same program? I'm, I'm having a hard time remembering. I know Senator Strommen had a-- was with the CRNAs.

RIEPE: Nurse Anesthetist?

FREDRICKSON: Yes.

RIEPE: Yes.

FREDRICKSON: Is this the same scholarship program and, and so your bill is a similar bill to his?

RIEPE: Yes.

FREDRICKSON: It would just-- it would include dietitians?

RIEPE: Yes. And there are other professions that are included in this--

FREDRICKSON: Yep. OK.

RIEPE: --pool, if you will.

FREDRICKSON: Got it. Thank you.

HARDIN: OK. Other questions? Will you stick around?

RIEPE: Absolutely.

HARDIN: Thank--

RIEPE: I can't think of a better way to spend a Friday afternoon.

HARDIN: That's right.

RIEPE: Thank you.

HARDIN: Proponents, LB553? I just became very self-conscious about what I've been eating.

WHITNEY LARSEN: Well, we were just talking about,--

HARDIN: I'm sorry, go ahead.

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WHITNEY LARSEN: --it's snack time, right? It's 4:00 in the afternoon. I thought we-- we're dietitians, we should have brought some snacks. So, OK.

HARDIN: Welcome.

WHITNEY LARSEN: Thank you. Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Whitney Larsen, spelled W-h-i-t-n-e-y L-a-r-s-e-n, and I am testifying in support of LB553 as the President of the Nebraska Academy of Nutrition and Dietetics, representing licensed dietitian nutritionists across Nebraska. First, we would like to thank Senator Merv Riepe for introducing this bill and recognizing the importance of including registered dietitians in the Rural Health Systems and Professional Incentive Act. LB553 will update this act to offer the opportunity for licensed dietitian nutritionists to apply for the loan repayment award if they practice in underserved or rural communities in Nebraska. Currently, the allied health professions eligible to apply for this loan repayment award are pharmacy, occupational, and physical therapists. A dietitian is a nutrition expert who holds a degree from an accredited program, complete supervised practice requirements, and passes a national exam. Dietitians play a vital role in health care settings, including hospitals, clinics, community health centers, and assisted living facilities, where they contribute to the prevention and management of chronic diseases through medical nutrition therapy. I am a registered dietitian working as a licensed dietitian nutritionist in an outpatient private practice. I primarily provide nutrition therapy to individuals diagnosed with eating disorders. Eating disorders are serious, complex, and potentially life-threatening mental illnesses. To best serve these patients, it requires an interdisciplinary medical team. The role of the registered dietitian is vital to the patient's health, well-being, and long-term ability to remain in eating disorder recovery. Yet, it is not available to most patients living in rural areas of our state due to lack of access to registered dietitian services in the area. Many times, eating disorders in these communities go undiagnosed or untreated, resulting in serious medical complications and even death. In addition to the testimonies you will hear today from students and colleagues of mine that have more statistics, I want to highlight the letters of support from many of our members who are practicing in rural areas of our state. Many who work within assisted living communities and nursing homes drive 2 to 3 hours to provide medical nutrition therapy to their residents. Letters also came from students within the Allied Health college at the University of Nebraska at Kearney campus, who are interested in providing nutrition services to

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rural areas of Nebraska. The intention of adding our profession to the statute is not to create an excessive financial burden on the program, but simply to allow qualified dietitians the opportunity to apply for this support. On behalf of our 404 members at the Nebraska Academy of Nutrition and Dietetics and all licensed dietitian nutritionists across Nebraska, we respectfully request your support and advancement of LB553, and thank you for your time and attention.

HARDIN: Thank you. Questions? Senator Ballard.

BALLARD: Thank you, Chair. Thank you for being here. So if I understand your testimony correct, it's a 4-year program or 4-year education? 6 year?

WHITNEY LARSEN: To be a registered dietitian now, it is a 6-year program. It's a graduate program.

BALLARD: It's a graduate program so 4 years undergrad, 2 years of graduate work.

WHITNEY LARSEN: Yep.

BALLARD: OK. Perfect. And then does every school in Nebraska have a dietitian program like UNK, UNL?

WHITNEY LARSEN: UNK, UNL, and then University of Nebraska in Omaha does as well.

BALLARD: OK. Thank you. Appreciate it.

WHITNEY LARSEN: Yes. You're welcome.

HARDIN: Senator Hansen.

HANSEN: Thank you. What's the worst three things you could eat?

WHITNEY LARSEN: Oh, my goodness.

FREDRICKSON: On the record, too.

WHITNEY LARSEN: Well, here I'm of the positive, like--

HANSEN: I'm curious to see what you say.

WHITNEY LARSEN: --all foods fit, right? Positive nutrition. Let's talk about what we should add, not take away.

HANSEN: Ah, OK, psychology there. OK.

WHITNEY LARSEN: So the three best, the best foods.

HANSEN: OK. I, I, I won't, I won't, I won't have you say anything on the record so don't worry about it.

WHITNEY LARSEN: OK. Thank you.

HARDIN: Has our food pyramid been wrong? Most of us here are older, Senator Ballard and, well, Senator Fredrickson notwithstanding, probably Senator Hansen, too, but we grew up with a certain paradigm, has that changed?

WHITNEY LARSEN: Yes, it has changed. We now-- I don't know, are you all familiar with MyPlate? So we, we use a plate because we all eat on plates, right, so it's a little bit more tangible, a little bit more visible, a visual, than the, the pyramid. And so the MyPlate still has those food groups because we know those food groups are very important in terms of, like, the, the nutrients that they have. So that's why they're there and represented. But we use the plate to just show better proportions of, of how much of each nutrient we should really be eating and focused on for health prevention of chronic disease as well as weight management.

HARDIN: Is it still-- is it fun or is it somehow squelching to our souls to take this on? I'm just saying emotionally.

WHITNEY LARSEN: For me personally or for you guys?

HARDIN: No, I'm saying for the public, in general.

WHITNEY LARSEN: For the public.

HARDIN: Are we going to accept this as a, as a something we've got to do? Clearly, we've got all kinds of challenges in our country. And my question is emotionally, is this something that people are open to in terms of getting this kind of help when it's shown to them? Do they show resistance to it? Is it scary? Kind of talk us through-- how can, how can you hold our hands as we learn to eat better?

WHITNEY LARSEN: Yeah, and that's a great question. I work with, you know, patients with eating disorders. So for my patients, food is very scary. And so I am there as that support to really help them get that education and understanding of, you know, there's lots of myths out there of what we should and shouldn't be eating and doing as far as

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nutrition. And so I really am there to support these patients. And even patients I work with that don't have eating disorders really serve as that, just professional that's going to stand and, and explain what they should be eating and, and help make it applicable for them, help make it easy for them, fit it into their lives versus sometimes, you know, being given a handout or something. It's not as, as, as easy to do, right? We're changing behaviors, that's difficult. So our job is to really sit down with the patients and, and figure out how we can make it as, as easy for them as possible.

HARDIN: We're short, anywhere from thousands to hundreds to dozens of medical professionals in every category. How many dietitians do we need across this state that we're lacking, do you know?

WHITNEY LARSEN: That are lacking or how many do we have?

HARDIN: How many do we need that we don't have?

WHITNEY LARSEN: Oh, how many do we need that we don't have? Well, in our-- the student that's testifying after me, she has a map that shows how many diet-- dietitians are in the whole state of Nebraska. I would say there's roughly 100, 200 to 300 over here in the Omaha, Lincoln-- Omaha metro, Lincoln area. But when we look at, like, central and, and western Nebraska, you know, we have 20 to 30. And so I think more of our focus with this is, is trying to get more dietitians in these rural communities. And we, we started a program at the University of Nebraska at Kearney campus. We're just trying with this bill to, then, retain those students who are studying there to stay in the rural areas. Does that answer your question?

HARDIN: Yeah.

WHITNEY LARSEN: OK.

HARDIN: Senator Hansen.

HANSEN: Thank you. I'll say the food pyramid was probably the worst scam in American history, but that's just me.

HARDIN: Thank you.

HANSEN: A question about do you have to work directly under a physician or-- because I think you're in a private practice, aren't you?

WHITNEY LARSEN: Yes.

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HANSEN: Are you able to have a private practice without under the direction of anybody else, correct?

WHITNEY LARSEN: Yes.

HANSEN: OK. I got to ask to make sure. Thanks.

HARDIN: Any other questions? Thank you.

WHITNEY LARSEN: Thank you.

HARDIN: Proponents, LB553?

HANNAH HARRISON: Here's the testimony and then the map. Thank you.

HARDIN: Welcome.

HANNAH HARRISON: Hello. Thank you. Chairperson Hardin and members of the Health and Human Services Committee, thank you for the opportunity to provide testimony on LB553. My name is Hannah Harrison, H-a-n-n-a-h H-a-r-r-i-s-o-n. I am a native Nebraskan and spent much of my childhood way out west in Scottsbluff before moving east to finish high school in Gothenburg. I am here today to advocate for important updates to the Rural Health Systems and Professional Incentive Act. My testimony reflects my personal views and does not represent my school, the University of Nebraska Medical Center, the College of Allied Health Professions, or my peers. So I'm currently pursuing a master's degree in Medical Nutrition at UNMC, preparing to become a registered dietitian nutritionist. When I chose this career path, I understood that graduate school would require an investment of both time and financial resources. However, it was a necessary step to achieving my career goal. To make this investment possible, I rely on an unsubsidized student loan. I was encouraged to learn about Nebraska's loan repayment program, which incentivizes health care professionals to work in rural, underserved counties. However, I was surprised to discover that dietitians are not included in this program despite a clear statewide shortage. Efforts to address these shortages are already underway. UNMC has expanded its medical nutrition program to the Kearney campus, providing students with hands-on clinical experiences in central and western Nebraska. I recently had an exceptional clinical experience at Great Plains Health in North Platte, an opportunity that may not have been possible without the camp-- Kearney campus expansion. While training in rural Nebraska increases the likelihood of students receiving job offers in these communities, it does not guarantee long-term retention. The loan repayment program, which offers a 2- to 4-year service commitment, has

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proven to be an effective investment strengthening partnerships between employers and the state. Nutrition plays a critical role in major chronic diseases such as diabetes, heart disease, and obesity, diseases that impact countless Nebraskans. I'm eager to serve in a community where my knowledge and skills can make a meaningful impact. Expanding the loan repayment program to include registered dietitian nutritionists would reinforce my commitment to practicing in rural Nebraska and motivate future graduates to do the same. This inclusion is a direct step toward addressing health care workforce shortages and improving access to quality care in rural Nebraska. Passing LB553 is a strategic investment in building and sustaining Nebraska's dietitian workforce, ensuring all residents receive the same nutrition care they need, no matter where they live. Thank you for your time and consideration.

HARDIN: Thank you.

HANNAH HARRISON: Yes.

HARDIN: Questions?

HANNAH HARRISON: And I did quite a bit of research so if you have questions, I would be a good resource.

HARDIN: Well, the troubling thing about your testimony is why on earth would you ever leave Scottsbluff?

HANNAH HARRISON: I know, a job opportunity for my family took us to Gothenburg.

HARDIN: This map is very helpful. Tell me what you-- I, I can see lots of zeros in those counties. Meaning that's how many dietitians there are there. Tell me what you see when you look at this map.

HANNAH HARRISON: So I referenced that experience at Great Plains in North Platte. So I was just there for the last month. And they have one inpatient dietitian and two outpatient dietitians. And right now, the one inpatient dietitian is swamped. It's not-- I mean, there is another position available at Great Plains, actually right now standing that they haven't filled yet. Another inpatient opportunity. So just in seeing that all the dietitians in that area recognized that there was a lot more work than there were people to fill the, fill the jobs.

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HARDIN: Do patients find you on their own? Do they come predominantly through referrals from other docs? How exactly do you end up engaged with these folks?

HANNAH HARRISON: Yeah. Great question. So in the inpatient setting, a patient would come in and they would get screened. We have a screening tool that nurses will ask patients these series of questions. It varies hospital to hospital. But that's pretty much generally the process, and then depending on how a patient answers this question. So have you lost weight recently? How much weight have you lost? A dietitian will be pinged for going to visit with that patient. Something in the inpatient setting that we look for is malnutrition, which impacts 20 to 50% of all patients in the hospital. Malnutrition is kind of a heavy emphasis in dietetics, because it increases a patient's mortality rate by almost three and a half times. So being able to catch those diagnoses would-- is kind of one of the most focused points of an inpatient dietitian. And then the outpatient setting, it would be more referral based.

HARDIN: When you talk about terms like malnutrition, what's the demographic breakdown of that? How many of these are seniors versus middle-aged folks versus kids,--

HANNAH HARRISON: I'm glad I wrote that down.

HARDIN: --that kind of thing?

HANNAH HARRISON: Yes. So it's 1.7 times more prevalent in a population of greater than 85 years.

HARDIN: OK.

HANNAH HARRISON: So definitely predominant in the elderly.

HARDIN: OK. Senator Meyer.

MEYER: Thank you, Chair Hardin. Well, you're a licensed, a licensed dietitian. Do you work with, say, public institutions? Say county jail? From my experience, we have a-- essentially a regional jail in Thurston County. And we were contracting with the restaurant to provide meals. Breakfast was a cold breakfast, but then lunch and dinner. We contracted with the restaurant to provide those meals, and they had to be approved with a-- by a licensed dietitian. So do you work with public entities? Is that part of your practice, or is there some, some other professional structure that provides that service? Because as, as I look at your map, we've got zeros and ones pretty

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much predominantly all over everything here. And so how does that work? How does that work in our underserved communities?

HANNAH HARRISON: Yeah. So that's a great question. So dietitians are required to be at every hospital. So that would be one facet of it. And then so for example like a senior center when they are prepping their meal plans, which would be kind of comparable to your public entity.

MEYER: Sure.

HANNAH HARRISON: So for example, the senior center in my hometown consults with the Cash-Wa dietitian. So Cash-Wa employs dietitians and they help oversee the meal plans and make sure that they're fitting the standards for that population. So that would be another area.

MEYER: It seems, with so few licensed dietitians in the state, that it's almost an impossibility to cover all of the institutions and, and, and, and public bodies like hospitals and, and certainly schools and things of that nature. So I, I just-- I can't imagine that it's even remotely possible for you to or for all the-- of the, the aggregate of all the dieticians that are on this map, that your workload must be overwhelming at the very least. And I would imagine there are some institutions falling through the cracks in all probability, so.

HANNAH HARRISON: Yep, your point makes me think of-- so in Logan County, which is in west central Nebraska, within 100 miles of Logan County, there are only 17 dieticians licensed within that 100-mile radius. So that's about 3% of the state's dietitians. But that radius has 16 hospitals with 358 beds and about 25 skilled nursing facilities with about 1,500 beds. So that's pretty, pretty widespread.

MEYER: And, and then there's the assisted living facilities, nursing homes, things of that nature that all require a licensed dietitian to provide--

HANNAH HARRISON: Yeah, there's--

MEYER: --guidance with regard to meals, so.

HANNAH HARRISON: There's a service called DiningRD, which will contract dietitians and they will travel to the assisted living facilities.

MEYER: Thank you.

HANNAH HARRISON: Yeah. Thank you.

HARDIN: Square this world for me when you say dietitians are required at every hospital, is that acute care or critical access or both? Can you tell me what that means? And then where I'm going next is what's the word required mean, because evidently some of them are without a dietitian?

HANNAH HARRISON: Yes.

HARDIN: Do they have to do push-ups? I'm just trying to figure out how that works.

HANNAH HARRISON: So for my understanding, so Gothenburg is a critical care hospital, it has 15 beds, and they have a part-time dietitian in their health care team. So that would be an example of some of those critical care access hospitals. I-- maybe some of the following testifiers might have a little more information on that since I am still a, a student on the outside about to be entering this profession. But that would be my experience in the critical access.

HARDIN: OK. Thank you.

HANNAH HARRISON: Yes. Thank you.

HARDIN: Oh, I'm sorry. Senator Meyer.

MEYER: Just a bit. And, and, perhaps, my questioning was, was implying that they had to be on site, they don't have to be on site. It's-- you can, you can remote work and approve a meal plan or a weekly meal plan or that type of thing, but, still, it just-- the appearance that you guys-- it's, it's spread pretty thin and, and certainly there's people falling through the cracks here, so.

HANNAH HARRISON: Yeah, absolutely.

MEYER: I appreciate your time. Thank you.

HANNAH HARRISON: Thank you.

HARDIN: Other questions? Thank you.

HANNAH HARRISON: Thank you very much.

HARDIN: Proponents, LB553? Welcome.

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AMY VOLKMAN: Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Amy Volkman, A-m-y V-o-l-k-m-a-n. I am testifying in support of LB553. And thank you to Senator Riepe for introducing the bill. I'm a dietician at the University Nebraska Medical Center's Munroe Meyer Institute. I am here representing my own personal beliefs and not on behalf of UNMC. However, my work focus is on preventing malnutrition in children with complex medical conditions, food allergies, and feeding difficulties. In addition, I work with the genetics team and I assist patients with metabolic conditions follow lifesaving by complex diet plans. I have also worked in nursing homes, a variety of nursing homes around the state, where I wrote orders for tube feeds and prevented malnutrition and elderly adults. Without my work, many patients would require more medical interventions and hospitalizations. Every day I use food and supplements in a preventative way to help patients remain independent and reduce hospital stays. I provide my services for patients all across Nebraska. Many families drive into Omaha to see me and my medical team. Just yesterday, I had a mom drive in with her 8-month old over 2.5 hours from Cedar County in order to see a dietitian. She was-- had been looking for a pediatric dietitian for a couple of months for her baby. And Munroe Meyer has a remote clinic in Hastings that has speech therapists who provide feeding therapy but they do not have access to a dietitian. They frequently request my consult for nutrition guidance for their patients, but I am at my limit with the number of patients I can see. Across Nebraska, there are numerous hospitals and nursing homes that are required to have a dietitian overseeing nutrition services like we just discussed. And then there is that attached map where you can see one to zero dietitians in a very big chunk of the state. There are not enough dietitians to work in the many nursing homes and hospitals in the area, let alone enough dietitians to provide outpatient care for, like, weight loss support or feeding therapy, community nutrition programs, diabetes management. As discussed, University of Nebraska extended their dietetic master's program to Kearney to help address dietitian shortage. But now we need help to retain dietitians in western and central Nebraska. I actually have quite a bit of family in Dawson and Custer counties, so I know from them their struggles of finding adequate medical nutrition care. I really feel very strongly that our rural Nebraskans, our farmers, our farmers' children deserve medically trained nutritionists to prevent and treat medical complications. They deserve to be treated by a medical professional who lives near them, and who understands the unique and amazing lifestyle of rural Nebraskans. Nebraska has that statute that helps to retain qualified medical professionals in

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shortage areas. And we're just asking that licensed dietitians be included in the statute. Thank you.

HARDIN: Questions?

AMY VOLKMAN: Yes.

HARDIN: So telemedicine not a good idea for this, or is it a good idea for this?

AMY VOLKMAN: I-- so I can make it work, but it's best-- I give my best services when I'm able to see the child in person. I'm able to connect with the parents. I'm able to do a visual of the child, and there are times I've caught possible constipation issues, bloating, things like that by being able to see the child in person. So I feel really strongly that our services are best done in person.

HARDIN: OK. All right. Seeing no other questions, thank you.

AMY VOLKMAN: Yeah. Thank you.

HARDIN: Proponents, LB553? Welcome.

NIKI KUBIAK: Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Niki Kubiak, spelled N-i-k-i K-u-b-i-a-k, and I am testifying in support of LB553. Thank you, Senator Riepe, for introducing this bill. I am a registered dietitian nutritionist employed by the University of Nebraska Medical Center as a contracted employee for the Department of Health and Human Services, Division of Public Health, to manage the State Health Assessment and State Health Improvement Plan. I am a current member of the Medical Nutrition Therapy Board as well, but I am speaking today on behalf of myself and of the Nebraska Academy of Nutrition and Dietetics. The results from the 2022 Nebraska State Health Assessment show that 9.7% of Nebraskans have ever been diagnosed with diabetes. This is over a 2% increase over a 10-year time frame, and approximately 161,500 individuals. At the same time, combined rates of overweight and obesity have increased about 5% to 69% across the state within the same time frame. And research shows that obesity is linked to over half of new cases of Type 2 diabetes and treating the chronic disease of obesity can prevent or delay the onset of diabetes. Furthermore, obesity and diabetes prevalence rates have increased across all three geographic areas in Nebraska, including the rural, the urban small, and urban large over the last decade. In fact, Scotts Bluff County ranked number two against all Nebraska counties for diagnosed diabetes prevalence in 2021. So the highest rates of both obesity and diabetes

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combined are occurring in our urban small communities and rural areas have the second highest rate in obesity, with slightly lower rates of diabetes than urban large across areas across the state. So studies have confirmed significant cost savings in medical expenses due to medical nutrition therapy, resulting in as much as \$1,500 per year per patient. And for every \$1 spent on medical nutrition therapy, \$3.03 are saved on medication alone. Dietitians do make a difference and can positively impact these growing rates of diabetes and obesity in areas that are currently lacking these services. Access to health care is limited in many geographic areas of Nebraska. The benefit of having more registered dietitian nutritionists in the rural areas is not just their level of expertise, but also their versatility. So dietitians are competent to provide clinical, community, and nutrition management services, from providing medical nutrition therapy through the local clinic or hospital, to overseeing meal delivery programs to the town's elderly residents, and providing nutrition guidance during a parent and teacher meeting at the school to improve early childhood nutrition. So since Nebraska has an existing statute to help retain qualified medical professionals in shortage areas, we are asking that licensed dietitian nutritionists be included in the statute to improve access to nutrition care for all Nebraskans across the state. Thank you.

HARDIN: Thank you. Questions? Does this say that seven out of ten of us have obesity problems?

NIKI KUBIAK: It says that Senator Hardin. Yes. The growing rates-- maybe the room is not representative. What's interesting is within the 44 to 50-- let's see, it's 44- to 54-year-old age group, give or take a year or two there. That's where we're really seeing the, the increase in diabetes risk and obesity combined. And that age group right now is about 74%.

HARDIN: 74%--

NIKI KUBIAK: Yeah.

HARDIN: --of our people who are in their prime earning years.

NIKI KUBIAK: Yes.

HARDIN: I see. How do we compare to other states? Are we number one in the country in that category?

NIKI KUBIAK: Oh, shoot, I should have looked. We are not number one. We are not number one, but we are-- and if you look at the, the

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demographic maps, I want to say we're, like, in the top seven states for rates of obesity.

HARDIN: I see. OK. Questions? Senator Hansen, you seem to have a perplexed and flummoxed look on your face.

NIKI KUBIAK: I'm ready.

HANSEN: Nope.

NIKI KUBIAK: Bring it on. What questions do you have?

HANSEN: No, just-- I'll ask you later.

NIKI KUBIAK: Not for public record? OK, fair enough. But I, I can tell you if it's OK if I just add this. You know, the, the Division of Public Health is really focused on access to care, and UNMC is really focused on access to care. And this is a really effective way to support those efforts. And you can see from the research that-- and medical nutrition therapy is, is very effective. One more thing. This-- the Academy of Nutrition and Dietetics has research that shows 2 weeks to 12-- 2-- sorry, 2 sessions to 12 sessions of medical nutrition therapy can result in 1 pound to 18 pounds of weight loss.

HARDIN: Wow.

NIKI KUBIAK: So we do-- we, we are that answer to the obesity epidemic, but we have to get into these regions. If we, we don't get into these regions, we, we have the ability to one-on-one counsel and interact with individuals and set up personalized plans. Everything we do is tailored. We do not cookie cutter template anything, and there are effective programs that, that people can participate in. But when you look at the weight loss results and the improvements from those programs versus what medical nutrition therapy specifically provides, it's not the same. We are that answer. We are more effective.

HARDIN: Senator Fredrickson.

FREDRICKSON: OK, I'll take the bait. What about, what about GLP-1s?

NIKI KUBIAK: What-- OK. OK. That is such a fantastic question. How much time do you guys have? No, I'm just kidding. So what, what, what we are worried about as dietitians is the GLP-1s are creating such rapid weight loss that patients are losing immense muscle mass. And what happens when you lose muscle mass is your metabolic rate comes down. It declines. So what happens when these patients, and I ask the

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question because we don't know yet, what happens when these patients get off of these medications and try to resume a normal life, they're going to see increased weight gain by eating less food. And I've seen this, I'm a sports dietitian, I, I have, have many hats, and I've seen this in ultra marathoners where they run off their muscle mass. And I've had a, a woman who was running 50 miles a week eating 1,200 calories a day, gaining weight. But I fixed it with strength training and rebuilding that muscle mass, we were able to resolve her issues. So that's where we're looking at the GLP-1s. We're, we're going to struggle with what happens with these individuals. They're very expensive. How long can they stay on them? That's-- you know, that's another question because, you know, people want to stay on them long term, but we don't know the consequences of that either.

HARDIN: Senator-- I'm sorry.

FREDRICKSON: Oh, I'm done now.

HARDIN: Senator Hansen.

HANSEN: Now, I don't know, I don't know if it's defined so much in research yet, but I know there's some concerns about gastrointestinal issues with those. I, I just had this growing concern that this is going to be one of those medications that we're going to regret--

NIKI KUBIAK: Yes.

HANSEN: --like a year or two down the road because of all the permanent effects. And I'm even starting to see some patients who are on it who are starting to see some neurological issues maybe.

NIKI KUBIAK: Ooh, interesting. OK.

HANSEN: I mean like, like neuralgia type stuff, you know, in the lower extremities. And I heard that might-- I haven't dug in it as much yet, but I heard that might be kind of a side effect as well.

NIKI KUBIAK: OK.

HANSEN: So I-- but the rapid weight loss is-- that is, is blatantly obvious. And, and it's, and it's kind of--

NIKI KUBIAK: Yes, the consequences of that will be significant. I was still in direct patient care when those first came out for about 6 months. So that's the extent of experience I can speak from. But what I experienced was patients had no motivation to eat. So I don't know

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if you've been hearing that. They're, they're happy. They're, like, I'm not hungry, I'm not eating. And so I was just trying to coerce my patients to eat something. That was new. And then if they're not eating, that microbiota that we need-- their, their gut bacteria that keeps them healthy, that releases serotonin, that boosts our mood, that just runs our bodies, is going to die because we need fruits and vegetables and natural sugars and things and fibers to keep that going. So, yes, I, I would say, absolutely, we're going to see a lot of increased gut issues also with this.

HANSEN: I feel better, I drank my Kombucha tea this morning.

NIKI KUBIAK: Uh-huh. Get your probiotics. Absolutely.

HARDIN: Senator Meyer.

MEYER: I just had a comment to make. When you talk about obesity, some of us are just too short for our weight. I don't care what you say.

NIKI KUBIAK: Dietitians would argue that we can fix that.

MEYER: OK.

HARDIN: Thank you for being here.

NIKI KUBIAK: Thank you very much for your time.

HARDIN: Proponents, LB553? Any more proponents? Any opponents? Who wants to be an opponent to this? Those in the neutral, LB553? Well, Senator Riepe, now that we all feel guilty, come on back.

RIEPE: I'm not neutral.

HARDIN: OK. We had--

RIEPE: I'm going to go home and have a bowl of broccoli or something.

HARDIN: --we had 15 proponents, zero opponents, and 2 in the neutral.

RIEPE: Thank you, Chairman Hardin. One of the things that I love about dietetics is I think it's the doorway to preventive health. And we can do all the treatment and spend all the money that we want to. But unless we get into a preventive health side of this thing, and we'll never be perfectly successful at it, but we will never win if we don't try. I, I also think that this really makes-- dietetics makes it a central contribution to maternal and infant care. Because if you don't get a, a potentially unknown, maybe a diabetic mom who is pregnant or

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on the road to there, you may have a-- you may lose the baby and you may have a real serious problem, so. And that can happen whether you're living in town or you're living in the country. Today and going forward, I think we have to be aware of the food that we eat and we have to be aware-- avoid the, the critical food that we, maybe, long for, but we can't. And that, that is applicable whether we live in urban areas or whether we live in the rural. So we're all the same in that regard. That's all that I have. I would attempt to answer any questions, but I'm sure that after all of your questions, you're very well-informed.

HARDIN: Questions? Thank you.

RIEPE: You're going to let me off easy.

HARDIN: We appreciate it.

RIEPE: Thank you, all, very much. And thanks to all of those who testified and I appreciate it.

HARDIN: This concludes LB553 and our hearings for today. No exec, folks, and so have a safe weekend.