RURAL HEALTH ADVISORY COMMISSION

P.O. BOX 95026 • LINCOLN, NE 68509-5026 • PHONE (402) 471-2337 • FAX (402) 471-0180

M E E T I N G N O T I C E & A G E N D A

RURAL HEALTH ADVISORY COMMISSION (RHAC)

Friday, February 23, 2024
1:30 p.m. – 4:00 p.m.

Nebraska State Office Building
"Meadowlark Room" - Lower Level Conference Room
301 Centennial Mall South
Lincoln, Nebraska

Or

Virtual via Webex
https://sonvideo.webex.com/sonvideo/j.php?MTID=mbd513875d4115db8c9a385604ee57f71

Access handouts the day of the meeting at:
http://dhhs.ne.gov/Pages/Rural-Health-Advisory-Commission.aspx (under "Documents")

1. Call Meeting to Order; Open Meetings Act & Agenda Posted; Adopt Agenda; Approve Minutes of November 17, 2023, Meeting; Introduce Members and Guests

2. Administrative Items
   - Accountability and Disclosure Forms
   - Student Loans Form 1098s
   - Current Members Status Updates
   - Other Announcements

3. Rural EMS Issues
   - Report from Micheal Dwyer, EMT

4. RHAC Strategic Planning Session Follow-Up
   - Loan Repayment Prioritization Matrix
   - Marketing of Programs

- continued on next page -

NOTE: All items known at time of distribution are listed; a current agenda is available at the Nebraska Office of Rural Health during regular business hours (8:00 a.m. – 5:00 p.m. CST, Monday through Friday, except holidays), or on the DHHS web site, along with any public handouts. http://dhhs.ne.gov/Pages/Rural-Health-Advisory-Commission.aspx *(under "Documents")*

If auxiliary aids or reasonable accommodations are needed for attending the meeting, please call 402-471-2337. Persons with hearing impairments may call DHHS at 402-471-9570 (voice & TDD) or the Nebraska Relay System at 711 or 800-833-7352 (TDD). Advance notice is needed when requesting an interpreter.

5. Rural Health Systems and Professional Incentive Act Programs
   - LB 1015; LB 1062
   - Shortage Area Requests
   - Budget Update

6. Review Current Federal & State Legislative Activities Impacting Rural Health

7. Public Comment

8. CLOSED SESSION
   - Review Loan Repayment Applications
   - Accounts Receivable

9. OPEN SESSION
   - Motion(s) on Closed Session Discussion

10. Adjourn

NOTE: All items known at time of distribution are listed; a current agenda is available at the Nebraska Office of Rural Health during regular business hours (8:00 a.m. – 5:00 p.m. CST, Monday through Friday, except holidays), or on the DHHS web site, along with any public handouts. http://dhhs.ne.gov/Pages/Rural-Health-Advisory-Commission.aspx *(under "Documents")*

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NEBRASKA OFFICE OF RURAL HEALTH
P.O. BOX 95026 • LINCOLN, NE 68509-5026 • PHONE (402) 471-2337 • FAX (402) 471-0180

DRAFT MINUTES of the

Rural Health Advisory Commission (RHAC)

Friday November 17th, 2023
1:30 p.m. – 3:11 p.m.
Nebraska State Office Building
Lower Level Goldenrod Conference Room
301 Centennial Mall South
Lincoln, Nebraska

- or –

Virtual Via Webex

1. **Call Meeting to Order; Open Meetings Act and Agenda Posted/Available for Download; Adopt Agenda; Approve Minutes from August 18th, 2023 Meeting**
   Chairman Marty Fattig called the quarterly meeting to order at 1:35 p.m. with the following members present: April Dexter, N.P.; Marty Fattig; Jeffrey Harrison, M.D.; Kate Hesser, M.D.; Kate Kusek, D.D.S.; Rebecca Schroeder, Ph.D; Myra Stoney; Timothy Tesmer, M.D.; Jeffrey Wallman, M.D.; Roger Wells, PA-C.

   Mr. Fattig announced that the meeting notice had been posted to the DHHS website and sent out via email and USPS on October 27, 2023.* Handouts and meeting agenda were also posted on the DHHS website, with a link to these given on the agenda itself *(http://dhhs.ne.gov/Pages/Rural-Health-Advisory-Commission.aspx - under "Documents").* Additionally, the Open Meetings Act and meeting agenda were posted outside the meeting room.

   **Sent as usual to: NE Rural Hospital CEOs, NE Certified Rural Health Clinic Directors, NE Local Public Health Departments, NE Community Action Partners, NE Community Health Centers/FQHCs, NE Professional Associations/Organizations, NE State Senators, the Offices of the Governor and Lt. Governor, and other rural interested parties and groups.*

   Myra Stoney moved to approve the November 17th, 2023, meeting agenda and Kate Hesser, MD seconded the motion. Deb Stoltenberg initiated roll call vote. YES: Dexter, Fattig, Harrison, Hesser, Kusek, Schroeder, Stoney, Tesmer, Wallman, Wells. ABSTAIN: None. EXCUSED: Green, Greene, Hunt.

   Roger Wells, PA-C moved to approve the August 18th, 2023, meeting minutes with the correction that there are 23, not 223 FQHCs where referenced, and Myra Stoney seconded the motion. Deb Stoltenberg initiated roll call vote. YES: Dexter, Fattig, Harrison, Hesser, Kusek, Schroeder, Stoney, Tesmer, Wallman, Wells. ABSTAIN: None. EXCUSED: Green, Greene, Hunt.

2. **Administrative Items**
   Commission Member Update

Timothy Tesmer, MD was welcomed by the chair and other commission members.

Nominate and Vote for Chair and Vice-Chair
Chairman Fattig discussed that he is willing to serve one more term.

Jeffrey Harrison, MD moved to nominate Marty Fattig as Chair and Roger Wells, PA-C seconded the motion. Deb Stoltenberg initiated roll call vote. YES: Dexter, Fattig, Harrison, Hesser, Kusek, Schroeder, Stoney, Tesmer, Wallman, Wells. ABSTAIN: None. EXCUSED: Green, Greene, Hunt. Motion Carried.

Kate Hesser, MD moved to nominate Rebecca Schroeder, PhD as Vice-Chair and Jeffrey Wallman, MD seconded the motion. Deb Stoltenberg initiated roll call vote. YES: Dexter, Fattig, Harrison, Hesser, Kusek, Schroeder, Stoney, Tesmer, Wallman, Wells. ABSTAIN: None. EXCUSED: Green, Greene, Hunt. Motion Carried.

Set Meeting Dates for 2024
The commission will meet on the following dates and times:
1. Friday, February 23rd from 1:30-4pm in Lincoln, Nebraska State Office Building (or via Webex)
2. Wednesday, June 5th from 1:30-4pm in Kearney, Nebraska to coincide with the Annual NE Rural Health Conference
3. Friday, August 16th from 1:30-4pm in Lincoln, Nebraska State Office Building
4. Friday, November 15th from 1:30-4pm in Lincoln, Nebraska State Office Building (or via Webex)

3. RHAC Strategic Planning Session Follow Up

Commission members discussed next steps and determined they should choose 2-3 of the strategic goals identified in the session in August. They would then have a subcommittee meet and discuss. Marketing of loan program, optimizing financial support, and optimized rural workforce were the three areas discussed. Subcommittees were not determined. Marketing the programs was discussed as a major item and Office of Rural Health (ORH) staff mentioned they have a brochure available and do some outreach but could do more if there are specific organizations the commission feels would be good to focus on. Members asked ORH to reach out to Dr. Harrison and Dr. Greene to determine which areas to focus on. Kearney Hub was mentioned, and April Dexter remarked that nursing students in Wayne and Kearney should also be considered.

Heidi Peirce spoke about a needs assessment ORH is pursuing per Roger Wells, PA-C request after the last meeting. ORH will be contracting with Dave Palm on a needs assessment to determine what areas of Nebraska are experiencing shortages and which provider types are most needed, looking at primary care, dental, mental health. Would then be able to base a matrix on the finds of this assessment. HPTS data will be used.

4. Rural Health Systems and Professional Incentive Act Program Updates

Shortage Area Requests
Nuckolls County requested re-assessment as a shortage area for Occupational Therapy. Upon review by ORH (verified by HPTS), they do not qualify.

Budget Update
Fiscal Year 2023-24; July 1, 2023-June 30, 2024 - first year of new biennium:

Total allocation = $2,180,723
$1,906,339.54 obligated
$274,383.46 remaining

New applications will obligate some of these funds (remaining amount can be carried over to FY24-25).

Cherlyn Hunt joined the meeting via Webex at 1:46pm.

RHAC's 2023 Annual Report and Distribution
Roger Wells, PA-C moved to approve the Rural Health Advisory Commission's 2023 Annual Report, with updated maps to be added to the report after today's meeting, and agreed that the Chair would distribute the Annual Report with a cover letter from the Commission via email to the following individuals/groups: Governor, Lt. Governor, all State Senators,

Nebraska's Congressional representatives, and DHHS' Directors. April Dexter, RN seconded motion. Deb Stoltenberg initiated roll call vote. YES: Dexter, Fattig, Harrison, Hesser, Hunt, Kusek, Schroeder, Stoney, Wallman, Wells. ABSTAIN: Tesmer. EXCUSED: Green, Greene. Motion carried.

Annual Report will be added to the webpage that ORH maintains for the Commission, replacing prior versions. If any physical copies are desired, ORH can assist with printing these documents.

Dental Checkup

ORH sent a note to dental providers in the program and asked them to report on the situation with Medicaid patients in their areas. Two responses were received. Kate Kusek, DDS appreciated the messages and agreed with many points. Most dentists limit the number of Medicaid patients they see or limit days they accept Medicaid in order to keep their practice financially viable. Claims process is going from 1 to 3 companies (increased complexity), but annual cap is being lifted. There are still limits to procedures that can be done, but after this change, they will be able to take out teeth and deliver a denture in the same session. Dentistry is struggling with ethics right now; needs to be treated as essential healthcare. There is astronomical need: two-year waitlists. Myra Stoney mentioned that the health directors have been discussing convening a dental summit; they try to address some needs with "dental days" but, as Kate Kusek, DDS remarked, "people need a dental home"/a permanent provider to go to. Tim Tesmer, MD remarked that as CMO his role is to be a liaison between healthcare agencies. He will talk to Medicaid and see if anything additional can be done.

Annual PRISM Update

Heidi Peirce reported on the PRISM system used by ORH and other states to survey loan repayment participants in all programs (about 35 states currently are using this system). Types of surveys – annual, end of year (provider, administrator) – alumni, 1 year after completion. J1 visa waiver recipient study – starting 2nd year. Date range – data pulled from last year for this report (planning to report back annually). Surveys in contract period – demographics, characteristics of job worked – alumni survey adds forecasting into the future. Key indicators of overall feeling about the program and their interaction with administration.

5. Review Current Federal and State Legislative Activities Impacting Rural Health

Roger Wells, PA-C remarked that CMS 2024 regulatory update allowed Medicare coverage for marriage and family therapists; offering intensive outpatient treatment program. Changed definition of Nurse Practitioner to be all inclusive/standardized. Congressman Smith – modernization act – decrease administrative burden (updating requirements that haven't been looked at since the 70s) – unsure if this will pass.

Chairman Fattig mentioned that there will be some legislative acts to watch during the upcoming session in state legislature, one dealing with EMS, one with COVID. Sixty-day session is coming up, so anything you'd like to get introduced, get it in quick. Also mentioned Medicaid eligibility was changed from 90 days post-delivery to 12 months. Governor's taskforce to talk about workforce shortage – discuss rural housing and childcare.

6. Public Comment

No comments.

7. CLOSED SESSION

Kate Hesser, MD moved to go to Closed Session for the purpose of review and discussion of accounts receivable, loan repayment program applications, and other confidential information, and for the prevention of needless injury to the reputation of the individuals at 2:56 p.m.

Roger Wells, PA-C seconded the motion. Deb Stoltenberg initiated roll call vote. YES: Dexter, Fattig, Harrison, Hesser, Hunt, Kusek, Schroeder, Stoney, Tesmer, Wallman, Wells. ABSTAIN: None. EXCUSED: Green, Greene.

Chairman Marty Fattig announced that the Commission would go into Closed Session at 2:57 p.m.

It was announced that guests should leave the room and the Webex.

8. OPEN SESSION

Myra Stoney moved to go into Open Session at 3:07 p.m. and Roger Wells, PA-C seconded the motion. Deb Stoltenberg initiated roll call vote. YES: Dexter, Fattig, Harrison, Hesser, Hunt, Kusek, Schroeder, Stoney, Tesmer, Wallman, Wells. ABSTAIN: None. EXCUSED: Green, Greene. Motion carried.

Myra Stoney moved to approve the loan repayment applications with estimated loan repayment start dates and loan repayment amounts as indicated or as determined by Office of Rural Health staff, based on issuance of license and/or loan documentation, practice time in the shortage area, and the availability of funds for the state match, and also to approve action discussed during the accounts receivable portion. Kate Hesser, MD seconded the motion. Deb Stoltenberg initiated roll call vote. YES: Dexter, Fattig, Harrison, Hesser, Hunt, Kusek, Stoney, Tesmer, Wallman, Wells. ABSTAIN: Schroeder. EXCUSED: Green, Greene. Motion carried.

Date application submitted	First Name:	Last Name:	Profession:	Name of Facility:	County	Average hours per week	Average ER hours per week	Date provider began or will begin practice in the shortage area:	Loan Balance	Matching Funds	State Start Date:	State Award Amount:	SLRP Start Date:	SLRP Minimum Award Amount:	SLRP Maximum Award Amount:
8/16/2023	Shauna	Lindstedt Easterday	MD/DO, Obstetrics and Gynecology	North Platte OBGYN	Lincoln	40	0	7/29/2024	$252,769.62	$30,000.00	8/1/2024	$180,000.00			
8/16/2023	Danielle	Rose	Nurse Practitioner, Family Practice	Community Action Health Center	Scotts Bluff	35	0	6/23/2020	$ 70,723.04	$15,000.00			7/1/2024	$43,750.00	$ 70,723.04
8/30/2023	Darian	Nordhues	Nurse Practitioner, Family Practice	Valley County Health System	Valley	40	20	1/22/2020	$119,972.10	$15,000.00			9/1/2025	$25,000.00	$ 50,000.00
9/25/2023	Michelina	Hollister	Licensed Mental Health Professional	Blue Valley Behavioral Health Beatrice	Gage	35	0	11/3/2020	$125,000.00	$ 4,000.00	1/1/2024	$ 24,000.00			
9/27/2023	Katelyn	Wisnieski	Physician Assistant, Family Practice	Alegent Health Memorial Hospital DBA CHI Health Schuyler	Colfax	40	0	7/24/2023	$202,992.00	$15,000.00	1/1/2024	$ 90,000.00			
9/28/2023	Karla	Crane	Licensed Mental Health Professional	Kearney Counseling Associates	Buffalo	45	0	6/17/2022	$ 52,206.53	$ -	1/1/2024	$ -			
10/2/2023	Crystal	Wilson	Licensed Mental Health Professional	Fillmore County Hospital	Fillmore	40	5	4/1/2022	$ 66,620.88	$10,000.00	9/1/2024	$ 60,000.00	9/1/2025	$ -	$ -
10/18/2023	Emily	Royer	MD/DO, Psychiatry	Columbus Community Hospital	Platte	40	0	8/1/2024	$170,591.88	$30,000.00	7/1/2024	$170,591.88			
10/23/2023	Christopher	Buckley	MD/DO, General Internal Medicine	Columbus Community Hospital	Platte	40	0	9/5/2022	$470,000.00	$30,000.00	1/1/2024	$180,000.00			
10/25/2023	Alexi	Peterson	Physician Assistant, Obstetrics and Gynecology	North Platte OBGYN	Lincoln	40	0	2/9/2021	$148,000.00	$15,000.00	1/1/2024	$ 90,000.00			
10/26/2023	Kathryn	Weaver	Nurse Practitioner, Obstetrics and Gynecology	North Platte OBGYN	Lincoln	40	0	1/11/2022	$ 48,238.85	$ 8,000.00	1/1/2024	$ 48,000.00			
10/30/2023	April	Vonderfecht	MD/DO, Family Practice	Brodstone Healthcare	Nuckolls	40	6	6/1/2025	$188,758.27	$30,000.00	6/1/2025	$180,000.00	9/1/2025	$90,000.00	$180,000.00
11/2/2023	Allyson	Jablonski	Nurse Practitioner, Family Practice	Chase County Community Hospital and Clinics	Chase	40	34	9/25/2023	$185,667.99	$15,000.00	1/1/2024	$ 90,000.00	9/1/2025	$ -	$ -

Note: If award amount is blank for a particular program, provider does not qualify for that program. If $0 is listed, funds for that program were already obligated and provider will be added to a waitlist to allow time for them to find a match or to potentially be funded in the case of another provider's withdrawal.

9. Adjourn

Kate Hesser, MD moved to adjourn at 3:11 p.m., and no second is necessary. Deb Stoltenberg initiated roll call vote. YES: Dexter, Fattig, Harrison, Hesser, Hunt, Kusek, Schroeder, Stoney, Tesmer, Wallman, Wells. ABSTAIN: None. EXCUSED: Green, Greene. Motion Carried.

The next meeting will take place on Friday February 23rd from 1:30-4pm in Lincoln, Nebraska in the NE State Office Building.

The Future of EMS in Nebraska

I believe what we begin today will impact generations, SEVEN GENERATIONS!

Report to Nebraska 2024

Micheal Dwyer

Arlington Fire and Rescue - FF / EMT

NSVFA Legislative Committee

Nebraska Line of Duty Death Team

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Report on the State and Future of EMS in Nebraska
Updated Jan. 22nd 2024

Introduction and Executive Summary

Rural EMS in Nebraska - Where we are and where we can go.

At the moment you're reading this, the nearly two million Nebraskans are going about their daily lives, working, raising families, growing businesses, and growing their communities. That's the nature of Nebraska's *Good life!* At the same time, approximately 2100 times a day[1] someone calls 911 to ask for help. Many of those calls are for a fire department or an ambulance. For over half a century, an exceptional network of local Emergency Medical Service (EMS) providers has admirably ensured that residents and visitors of Nebraska have access to excellent, low cost out-of-hospital emergency care. In rural Nebraska virtually all of those providers are volunteers.

The essence of volunteerism is a physical expression of human relationships. In volunteer fire and EMS, that expression means individual people make individual decisions to leave family and work, ball games and board meetings at all hours of the day and night, 24/7, and risk their lives - for nothing - more than the chance to serve their neighbors. The practical expression of this is that volunteer fire and EMS is the largest private subsidy of a government program in our nation, saving an estimated 46.9 BILLION dollars a year[2]. The collateral damage of this subsidy is that it has hidden the true cost and thus the true value of volunteer pre-hospital emergency services.

This system of volunteers providing fire and EMS protection is increasingly under significant stress – across the nation and across Nebraska. As I said in my testimony for the Governor's Volunteer First Responder Summit, "The current status of rural EMS in Nebraska and across the nation is pretty simple: **The number of calls is up - the number of responders is down**. This is not sustainable. Everyone in the EMS system, from doctors and nurses in rural hospitals to Paramedics in suburban areas, to flight services, to volunteer EMRs and EMTs in the smallest Nebraska towns knows that EMS in Nebraska and around the nation is struggling essentially with two fundamental issues; staffing and funding.

The health of pre-hospital EMS is more severe in rural and 'frontier[3]' areas because these areas lack the tax base to create their own funding and the breadth of population to draw recruits - paid or volunteer - into EMS. Volunteerism across all sectors and regions of the country is down, while educational requirements and citizen expectations for EMS continue to increase. In addition, there is not now, nor has there ever been, a consistent structure to fund, support, recruit and lead this volunteer system. The system is surviving on the shoulders of shrinking numbers of *active*[4] volunteers that are aging and increasingly 'burned out' by the weight of doing more with less. More calls and more training. Less volunteers, less funding and less recognition in the eyes of policy makers that EMS *is* essential.

From citizens to policy makers, most Nebraskans just don't think about an ambulance until they really need it, in an emergency, when seconds matter, during a moment they and their family will likely remember for the rest of their lives. When the pressure is off and there is no pain and no emergency, EMS service is a distant building and the responsibility of someone else. Simply assuming that when Nebraskans dial 911 someone is coming to help, is not a plan and is not a sustainable model.

While there is superficial recognition of EMS as essential, harder decisions about who should be responsible for leadership, oversight and funding of any new or existing

EMS initiatives have been and will continue to be more difficult. Many other states are recognizing that for two long our collective communities have offered bread crumbs and 'at a boys', while refusing to offer or fund any long term system, plan or funding. Nebraskans at all levels must embrace the principle that *EMS is an essential service* and be willing to make the sacrifices that flow from that principle before we can ever hope to find sustainable solutions.

Virtually every other state in the U.S. with any rural footprint is struggling to find a sustainable future for EMS. The information in the following pages will try to give breadth and depth to the issues that Nebraska and surrounding states face around EMS, particularly in rural areas. But also, to strengthen and bring more urgency to conversations about ideas and options, many of which are already being tested.

Our neighbors South Dakota and Colorado have recently completed extensive studies on EMS sustainability. Iowa and South Dakota have made significant investments of time and money in practical ideas around workforce and technology to support EMS. While there are certainly differences in our states, there is much we can learn from their work – and we can do so without reinventing the wheel. On the other hand, Nebraska is a very diverse state and the conversations, and the solutions must be equally diverse.

There is one thing that Nebraska should do quickly and with little relative cost - get good ***data!*** Every time a Nebraska EMS service responds to a call for help, that service is required - within 72 hours - to complete a report of that call. Those reports must be made via a NEMSIS (The National Emergency Medical Services Information System) v3 compliant software. That reporting and subsequent information was designed to inform patient care and policy decisions and contains a wealth of information. Reports are available – minus patient specific information – based on this data. NEMSIS produces a national report yearly. Nebraska has not prepared such a report since 2016. This data is critical for Nebraskans at all levels to make wise decisions about policies that will produce sustainability in EMS. Without data, any policies we create or money we spend will be uninformed and worse yet, driven by those of us who are passionate about EMS and not by factual information. With that data, the next logical step is an ***EMS task force*** that with a broad range of perspectives is capable of being objective about all of our options and at least some authority, implied or otherwise, to do something with them.

The information in these pages is based on 67 interviews, over 300 hours of research and countless texts, emails and loud conversations. I've worked hard to give an honest reflection of what Nebraska is currently doing and what other states are doing the same or differently. With that information I've tried to honor and cultivate the ideas that so many servant leaders have shared passionately. I hope that in reading this that you hear their voices.

Whether anyone reading this agrees with any or all of these ideas is not the point. The goal I and the people I've interviewed have is that these options begin conversations. There are tremendous challenges ahead of us and the stakes could not be higher. Whether we like it or not, tonight and for all our tomorrows we're stuck in the same sand box, together. As Governor Pillen is fond of saying, "for generations – seven generations!"

Original Testimony - Governor Jim Pillen's Fire and EMS Summit
August 19th, 2023, Broken Bow
Micheal Dwyer

Governor Pillen THANK YOU for your dedication to Nebraska and your interest and commitment to Nebraska's fire and EMS providers. Thank you also to State Fire Marshal Cordes and Jerry Stilmock for your leadership and vision. My name is Micheal Dwyer. I've been an active member of the Arlington Volunteer Fire Department for 38 years, a practicing EMT for 40 years. For 21 years have served on the Nebraska State Volunteer Firefighters Legislative committee and I am a member of the Nebraska Line of Duty Death Team. We are honored to have you here and excited by your interest in 'Saving Rural EMS', to steal a title from John Bomar.

When Fire Marshal Cordes first mentioned this summit, I volunteered to begin research around the status of EMS in Nebraska and elsewhere with three simple questions: How's it going? What's working - and what's not? I've conducted 29 interview sessions with over 50 people, including Fire Chiefs, EMS and Emergency Management agencies, hospital administrators, state senators, agency directors and most importantly EMS practitioners from across Nebraska and across the nation. What follows is based on those interviews, 4 months of research, and to a lesser degree on my own experience. What a privilege it has been to talk to so many bright, driven and dedicated men and women who leave family and work, ball games and board meetings, and risk their lives - for nothing - more than the chance to serve their neighbors. Governor Pillen, I am convinced there is no better example of unselfish volunteerism than Nebraska's Volunteer Fire and EMS providers!

The current status of EMS in Nebraska and across the nation is pretty simple: The number of calls is up - the number of responders is down. Simply, put this is not sustainable. While individual fire departments, mutual aid associations, NSVFA and the Nebraska Legislature have tried to put its collective fingers in the dam - still the trends continue, and the problems remain.

We are certainly not alone in these struggles. I've spoken to directors and EMS providers in the four states surrounding Nebraska and they are in the same sand box we are. And this is not exclusive to volunteer EMS. Paid fire departments and law enforcement are struggling to find qualified responders as well.

At the risk of stating the obvious; nothing happens in our world, unless people do it! Unless people choose to put their hearts and hands to the end of a fire hose or the hand of an injured child, nothing happens - without people. If we don't work, beginning today, to get the people piece of this right - nothing else will matter.

The cost to 'reinvent' fire and EMS in rural Nebraska without a significant presence of volunteers would be astronomical and cities, counties and the Nebraska Legislature know that. More importantly, I haven't met anyone in volunteer fire and EMS that expects be paid. Many volunteers have legitimate concerns about money dissolving the glue that's holding the volunteer system together. That does not mean Nebraska shouldn't do everything we can to support the volunteer system – if only for the economic value.

I am convinced, based on these interviews, the key to this is leadership. Leadership from the Governor's office, to the legislature, to NSVFA and the EMS board - and everyone in EMS. Whatever we do has to be filtered through the leadership in 472 volunteer and combination departments in Nebraska. That will take significant work – as a team - and monumental leadership -- from everyone.

In closing; I do believe the stars are trying to align!!! We have a great new Fire Marshall that is passionate and engaged. There are TWO new movies out: "Long hours, No pay, Cool hat, that's being promoted by the National Volunteer Fire Council and John Deere and another movie being produced by Nebraska Public Media, that's due to be released in October. The Nebraska Department of EMS and NET – with the cooperation of NSVFA are both doing surveys - working to get data on where we are and where we might go. There are 3 Legislative Resolutions in the legislature scheduled to be heard this fall around Fire and EMS issues, AND we have a Governor that 'gets it'. I am more optimistic about the potential for progress around these issues than at any other time in my 40 plus years in EMS. But;

This will NOT be an easy fix. The issues surrounding EMS are complicated, covered in layers of local, state and federal bureaucracy and everyone in and around EMS is deeply passionate about how we should fix this – and that's the good news! If I may Governor; your first job is to get us on the same team, in the same playbook and ready – not for a game, but for a long season. All that said, I believe - what we begin today will impact generations - SEVEN GENERATIONS!

Governor, in that context, I ask that you appoint a 'working group' to continue - with both cooperation and urgency - the work we've begun here today. In July you created the Valuations Reform Working Group with 15 stakeholders from all over Nebraska, the Legislature and members of your team - to 'work' that issue. I am asking you to consider a similar effort that would include many of the agencies and people here, with your team - the goal being to build a team that can effectively work to solve these issues. I respectfully submit a list of ideas – again based on these interviews - for you to consider. (Note added after the summit: On Monday, August 21st, two days after the summit, Governor Pillen created a similar working group around broader workforce issues.)

Governor Pillen - thank you. For what you've already done and for the leadership you will bring. I would be happy to answer any questions.

Micheal Dwyer
Arlington Volunteer Fire and Rescue
E: micheal@mdpinc.com
C: 402-720-0071

State and Future of EMS In Nebraska
Current EMS Systems in Nebraska and Other States
August 19th, 2023 (update October 24th, 2023 and Jan. 22nd, 2024)

The landscape: According to a national study published in May of 2023 by the Rural Health Research Centers, a Federal program that is dedicated to producing policy-relevant research on healthcare in rural areas, more than 4 million people across the U.S. live in an "ambulance desert", described as anywhere 25 minutes or more from an ambulance station. Nebraska has 71 counties that have at least one ambulance desert. PJ Ringdahl, regional adviser for the North Dakota EMS and paramedic association in a recent USA Today article said, “We're all in crisis mode. We're all short-staffed. We have to figure out an appropriate model to deliver health care to those communities.” She added; “…EMS needs a home.”

Calls: Most rural fire departments are no longer in the business of fighting fires. For fire departments that offer EMS, over 80% of a typical rural fire departments calls – are for EMS services. Although specific data on Nebraska EMS runs is lacking, many services report a 12-20% increase of the last two years. Geriatric, mental health and non-emergent calls for EMS further adds to the increase in call volume. Rural area are certainly not immune to this. The United States has spent over 60 years teaching everyone to call 911 for any emergency. Many citizens heard that so well that they now call 911 for ***any*** emergency, real or perceived. No one I know or have interviewed in EMS thinks any call to 911 is a nuisance, however non-emergent emergencies are clouding and clogging the system and there is no easy fix.

Staffing: Workforce issues are at crisis levels in some parts of our country – and emergency services are not immune. Medical, law enforcement and fire services, up and down the system are all currently experiencing dangerous staffing shortages. Governor Pillen knows this and has created a Working Group to recommend solutions. The Nebraska Legislature has recognized these shortages and has provided a list of incentives for nurses and law enforcement. Paid Fire and EMS – typically the fiscal responsibility of cities and villages – have tried many ideas with limited amounts of success. Private ambulances services and even air ambulances are struggling and are having turnover issues and sometimes have to delay or defer services. During all of these recent shortages, volunteer EMS providers have been largely forgotten.

Common Pre-Hospital EMS Systems

Nebraska: Most Nebraskans are familiar with the traditional pre-hospital EMS systems - paid or volunteer fire departments - that are currently being used in Nebraska and elsewhere. Roughly 72% of Nebraska is protected and served by volunteer fire and EMS departments. Paid departments generally provide quick response times and a technically higher level of skill, while volunteer departments provide a commitment to their communities that is hard to match – not to mention that volunteers save the nation an estimated nearly $47 billion each year, according to the National Fire Protection Association. In that lies the good news / bad news; volunteer EMS provides excellent care and personal commitment, however it is voluntary and volunteers across all sectors are tough to find. In addition, as the former Director of EMS in Nebraska said;

'the Achilles heal of volunteer EMS is selective response.' Volunteers have the freedom to choose to – or not to respond, based on their schedules, the nature of the call and their particular skill set. The 'white elephant' in the room is that in many volunteer fire and EMS services, a significant portion of the members are consistently choosing not to respond, only compounding the shortages of responders. Many refer to this as the 80/20 rule.

Generally speaking, volunteer fire and EMS get some funding from local *Rural Fire Districts*, that provide taxing authority for vehicles, maintenance, fuel and some training. Rural Fire Districts generally have very small levy's and bond for large purchases such and fire trucks. Volunteer EMS systems that are not affiliated with a fire department have no taxing authority and thus no source of sustainable funding. All EMS systems can bill for their services; however rates are subject to Medicaid billing restrictions, services can only bill if the patient is transported and the process is arduous for small volunteer departments.

Paid per call; is essentially a volunteer system that provides a stipend per call. The stipend can range from $25 to $150, based on the level of care and time spent and of course differs widely across departments. According to the Nebraska Fire Marshall's website, of the 15,000 firefighters in Nebraska, 308 are paid per call. The paid per call system is more common in other states and is virtually the norm in South Dakota[5].

EMS systems that are not as well-known generally fall into two categories: **County based** and **hospital-based** systems with a number of variations on those basic models. The challenges in all of these systems are essentially the same, staffing and cost. The cost of a county or hospital-based EMS department can range from **$350,000 to over $1 million a year** depending on staffing, levels of certification (EMT or Paramedic), number of calls, transport distances and to what degree (if any) they use volunteer responders. Some volunteers, while understanding the challenges they face, aren't crazy about 'someone else taking care of our neighbors', although both sides say these can be smoothed over with good and cooperative training.

In most **county-based** EMS systems there is a centrally located station, staffed either part time or 24/7 with paid EMTs and Paramedics that respond – with or without the volunteer departments - to most of the calls in their county. Cass county is the most recognized county-based model, at least in eastern Nebraska. I talked at length with Sandy Meyers, the (former) Cass County Emergency Manager who directs that program. Here are some highlights from that interview:

- Centrally located at Cass Co Fairgrounds
- Paramedic & EMT, staffed 24/7, responds to all but 'lift assists' in Cass Co.
- Non-Transport agreement with all Cass Co EMS agencies. The local, volunteer ambulance service transports.
- With a Paramedic on board, squads can bill at a higher rate – and the local / volunteer ambulance keeps the $$.
- Response time within 17 minutes to any part of the county
- Assisting most departments – handling 95% of some departments EMS calls because of shortage of EMTs.

- 800 – 1000 calls per year. Most of Cass Co.'s transports go to Omaha or Lincoln Hospitals. Critical to managing patients (with ALS) on long transports.
- Some resistance early from volunteer departments, but it is more accepted now.
- Challenged when 2 calls, close in time / far in distance come in. Paramedics have to prioritize response.
- From Jefferson County:
    - 2 EMT's 24 / 7, 2 (previous shift) and paid on page. 8 total.
    - Works well. Many of paid EMT's are also EMT's on a volunteer service.
    - "County doesn't like the expense."

Hospital based EMS systems are similar in that they staff EMTs or Paramedics in a hospital, that are either pre-hospital only or that leave their hospital work to respond to EMS calls in their district - with or without volunteer departments. I spoke at length with administrators, doctors, and nurses with both the Wahoo, Fremont and Blair hospitals and their comments and concerns were much the same. Here are some highlights from the interviews about hospital-based EMS systems:

- Many hospital administrators said, "Bottom line is, t**here is no money in EMS!**"
- Regional West, Hospital based response lost $1.2m – 'pulling the plug' on ambulance service in Sidney and Cheyenne Counties.
- 'Good and bad results'. Paid services AND hospitals are stressed too!
- Medicaid / Medicare reimbursements are a real issue!
- Community Paramedicine as the 'system of the future'!
- 2022 survey; EMS workers are worth $31.82 an hour.
- In western Nebraska - distance is a real issue! Med Helicopters are needed but systems like Air Methods are having their own issues with Medicare reimbursements and staffing.
- Gering uses a hybrid model:
    - Volunteer EMS responds directly to the scene. Assesses and stabilizes patient.
    - Hospital Ambulance responds and transports patient and provides ALS.
    - The hospital takes all of the billing $$.

What's Happening in Other States

As in Nebraska, every state I looked at is struggling with the same issues around EMS: Increasing calls, specifically non emergent 'frequent flyer', and assist up calls. Recruiting and retaining a volunteer ***and*** paid workforce has never been more difficult. Ever increasing training and certification requirements, the lack of workable solutions for funding and increased costs for everything from medications to fuel to new ambulances, only exacerbate staffing issues. All of these same issues are worse in rural areas where the need is still there, but options, specifically workforce and funding are more limited. I wish I could tell you there is a state or a model that's really doing rural EMS well, but I haven't found one.

In May of this year the ***Pennsylvania*** House Majority Policy Committee convened a hearing to discuss emergency management services in Pennsylvania and it quickly turned into a conversation about problems in Delaware, New York, and Pennsylvania. In testimony Donald DeReamus, Legislative Chair of the Ambulance Association of Pennsylvania said, "Any failure in the EMS system directly impacts morbidity and mortality, especially in rural areas."

"From a lack of proper funding to low staffing levels, EMS agencies in Pennsylvania face significant barriers every day. While these hindrances are nothing new, they continue to impact our first responders' abilities to do their jobs," said hearing host Rep. Lisa Borowski (D-Delaware). "It's time we take meaningful action in Harrisburg to address these concerns and help the people that dedicate their lives to helping our communities."

Idaho has no legal statute to ensure Emergency Medical Service (EMS) across the state like it does with police and fire fighters**.** State lawmakers are asking the Idaho Department of Health and Welfare to bring legislation forward in 2024 to ensure EMS gains 'essential service' status, according to Senate Concurrent Resolution 101.

"Idaho Bureau of Emergency Medical Services and Preparedness is working with all 44 counties to document coverage gaps and issues like that in Lincoln County. It will take years before the state can create sustainable EMS statewide; however, they anticipate their first steps of action in the 2024 legislative session", according to bureau chief Wayne Denny.

All 75 counties in **Arkansas** have at least one ambulance desert, meaning it takes ambulances longer than 25 minutes to drive to some residents' homes, according to a nationwide study published in May. Several factors, particularly limited public and private revenue in sparsely populated areas, drive this scarcity of potentially life-saving health services, according to medical professionals and elected officials throughout Arkansas.

"It's the whole medical institution that's in distress, and the most visible part of that is the ambulance service and their ability to serve the community," said Mayor Doug Hutchens of Lincoln, a small city in Washington County that sits in the middle of an ambulance desert. In the 41 states that provided data to researchers, 4.5 million people live in ambulance deserts — including 195,000 Arkansans, mostly in rural counties

according to the study from the Maine Rural Health Research Center at the University of Southern Maine.

Texas: According to Mike von Wupperfeld, Austin – Assistant Fire Marshal at the University of Texas at Austin, and who taught fire science for the USAF in Germany; Texas has a two major categories of emergency medical response structures – ***Transport agencies*** and ***First Responder Agencies***. Either can be BLS or ALS.

- **Fire Department** based EMS transport agencies can be career (paid) FD, Volunteer FD, or Combo departments – part paid / part volunteer.
- **Third Service** EMS Transport; For example: Austin / Travis County EMS which is a City / County Service.
- **Private Contractor** EMS transport agencies. Essentially a third service agency but contracted for by the local government unit (city or county).
- **Hospital systems** also typically use private contractors for non-emergency transport. Specialized transport such as neo-natal units can be hospital transport run, private contractors, or rarely government services (FD or Third Service EMS)
- **First Responder Organizations (FRO)** are typically not transport agencies. They operate under a medical director or medical director group.
- **EMS Only Response agencies** provide emergency medical care under a medical director then *transfer* patients to the *transport* agency as needed. The University of Texas at Austin and Texas A&M University have these. Large employers can create teams, such as Search and Rescue Teams, Cave Rescue, Dive Recovery and law enforcement tactical teams with medics.

Texas also has a structure called an **Emergency Service District (ESD)** which is a voter approved, independent taxing authority that can either contract with agencies for Fire and EMS responses or directly provide them. It was specifically designed for rural Texas to provide a stable source of revenue for the operation of Fire and EMS emergency services. It can level ad valorum taxes and can be structured to accept sales tax revenue also.

Closer to home, ***Wyoming*** is struggling as well. The Joint Labor, Health and Social Services Committee spent hours discussing the future of EMS in Wyoming during its last interim meeting. Since 2018, seven EMS agencies have closed across Wyoming, according to an October report from the Wyoming Department of Health, double the number that closed between 2005 and 2016. At the same time others have to respond to increasing calls over the last six years, data shows.

Lawmakers have taken some steps to address the challenges, using federal pandemic funds to shore up EMS and passing a bill during the last legislative session that allows county boards to form EMS districts. Creating an EMS district is one consideration, but the measure would have its own obstacles. County commissioners can pass a resolution, but funding the district would require voters to approve an increase in property taxes.

Lawmakers on a legislative health panel declined to move forward with a draft bill that would have made emergency medical services an essential service in Wyoming and would established a state-backed grant program for EMS providers.

Minnesota in 2021, had 4,474 EMS certifications expire while 1,558 certifications were issued – a deficit of 2,916 EMS providers. The Minnesota Ambulance Association (MAA) says that federal support for ambulance services began decreasing in the 1980s while the cost of operations has steadily increased, maintaining that running just one ambulance 24 hours a day, 7 days a week costs close to $1 million annually. Costs aren't the only thing rising: An increasing call load is putting more pressure on the EMTs and paramedics who respond to medical emergencies. The MAA says each year, 800 ambulances across Minnesota respond to nearly 715,000 service calls. Advocates say "EMS workers are leaving the field in droves."

A report on ABC's 6 News August 17th, 2023, said "EMS services throughout rural Minnesota have become increasingly hard to rely on. Health care providers and state legislatures '*want to stop the bleeding in the industry before more rural communities sell off their EMS vehicles'".* And there's a large number of younger people leaving the EMS workforce." According to Minnesota's Emergency Medical Services Board, 65% of EMS workers are not renewing their licenses. 39% of people who have left the paramedic profession across the state are 40 or younger."

Also of note is that Minnesota is one of the leaders in the nation in Emergency Medical Dispatch with 100% of the Public Service Access Points (PASP) using EMD.

Kansas: When I asked, Steve Hirsch - who is a lifelong fire fighter, a county attorney, and former National Volunteer Fire Council president – 'how is EMS in *Kansas'* he responded, "It sucks!" and followed up with **"In the effort to improve the quality of patient care, we've eviscerated the people that are volunteering to provide it with ever increasing education and certification demands."** According to my research, Kansas is dominated by paid services in the east and county based (part time or paid per call) services in the west. Kansas has only 2 EMS services west of Highway 81 that are fully staffed by volunteers.

In an article in the Topeka Capital Journal titled "*What if dialing 911 doesn't bring an ambulance? Some Kansas communities fear that reality". "*Many departments rely overwhelmingly on volunteers and a dwindling interest in working for little-to-no-pay has accelerated in recent times. The toll of the COVID-19 pandemic, rising costs of resources and difficult funding models have pushed officials to consider a new way of doing things."

Voters signed off on a proposed **1% sales tax levy** to carve out a more sustainable funding source for services moving forward. That translated into a deal with a private contractor to provide county-wide services. All the while, data from the Kansas Board of Emergency Medical Services shows providers responded to 407,792 calls in 2021 - more than they ever have before. "We don't want to be about dollars and cents," said Con Olson, regional director for TECHS EMS, the private EMS provider that will be operating in Doniphan County. "But dollars and cents keep an organization with an ambulance service [going], whether you're a town of a couple of 100 people with a

volunteer service, or a large metropolitan system like Wichita, Johnson County and Kansas City."

South Dakota is more progressive. In 2021 Governor Noem requested and the South Dakota Legislature approved $20 million for three EMS initiatives. 'Over the past several months, the Office of EMS and Trauma has worked extensively with our partners to roll out *Telemedicine in Motion*, *LIFEPAK monitor replacement*, and *Regional Service Designation Projects*.'

In my (great) conversation with Marty Link, South Dakota EMS Director he said, *"The key is sustainability!"* He said South Dakota has EVEL Care iPads with video and audio in 60 EMS services (1 rig per service). These iPads can connect EMS professionals in the field with Board Certified ER Physicians, registered nurses, and Paramedics through audio/video communications. EMS professionals never need to be alone in the back of an ambulance again!

Regional Service Designation is an initiative with two primary phases. Phase 1, which is being conducted now by Healthcare Strategists—an EMS consulting firm out of California—is a statewide assessment of the state of EMS in South Dakota present day, and how best to plan for long-term sustainability into the future. This initial phase is scheduled to take up to one year. During Phase 2 of this initiative, the DOH will be providing up to 15 $500,000 planning grants. Mr. Link also made two other comments worth noting. He said he has a "great working relationship" with Tim (Wilson – NE director of EMS) and "Gen X needs smaller bites.", referring to the idea of breaking EMS into smaller pieces, which I have heard before.

(1-2024 Update): On December 31st, 2023 South Dakota released the it's long awaited *Regional Services Designation Ambulance Study*. The 41 page report includes "*a compilation of over 400 stakeholder interviews in 8 months and a comprehensive review of historical performance data and surveys*", with "The goal of understanding the current ambulance system and identifying the strengths and improvement opportunities." The executive summary includes this "*EMS in South Dakota faces the same or similar daunting challenges of other rural providers across the country, exacerbated by changing workforce demographics, a struggling economy, and diminishing reimbursement."* And: *"The state's objective is an ambulance response time of 30 minutes or less to any resident or visitor who calls 9-1-1*." And "*Recruitment and retention are the greatest challenges facing ambulance availability in South Dakota*". Finally: "*Once (volunteers are) recruited, there is significant trepidation about training and testing, specifically, the National Registry EMT (NREMT) testing for EMR, EMT, and paramedic. This causes fewer recruits to enroll in the necessary training or take the NREMT test; the result is a loss of volunteers to staff ambulances*."

I had the privilege of interviewing Bill Bullard, CEO of Healthcare Strategists, the company that created the report and who does a lot of work with cities, counties and states around the country on EMS. He said several things of note:

- “There are no easy solutions. There is no template.”
- “South Dakota has given ‘Amazing effort – across the entire system.”
- “South Dakota is using telemedicine to reduce transports”, (tele-triage). “The end game is a number you can call ***besides*** 911 for triage, leaving 911 for true emergencies.”

Mr. Bullard had an interesting perspective on response times saying, *“They don’t matter.”* His point was that in a true medical emergency, most patients have 3-6 minutes, well short of the times any rural EMS agency can attain. He is in favor of a broader approach of having “every person trained” in non-invasive, ‘no harm’ interventions” they can deliver prior to EMS arrival, similar to the *Iowa United First Aid* program that’s based on Israel’s *United Hatzalah*. A piece of this and all conversations about pre-hospital EMS is Emergency Medical Dispatch.

Iowa: While different in many ways from Nebraska, Iowa still has many of the same issues – but is also trying to come up with solutions. Iowa passed the ‘EMS is an Essential Service’ Bill (Senate File 615), signed into law by Gov. Reynolds in 2021 it provided a framework for counties to declare EMS an essential service. It allows counties to create a referendum to raise property taxes to fund EMS via sales or property tax – by a 60% vote. So far however, only 9 counties have passed to support funding and each county must renew the tax asking every 5-7 years.

I spoke with Jules Scadden, a lifelong volunteer, former National EMS board member and director of the *Diasart Ambulance Service.* She said that; “Covid hurt volunteer responders *hard*. Some have recovered, some have not returned.” Our conversation also had two notable quotes; “We must make EMS more palatable to the current generation.” And “There has to be someone who sees EMS for the gem it is.” Jules believes it’s time for the federal government to declare EMS an essential service *and* provide funding. Garbage is. Fire and law enforcement and roads are! The declaration would do a lot to ‘make EMS responders feel essential – important’.

Missouri is regulated as part of the Missouri Department of Health and Senior Services. Of Missouri’s 115 counties, 111 of those counties have ambulance deserts and increasingly rely on air transports for critical patients. However, those too are short staffed. In 2022, Air Methods Corporation of Greenwood Village, Colorado, which operates the LifeNet of the Heartland service, canceled flights out of Rosecrans Memorial Airport. In a Newspaper article, Sheriff Kasey Keesaman of DeKalb County. "We're down to one local ambulance service, and that significantly increases the time it would take if we had a multi-vehicle accident or something that would require a Life Flight response."

After searching and leaving several messages, I did talk to one of Missouri’s State EMS Directors (I apologize for the lack of detail – I took the interview while driving) and he was very helpful, but essentially said Missouri is struggling with the same two issues: staffing and funding. He mentioned that Missouri is virtually all a county-based response system, staffing by paid, or paid on call paramedics. He also confessed that response times are ‘difficult’.

Colorado: In June of 2022, Governor Polis signed the "Ambulance Service Sustainability and State Licensing" bill (SB 22-225). The bill shifted the licensing of ambulance agencies to the state, and initiated a five-phase, five-year project that included the formation of an EMS System Sustainability Task Force with 20 members and chaired by a state senator. That task force issued its first extensive report that was completed in September of '23. The 72 page study looked at the data around; EMS history, "EMS in Colorado Today", agency call volumes, certification levels, workforce, education, economics, regulatory framework, payer profiles and what it called the "urban-rural" divide. The report identified 10 "critical observations". In the Executive Summary, the report said:

- "Despite public expectations, a widening disparity exists between these anticipations and the prevailing reality."
- The vulnerabilities uncovered, present significant challenges to equitable access to emergency medical services and affect the reliability, patient outcomes and sustainability of EMS.
- "The challenges primarily stem from inadequate funding, workforce shortages, diminishing volunteerism, and the heightened complexity of systems."

The report offered recommendations in 4 general categories over a 5-phase process:

- Funding: "Ensure Adequate Funding For Statewide Ambulance Services."
- Examine Data Accessibility
- Designate EMS as an Essential Service and "delegate the responsibility of ensuring the local provision of EMS to local and regional government entities, data accessibility and designating EMS as an essential service *and* designating responsibility for it."
- Conduct a Comprehensive Statewide EMS Systems Analysis including;
    - Establish Equitable Coverage Process
    - Conduct Workforce Planning Study
    - Evaluate True Costs, "the real costs of providing EMS… especially highlighting the costs in rural and frontier settings."
    - Increase Governmental and Public Understanding and Valuing of EMS.
    - Increase Governmental and Public Understanding and Valuing of EMS.
    - Develop and Support EMS Leadership.
    - Increase Funding for the Current EMTS Grant Program and Ensure Equitable Access.
    - Study Non-transporting Agencies.
    - Invest in Accessibility to EMS Education.
    - Review Community Integrated Health Care and Community Paramedic Statutes.

It is worth noting that as Nebraska considers increasing it's "EMS for Life" vehicle registration fee from .50 to $1., Colorado increased it's vehicle "fee" for EMS from $1 to $2 - *in 2009*!

Ideas For Improving EMS in Nebraska

Now what do we do? I, and without exception the over 120 people I've spoken to – all of whom are knowledgeable and passionate about EMS - agree that rural, pre-hospital EMS has serious problems and in its current state is not sustainable. Below are many - but not all of the recommendations that have been suggested**,** and / or that other states are currently doing or considering in some form. These ideas are placed in order based on three criteria: One; the number of times I've heard the issue raised. Two, what if any experience and data we have on the idea. And three, the practical possibilities the idea could actually be implemented. I have worked hard to keep my own opinions to a minimum, while also stressing the weight that many of those I interviewed gave to particular ideas. I have also tried to add some detail to the ideas, provided by the interviews and additional research, without coloring the original idea.

#1 Identify EMS as an essential service: Identifying EMS as an essential service and identifying a responsible entity is a foundational step to both local governance and a funding vehicle to provide some measure of sustainability for EMS. Nebraska Statute 38-1203 of The Emergency Medical Services Practice Act says that "*The Legislature finds that emergency medical care is a primary and essential health care service and that the presence of an adequately equipped ambulance and trained emergency care providers may be the difference between life and death…"* 13-303 Says that "*The county boards of counties and the governing bodies of cities and villages **may** establish an emergency medical service*… "The statute says "*may*" - not "*shall*" and that is what needs more clarity.

The rub has always been that when we *say* that it's an essential service, that comes with two obvious questions: Who's Responsible? And who's going to pay for it? In 2015 and 2016 a group composed of 8-10 EMS providers and instructors met for over a year to study who should be responsible for EMS. We looked at hospitals, counties, fire districts even creating new EMS districts. We recommended to the Nebraska Legislature that counties were the best suited to manage and be responsible for EMS. A Senator introduced a bill to that effect, however NACO fought hard against that calling it an 'un-funded mandate' and the bill failed to advance. Wyoming, Minnesota, Colorado, Iowa and South Dakota have had similar efforts to declare EMS essential, with limited results. Other political options are:

Regional EMS Districts is an idea that has gained some traction recently. It would provide both local control – allowing a local board make decisions about certifications, training and response issues - and opportunities for local funding through sales, property taxes or perhaps a 'use' tax. An EMS Board could hire a recruiting (HR) director responsible for staffing and response times. Of course the concerns would be around adding another layer of government and additional taxes.

Consolidation is another idea - allowing / encouraging individual departments to combine under one 'entity', counties would be the most obvious options. The advantages would be less duplication and more sharing of (thin) resources. The objections are many, including losing the independence and vitality of individual fire and EMS districts.

#2 DATA! We must have good data in order to make daily agency and system wide decisions and of course to make the long-range decisions facing EMS. Solid, factual, available data is very hard to come by around pre-hospital EMS and much of what is there is anecdotal. The good news is much of what we need is there, buried in the *E-Narsis* system. LB 415 ('23) would give the Department of EMS additional funds "for the statewide patient care reporting system and trauma registry described in section 71-8248." Passing – at the very least this piece of 415 is important! But we need to require the report.

NEMSIS – The National EMS Information System, is a "national database that is used to store EMS data from states and territories" derived from the E-Narsis reports responders are required to fill out after every run. With this data, NEMSIS produces an annual public data report with an amazing amount of information. States can access data to produce state reports – with any HIPPA protected data excluded. Having a Nebraska version of this report would be invaluable. The report should include, at the very least information like:

Number of calls by state, region & county
EMS Organizational Status; Volunteer, Non-Volunteer, or Combination
EMS Primary Patient Caregiver Level of Care (EMR, EMT, Paramedic, Nurse)
Response Times; PSAP, Dispatched, En Route, Arrived Scene, En Route (Hospital), Arrived (Hospital)
Number of unique 'primary patient caregivers' in Nebraska, sorted by level of certification and organizational status
Chief Complaint
Provider Impression
Patient Disposition (Cancelled, treated and released, transported, etc.)

Note that both Dr. Smith, chair of the EMS Board and Tim Wilson, the Director of EMS have both expressed support for this.

#3 Leadership – at all levels: During these interviews I met many amazing volunteer leaders. However, many of those same great leaders readily admitted that leadership skills are not always present in all fire and EMS departments. A 2020 National Volunteer Fire Council Recruiting and Retention Survey said, "leadership issues are the most commonly cited reasons people quit volunteer departments or don't join." Hospital nurses, physicians and administrators have quietly admitted that the 'standard of care' can vary greatly and that the one common denominator seems to be the leadership of the local department. In my own experience, the departments that have great leadership also have great skills and excellent recruiting and retention. From a purely practical perspective, whatever we do to improve and sustain EMS must be *championed* through the leadership of over 400 local, independent agencies.

Here are some highlights from my research:

- From a former fire chief and NSVFA Legislative Committee member; **"**We have to talk about leadership. In some departments, it's severely lacking."
- From a NE Nebraska fire chief with **91** volunteers on his department: Leadership is "Super important". **"**Good culture is the product of good leadership." And "If EMS doesn't survive, it will be because the current people won't embrace the new ones."

- “Most, if not all of the fire service leadership instruction tends to center around fire ***ground*** leadership and of course that's important. But it's also much easier. What's missing is leadership skills in the fire *HALL*. These skills are much different, much more nuanced and take much longer to develop.”
- Can we inspire teamwork and leadership in FDs with a competitive / sports / motivational approach?
- Could Serve Nebraska and the new Nebraska Volunteer Service Commission Act (LB 111) help?
- **Solutions to the 80/20 rule**: Nearly every person I interviewed mentioned; “20% of the people do 80% of the work”. It is not uncommon for a volunteer EMS agency to have a dozen or more EMTs on their roster, however a large number of those EMTs haven’t ‘made calls in years.’ Some departments reported having EMTs complete the EMT course, pass the National Registry test, and never do patient care, some saying; “it’s a resume builder.”

Some suggested requiring patient contacts or a number of calls as part of EMR / EMT / Paramedic re-certification. According to the American Nurses Credentialing Center, “Practice or work hours are an option to renew your certification, but are not required.” Could Nebraska allow ‘work hours’ (primary patient care contacts documented on the eNarsis forms) to be counted as part of the EMT / Paramedic renewal requirements? Note that there was some pushback from some responders about making patient contacts as part of recertification.

#4 National Registry (NR) test: By far the biggest challenge in recruiting new rural, pre-hospital EMTs are concerns about the hours it takes to become and EMT, specifically to study for and pass the National Registry exam. Classes average 160 hours and most require at least that much time to study and practice. Add to this the practical exams and any ‘ride along’ time and we are asking a prospective volunteer EMT to commit to 350+ hours for the privilege of serving.

On the other hand, National Registry is ***the*** standard for EMS certification in the nation and is incredibly well respected by regulatory agencies, instructors, and many current EMS providers. In addition, Nebraska is part of the EMS Compact, which requires the use of the National Registry test as certification of EMTs and Paramedics. Finally, all of my research has not found a single alternative test and creating our own test would be expensive and take significant time.

Some of the collateral damage of the difficulty of this test is that EMTs who do pass the test are pursuing paid careers in EMS. Given the workforce shortages up and down the EMS system there are significant paid opportunities for EMT and Paramedics that weren’t there just 5 years ago. While that’s not inherently a bad thing, it further drains the volunteer side of the pre-hospital system.

Perhaps most importantly is that while the test is an incredibly high bar for a volunteer, any effort to change or remove National Registry will be met with considerable opposition by a significant percentage of the EMS community. I have been told repeatedly that “any changes to National Registry are off the table.” Any battle to get rid of the National Registry would run the risk of dividing the EMS community at a time when we need to be unified in the goal of creating sustainability. In short; even if we win, we lose.

Bottom line: Balancing this conundrum for policy makers is very difficult. Legislators and the Governor's office continue to indicate to me that they want the EMS community to coalesce around a solution – before they act. A conservative legislature and governor, in a conservative state that is still learning about the true cost and value of EMS, are not ready to create any additional layers of government and give it taxing authority. On the other hand, the trends are pretty clear that the number of volunteer EMS providers will continue to shrink unless we find a better balance between the educational demands and the lack of soft or hard incentives. Ultimately, we ***must*** come together to find this balance around the National Registry test or begin moving – as Missouri, Kansas, Colorado and to a lesser degree South Dakota and Iowa already have – to some version of a paid workforce in EMS. Simply put; there is a limit to what you can ask a volunteer to do.

#5 FULL funding for required EMS training and education: Currently reimbursements for EMT classes rarely cover the full cost of the classes and only if you pass the test. In a practical sense that means that volunteer departments are having to fundraise for education their patients will never be able to benefit from because the provider didn't pass. One comment I heard a lot was: 'The fire marshal's office doesn't charge for training, why does EMS?'

LB 1108 (Senator Dorn) in the Legislature this year would increase the 'Fifty Cents for Life' fee on every motor vehicle registered in Nebraska to one dollar. While of course volunteer EMS providers support this bill, if you compare that to the $20 million that South Dakota is spending, is $1 million truly enough? In addition, some providers have expressed concerns about the money getting down to the 'street level' and not being lost in the bureaucracy of HHS. Of note is that Colorado increased its vehicle "fee" for EMS from $1 to $2 - **in 2009**!

Other related ideas include: **Broader training between EMS *and* Fire:** During these interviews it was clear, the Nebraska State Fire Marshall's Training Division (SFM) is incredibly well respected. Some people I interviewed suggested having SFM do *all* EMS training. In my experience EMS and Fire have much different paradigms and culture, thus their training is also different. Both state training directors, Wendy Snodgrass (EMS) and Alan Joos (Fire) were very receptive and suggested more joint / cooperative training. There is an idea in the *New ways of looking at emergency response,* section above about an 'Intro to EMS' class similar to the 'Intro to Firefighting' class that the SFM teaches at Nebraska Fire School. There are obvious funding, scope of practice and cultural questions with this.

#6 Promote EMS! EMS is misunderstood and while it is appreciated when someone has a crisis, EMS is forgotten until the next time. Could we do PSAs by the Governor / coaches / 'rock stars', highlighting the benefits of serving in volunteer fire and EMS. Note that Governor Pillen has already done one of these. Dr. Jim Smith, Chair of the Nebraska Board Of Emergency Medical Services has suggested an 'EMS Day' in Nebraska to promote EMS, but also to warn Nebraskans about the challenges EMS faces.

School to EMS to Work programs: Several fire departments in Nebraska and around the country have a cadet program. These typically reach out to high school

students and teach them about fire and EMS. Gering has a 'public service' cadet program, which combines modules on several services; fire, EMS and law enforcement.

Could we strengthen this by adding a school to work piece? You volunteer with your local fire and EMS service for two years, that FD will pay for your training and give you an apprenticeship at the same time – and that cost would be reimbursed, through a grant, to both the agency and the student. This could further be expanded by creating a partnership with a paid fire department that virtually guarantees a job at the end of the two years. A similar idea would be to provide free or reduced tuition to a Nebraska College for anyone who is an *active*[4] volunteer fire and EMS provider.

#7 Incentives for active[4] EMS volunteers.

Expand, simplify, and promote Nebraska's $250 volunteer responders tax credit: Of the roughly15,000 volunteer firefighters in Nebraska, only 2100 apply for this benefit. Simplifying the tracking and reporting – which only adds to a volunteer's responsibility - would help significantly. Increasing the amount of the tax credit would help make it more attractive. Promoting it at meetings, Fire School and NSVFA Conference would also help. Some ideas were:

- Eliminate the 2-year waiting period to qualify. NSVFA is considering this as a primary legislative initiative in 2024.
- Cap the 10% of calls. As call volume increases everywhere, so does the number of calls (hours) required to meet the 10% of calls. Some volunteer departments are running 800 calls a year or more. Capping the number of calls would make it fairer to larger / higher volume departments.
- Combining categories like Training and Drills or Meetings and Mutual Aid Meetings and simply making it one point per hour.
- Add an additional $250 tax credit for volunteer EMTs or Paramedics that qualify for the 'base' credit while making 20% of their departments EMS calls as the Primary Patient Caregiver.

Additional Ideas for incentives for Volunteer EMS:

Partial reimbursements for cities, counties and employers that allow and encourage employees to respond with fire and EMS. John Deere is a leader in this. Could we strengthen laws that protect employees when volunteering for a call during work hours is needed?

Tax breaks for companies that offer discounts for credentialed volunteer fire & EMS personnel. This is one way to 'back into' paying volunteers. Ideas would be companies like Cabella's, Casey's, John Deere, Pinnacle Bank that have a significant presence in rural Nebraska would offer products, services, and discounts to volunteers in the communities they serve.

#8 Tele-Health and AI: In 2021 the Federal Interagency Committee on EMS created a 'framework' for telemedicine in EMS to "provide EMS and 911 organizations with an understanding of opportunities to leverage telemedicine as a pathway for providing patients with quality and cost-efficient care at the right place and the right time." The technology would hope to "allow 911 operations, EMS practitioners, non-EMS healthcare providers, and patients to interact in synchronous communication and share health data."

South Dakota is testing a program called **Telemedicine in Motion** that connects EMS professionals in the field with Board Certified ER Physicians, registered nurses, and Paramedics within the *Avel eHub* through audio/video communications (think the 1970s TV show *Emergency*). "EMS professionals never need to be alone in the back of an ambulance again." A 'sister' to this idea could be phone apps that assist EMS with difficult calls with quick access to protocols, extrication 'maps' for vehicles and a simple way to read and transmit patient vitals.

Tele-Triage: Several people spoke about the importance of Emergency Medical Dispatch (EMD). EMD provides a structure for 911 operators to triage incoming medical calls and ensure the right services are sent as quickly as possible. Only about 20% of Nebraska's PSAPs (Public Service Access Points) have EMD. Since time is so crucial in EMS, especially in rural areas, expanding the number of PSAPs with EMD would be highly beneficial. The Nebraska Public Service Commission has 'highly recommended', but not required EMD in all 911 services, expressing legitimate concerns over funding and staffing - which many times in 'fronter'[3] areas is one person on shift.

An expanded version of Emergency Medical Dispatch that could defer some of the mountains of non-emergent EMS calls such as lift assists, mental health and simple transports that are flooding the 911 and EMS systems. Tulsa Oklahoma is experimenting with this – even offering a free Uber ride to a clinic as opposed to calling and ambulance!

100 % of Minnesota is using EMD. Hennepin County (west Minneapolis) is testing a system called 'Good Sam' that lets an ER doc connect with a patient, by phone and video, moments after the call is dispatched and 'triage' the patient, help where they can, and communicate what they're seeing to the EMS responders. "It saves lives every day! You can assess the mechanism of injury, how sick they look, what their breathing rates are like, what their consciousness level is like. All the things that over an ordinary audio call take quite a lot of time to ascertain." The platform uses an artificial intelligence algorithm to check vital signs.

It must be noted here the tremendous opportunity that **AI** (artificial intelligence) could bring to rural, pre-hospital EMS. Every physician I spoke to about EMS mentioned that AI has tremendous potential, particularly in assessments. UNMC is pioneering '*Telestroke'* that provides real-time expert neurological assessment and recommendation of treatment for patients presenting with stroke-like symptoms at other hospitals.

In an April 2023 article from the National Library of Medicine said: "AI-powered ECG interpretation has shown promising results, improving detection of arrhythmias, ST-segment changes, QT prolongation, and other ECG abnormalities. In addition, AI can also detect cardiac structural damage, such as myocardial hypertrophy or left ventricular systolic dysfunction.

Imagine a glove that would do blood pressure, O2 sats, respirations, blood sugar and a 5 lead ECG – wirelessly. Imagine this 'glove' would help a provider, accurately detect a STEMI, alert an ALS ambulance in the next village while transmitting the information to the nearest ED. I don't believe this is that far away.

#9 New ways of looking at emergency response: As states all over the nation are looking for ways to sustain rural EMS there are a few innovative ideas 'out there' for improving the *response* piece of EMS. For instance; improving tiered response by broadening both ends of the pre-hospital response spectrum. Getting hands on a patient quicker through 'first aid' teams, but also strengthening ALS and air medical response through targeted incentives for rural paramedics and air medical services that are struggling financially.

Iowa in pioneering ***Iowa United First Aid***. Modeled after a program used in Israel called United Hatzalah, the goal is to shorten the time from the first call to 911 and when someone is there to help. Volunteers are trained in publicly available, non-invasive, "do no harm" techniques including CPR and the use of an AED, Stop the Bleed techniques and basic first aid. These responders are not certified 'professionals' and do not transport. Once trained, members have an app that on select calls (through Emergency Medical Dispatch) notifies – simultaneously with EMS – the 5 closest responders that can provide some care until EMS arrives. Luke Winkelman, the Iowa Paramedic who originally created the program said; "this builds off the idea of 'micro-volunteerism'", the idea that people that may not commit to joining a fire department and taking an EMT class still want some way to help in an emergency. The United Hatzalah website touts it has "cut down emergency medical response time in Israel to less than 3 minutes."

Allow Emergency Medical Responders to transport: Allowing EMRs to begin moving the patient toward professional care – in emergent situations, when an EMT or Paramedic level intercept has been requested, just makes common sense. As one hospital administrator said, Give them a Diesel I.V. - transport IS an intervention!

One idea that was suggested several times was an 'intro to EMS' class, that offers the very basics of an EMS call (CPR, Stop the Bleed, and basic first aid) but would not provide certification. The goal being new fire department members could better assist with a call and give them a good 'taste' of the real world before starting an EMT class.

Assistance with mental health calls. A large portion of the increased calls for EMS are mental health related. Many rural EMS providers are simply not trained or equipped to navigate these calls and resources for how and where we can transport are limited. Senator Fredrickson's LB 929 (2024) would "*help ensure that individuals who contact 911, but may need a mental health crisis response, are connected to trained mental health professionals*" by connecting 911 and 988 calls.

Lutheran Family Services, based in Omaha has launched a 24-7 ***Co-Responder*** program that **"***provides immediate, 24/7, response to law enforcement and EMS, when these organizations are working with someone experiencing a behavioral health crisis***,"** in four counties in Nebraska - Sarpy, Lancaster, Hall, and Lincoln - offering video based tele-health and in some cases actual on-scene 'co-response' with mental health calls.

#10 Community Paramedicine: Community Paramedicine allows paramedics to use their skills outside of emergency settings. The goal is to help patients access care, maintain, or improve their health and reduce ‘high utilizers’ dependence on ambulance rides and ER visits – helping the ‘calls are up’ side of the equation. The Nebraska EMS Board has done great work in this area and Chairman Dr. Jim Smith is a strong advocate. Not wanting to steal his thunder, I will defer to Dr. Smith, but know that this idea is widely accepted as a good option that bridges that gap between home, pre-hospital EMS and hospital care – particularly in rural areas. Community Paramedicine programs have gained particular traction in South Dakota and Wyoming. The issues, of course, are funding and staffing.

The importance of Growing Nebraska's Rural Communities

I want to mention a point that was made several times in these interviews: **EMS doesn't operate in a vacuum.** We are a critical piece of a government regulated, volunteer supported ecosystem. 'We rise and fall in an ever-changing organizational, economic and political climate, like the water in the Platte River.' More importantly, we are a critical piece of our communities. Here are some highlights from the interviews:

- "Blue collar workers - that are more likely to join a Fire / EMS service - can't find jobs in the small towns and villages that need them. If they do find the job – they can't find housing."
- "Communities that are shrinking often have larger aging populations and many times need more EMS services."
- "Better access to high-speed broadband encourages remote workers that may be more available to assist with daytime calls (at times where traditional volunteers are not always available), if their employers will allow that flexibility."
- "Affordable housing options in small towns is critical for many reasons including that it provides homes for workers who are ideal recruits for volunteer EMS. That demographic is typically intelligent, hardworking, good with their hands and many times used to working odd hours."
- **"… the volunteer fire department is what's holding this town together. I don't know where we'd be without them."**

Schools, Economic Development, Broadband access, Affordable housing, and Roads all have a large impact on local fire and EMS departments. Fire and EMS benefits from - and is challenged by - each of these important pieces. Thriving communities brings in more people, and if we do our jobs, some of those people will join fire departments and some of those people will become EMTs! **Many of the problems around EMS will be solved or at least 'salved' by stability and growth of our rural communities.** Great jobs, more people and broader tax bases - helps. Vibrant schools and more of our youth recognizing the beauty of Nebraska and the importance of volunteerism - helps. Fire and EMS touches kids, taxes, agriculture and certainly values. Growing Nebraska helps all of us.

Finally, **this conversation *must* be continued**. There are no easy fixes here. This is not rocket science, but it is advanced calculus. The issues are complicated potentially expensive, and the stakes could not be higher. Cooperative conversation and collaboration between ALL stakeholders up and down, east and west, urban and rural in EMS and the entire health system is critical! To everyone who reads this – **we need your help!** As I said in my original testimony; I believe - what *we* begin today will impact generations, SEVEN GENERATIONS, not only in Nebraska – but across the nation!

Appendix

Notes and definitions:

1. 2021 National 911 Annual Report.
2. National Volunteer Fire Council, Volunteer Fire Service Fact Sheet – 2021
3. Defined by the National Center for Frontier Communities:
    a. Density of between 12 and 20 persons per square mile
    b. Distance to a service/market between 30 and 90 miles
    c. Travel time to service/market between 30 and 90 minutes
4. As defined by the Nebraska Volunteer Emergency Responders Incentive Act; Neb. Rev. Stat. §§ 77-3101 to 77-3106
5. SOUTH DAKOTA'S REGIONAL SERVICES DESIGNATION AMBULANCE SYSTEM STUDY

I would like to thank so many people for their tremendous service and passion for Nebraska and the care and safety of its people: John Bomar, Jerry Stilmock, Senator's Myron Dorn, Bruce Bostleman, Joni Albrecht, Mike McDonnell, John Lowe, Merv Riepe and Dr. Ben Hansen, Governor Jim Pillen, Lt. Governor Joe Kelly, David Lopez, Maureen Larsen, Lee Will, Laura Strimple, Tom Hamernick, Scott Cordes, Alan Joos, Steve Dolesh, Pat Tierney, Pat Callahan, Angi Linn, Sandy Meyers, Carol Jorgensen, Dan Mallory, Chad Nixon, Dan Douglas, Kenny Krause, Cathleen Plager, Nathan Flowers, Ty Hernes, Mike and Sherry Dinkins, Marty Link, Dr. Jim Smith, Tim Wilson, Bill Kelly, Shad Bryner, Steve Hirsh, Joel Cerney, Justin Scamehorn, Jules Scadden, Keala Roy, Chris Tonneges, Pat Gould, Ann Fiala, Brad Negrete, Jed Hansen, Nikki Carritt, Will Chapella, Carol Rodenborg, Mike von Wupperfeld, Nick Thoreen, Lee Huber, Bill Bullard, Luke Winkelman, Morgan Fritz, Dr. Patrica A Terp, Dr. Lenworth Jacobs, and of course everyone on the Arlington Volunteer Fire and Rescue Department and my lovely wife, Gail Dwyer.

Micheal Dwyer is an entrepreneur and the retired President of MDP Inc., a diverse photographic company based in Arlington Nebraska. Micheal is also a volunteer firefighter / EMT and a member of the Nebraska State Volunteer Firefighters Association's Legislative Committee (21 years) and the Nebraska Line of Duty Death Response Team. He is also musician and songwriter, a political wonk and a cancer survivor. Micheal is the author books; *Preparing for the Digital Revolution* and *Simple Truths/Complicated Lies".*

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LEGISLATURE OF NEBRASKA

ONE HUNDRED EIGHTH LEGISLATURE

SECOND SESSION

LEGISLATIVE BILL 1015

Introduced by Walz, 15.

Read first time January 05, 2024

Committee: Health and Human Services

A BILL FOR AN ACT relating to the Rural Health Systems and Professional Incentive Act; to amend sections 71-5650 and 71-5652, Reissue Revised Statutes of Nebraska, and sections 71-5662, 71-5663, and 71-5668, Revised Statutes Supplement, 2023; to restate the purposes of the Rural Health Systems and Professional Incentive Act; to change provisions relating to loan repayments, financial assistance amounts, and loan repayment recipient agreements under the Rural Health Systems and Professional Incentive Act; to provide for financial assistance in the form of loan repayments to certain dentists who agree to provide dental services to medicaid patients as prescribed; to harmonize provisions; and to repeal the original sections.

Be it enacted by the people of the State of Nebraska,

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Section 1. Section 71-5650, Reissue Revised Statutes of Nebraska, is amended to read:

71-5650 Sections 71-5650 to 71-5670 and section 6 of this act shall be known and may be cited as the Rural Health Systems and Professional Incentive Act.

Sec. 2. Section 71-5652, Reissue Revised Statutes of Nebraska, is amended to read:

71-5652 The purposes of the Rural Health Systems and Professional Incentive Act are to:

(1) Create ~~create~~ the Nebraska Rural Health Advisory Commission and establish its powers and duties; ~~,~~

(2) Establish ~~establish~~ a student loan program that will provide financial incentives to medical, dental, master's level and doctorate-level mental health, and physician assistant students who agree to practice their profession in a designated health profession shortage area within Nebraska; ~~,~~

(3) Establish ~~establish~~ a loan repayment program that will provide financial incentives to medical residents who agree to practice their profession in a designated health profession shortage area within Nebraska; ~~, and~~

(4) Establish ~~establish~~ a loan repayment program that will require community matching funds and will provide financial incentives to eligible health professionals who agree to practice their profession in a designated health profession shortage area within Nebraska; and ~~.~~

(5) Establish a loan repayment program for certain dentists who provide dental services to medicaid patients.

Sec. 3. Section 71-5662, Revised Statutes Supplement, 2023, is amended to read:

71-5662 (1) To be eligible for a student loan under the Rural Health Systems and Professional Incentive Act, an applicant or a recipient shall be enrolled or accepted for enrollment in an accredited medical or dental

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education program or physician assistant education program or an approved mental health practice program in Nebraska.

(2) To be eligible for the medical resident incentive under the act, an applicant or a recipient shall be enrolled or accepted for enrollment in an approved medical specialty residency program in Nebraska.

(3) To be eligible for loan repayment under the act, an applicant or a recipient shall be a pharmacist, a dentist, a physical therapist, an occupational therapist, a mental health practitioner, a psychologist licensed under the requirements of section 38-3114 or the equivalent thereof, a nurse practitioner, a physician assistant, a psychiatrist, or a physician in an approved specialty and shall:

(a) Be ~~be~~ licensed to practice in Nebraska; ~~,~~

(b) Not ~~not~~ be enrolled in a residency program; ~~,~~

(c) Not ~~not~~ be practicing under a provisional or temporary license; ~~,~~ and

(d) Except as provided pursuant to an agreement under section 6 of this act, enter practice in a designated health profession shortage area in Nebraska.

Sec. 4. Section 71-5663, Revised Statutes Supplement, 2023, is amended to read:

71-5663 (1) The amount of financial assistance provided through student loans pursuant to the Rural Health Systems and Professional Incentive Act shall be limited to thirty thousand dollars for each recipient for each academic year and, except as provided in subdivision (4)(a) of this section, shall not exceed one hundred twenty thousand dollars per medical, dental, or doctorate-level mental health student or thirty thousand dollars per master's level mental health or physician assistant student.

(2) The amount of financial assistance provided through the medical resident incentive program pursuant to the act shall be limited to forty thousand dollars for each recipient for each year of residency and,

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except as provided in subdivision (4)(b) of this section, shall not exceed one hundred twenty thousand dollars.

(3) The amount of financial assistance provided by the state through loan repayments pursuant to the act is limited as follows:

(a) For dentists pursuant to section 6 of this act, up to sixty thousand dollars per recipient per year of full-time practice and up to a maximum of three hundred thousand dollars per recipient;

(b) For ~~for~~ physicians, psychiatrists, dentists, and psychologists, up ~~shall be limited~~ to thirty thousand dollars per recipient per year of full-time practice in a designated health profession shortage area and, except as provided in subdivision (4)(c) of this section, up to a maximum of ~~shall not exceed~~ ninety thousand dollars per recipient; and

(c) For ~~(b) for~~ physician assistants, nurse practitioners, pharmacists, physical therapists, occupational therapists, and mental health practitioners, up ~~shall be limited~~ to fifteen thousand dollars per recipient per year of full-time practice in a designated health profession shortage area and, except as provided in subdivision (4)(c) of this section, up to a maximum of ~~shall not exceed~~ forty-five thousand dollars per recipient.

(4)(a) The total amount of financial assistance provided through student loans for a doctorate-level mental health student or master's level mental health student shall be the full amount of such loans for a person who practices psychiatry, psychology, or mental health practice:

(i) For at least five years in a designated health profession shortage area; and

(ii) If all or a majority of such practice consists of the treatment of members of the community supervision population.

(b) The total amount of financial assistance provided through the medical resident incentive program for a psychiatrist shall be the full amount of such psychiatrist's qualified educational debts if such person practices psychiatry:

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(i) For at least five years in a designated health profession shortage area; and

(ii) If all or a majority of such practice consists of the treatment of members of the community supervision population.

(c) The total amount of financial assistance provided through loan repayments pursuant to the act for psychiatrists, psychologists, and mental health practitioners shall be the full amount of such person's qualified educational debts if such person practices psychiatry, psychology, or mental health practice:

(i) For at least five years in a designated health profession shortage area; and

(ii) If all or a majority of such practice consists of the treatment of members of the community supervision population.

(5) For purposes of this section, community supervision population means persons on probation, post-release supervision, and pretrial release.

Sec. 5. Section 71-5668, Revised Statutes Supplement, 2023, is amended to read:

71-5668 Except as otherwise provided in section 6 of this act, a ~~Each~~ loan repayment recipient shall execute an agreement with the department and a local entity. Such agreement shall be exempt from the requirements of sections 73-501 to 73-510 and shall include, at a minimum, the following terms:

(1) The loan repayment recipient agrees to practice his or her profession, and a physician, psychiatrist, dentist, nurse practitioner, or physician assistant also agrees to practice an approved specialty, in a designated health profession shortage area for at least three years, or the period required by subdivision (4)(c) of section 71-5663, and to accept medicaid patients in his or her practice;

(2) In consideration of the agreement by the recipient, the State of Nebraska and a local entity within the designated health profession

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shortage area will provide equal funding for the repayment of the recipient's qualified educational debts except as provided in subdivision (5) of this section, in amounts up to thirty thousand dollars per year per recipient for physicians, psychiatrists, dentists, and psychologists and up to fifteen thousand dollars per year per recipient for physician assistants, nurse practitioners, pharmacists, physical therapists, occupational therapists, and mental health practitioners toward qualified educational debts for up to three years or a longer period as required by subdivision (4)(c) of section 71-5663. The department shall make payments directly to the recipient;

(3) If the loan repayment recipient discontinues practice in the shortage area prior to completion of the three-year requirement or the period required by subdivision (4)(c) of section 71-5663, as applicable, the recipient shall repay to the state one hundred fifty percent of the total amount of funds provided to the recipient for loan repayment with interest at a rate of eight percent simple interest per year from the date of default. Upon repayment by the recipient to the department, the department shall reimburse the local entity its share of the funds which shall not be more than the local entity's share paid to the loan repayment recipient;

(4) Any practice or payment obligation incurred by the loan repayment recipient under the loan repayment program is canceled in the event of the loan repayment recipient's death or total and permanent disability ~~or death~~;

(5) For a loan repayment recipient seeking benefits under subdivision (4)(c) of section 71-5663, the recipient agrees to such other terms as the department deems appropriate; and

(6) Beginning on July 1, 2022, any agreements entered into by December 31, 2024, shall first use federal funds from the federal American Rescue Plan Act of 2021 for the purposes of repaying qualified educational debts prior to using any state or local funds. Agreements

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using federal funds from the federal American Rescue Plan Act of 2021 shall not require equal funding from a local entity. Any federal funds from the act committed to agreements during this time period shall be used by December 31, 2026.

Sec. 6. (1) In lieu of the agreement required by section 71-5668, a loan repayment recipient may execute an agreement with the department under this section if such loan repayment recipient is a dentist who:

(a) Has practiced dentistry for less than five years at the time of entering into such agreement; and

(b) Has not received any prior financial assistance under the Rural Health Systems and Professional Incentive Act.

(2) An agreement under this section shall be exempt from the requirements of sections 73-501 to 73-510 and shall include, at a minimum, the following terms:

(a) The loan repayment recipient agrees to:

(i) Practice dentistry for five years in the State of Nebraska beginning on the date of the agreement; and

(ii) Provide dental services for not less than the number or percentage of medicaid patients determined by the commission. Such number or percentage shall be included in the agreement;

(b)(i) The department shall make payments directly to the recipient for the repayment of the recipient's qualified educational debts in amounts up to sixty thousand dollars per year per recipient toward qualified educational debts for up to five years; and

(ii) The recipient shall prove to the commission that all of such payments have been used to pay for the qualified educational debts of the recipient. The commission shall specify in the agreement the manner in which a recipient can comply with this subdivision (2)(b)(ii);

(c) If the loan repayment recipient breaches any term of the agreement specified in subdivision (a) or (b) of this subsection:

(i) The recipient shall pay to the state one hundred percent of the

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total amount of money provided to the recipient under the agreement and interest on such amount remaining to be repaid. Such interest shall begin on the date the recipient breached any term of the agreement and be calculated at a rate of eight percent simple interest per year; and

(ii) The state shall not be obligated to pay any additional money under the agreement to the recipient; and

(d) Any practice or payment obligation incurred by the loan repayment recipient under the agreement is canceled in the event of the loan repayment recipient's death or total and permanent disability.

Sec. 7. Original sections 71-5650 and 71-5652, Reissue Revised Statutes of Nebraska, and sections 71-5662, 71-5663, and 71-5668, Revised Statutes Supplement, 2023, are repealed.

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LEGISLATURE OF NEBRASKA

ONE HUNDRED EIGHTH LEGISLATURE

SECOND SESSION

LEGISLATIVE BILL 1062

Introduced by Ibach, 44; Brewer, 43; Erdman, 47; Halloran, 33; Holdcroft, 36; Hughes, 24; Murman, 38.

Read first time January 08, 2024

Committee: Health and Human Services

A BILL FOR AN ACT relating to the Rural Health Systems and Professional Incentive Act; to amend sections 71-5650, 71-5651, 71-5652, 71-5653, 71-5654, 71-5655, and 71-5664, Reissue Revised Statutes of Nebraska, and sections 71-5661, 71-5662, 71-5663, and 71-5668, Revised Statutes Supplement, 2023; to restate legislative findings under and the purposes of the Rural Health Systems and Professional Incentive Act; to define a term; to change the purpose, duties, and members of the Nebraska Rural Health Advisory Commission; to provide for financial assistance in the form of repayment of qualified educational debts owed by veterinarians as prescribed; to harmonize provisions; and to repeal the original sections.

Be it enacted by the people of the State of Nebraska,

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Section 1. Section 71-5650, Reissue Revised Statutes of Nebraska, is amended to read:

71-5650 Sections 71-5650 to 71-5670 and section 12 of this act shall be known and may be cited as the Rural Health Systems and Professional Incentive Act.

Sec. 2. Section 71-5651, Reissue Revised Statutes of Nebraska, is amended to read:

71-5651 (1) The Legislature finds that (a) residents of rural Nebraska frequently encounter difficulties in obtaining medical care due to the lack of health care providers, facilities, and services, (b) many rural communities experience problems in recruiting and retaining health care providers, (c) rural residents are often required to travel long distances in order to obtain health care services, (d) elderly and uninsured persons constitute a high proportion of the population in rural Nebraska, (e) many rural hospitals are experiencing declining patient revenue and are being forced to reconsider the scope and nature of the health care services they provide, (f) the physical and economic stresses of rural living can lead to an increased need for mental health services in rural Nebraska, (g) the conditions described in this section can lead to situations in which residents of rural Nebraska receive a lower level of health care services than their urban counterparts, and (h) some of the conditions described in this subsection also exist in underserved portions of metropolitan areas within the state.

(2) The Legislature further finds that the health care industry is a vital component of the economic base of many rural communities and that the maintenance and enhancement of this industry can play a significant role in efforts to further the economic development of rural communities.

(3) The Legislature further finds that the inherent limitations imposed upon health care delivery mechanisms by the rural environment can be partially overcome through a greater emphasis on the development of health care systems that emphasize the linkage and integration of health

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care resources in neighboring communities as well as the development of new resources.

(4) The Legislature further finds that postsecondary education of medical, dental, and mental health professionals is important to the welfare of the state. The Legislature further recognizes and declares that the state can help alleviate the problems of maldistribution and shortages of medical, dental, and mental health personnel through programs offering financial incentives to practice in areas of shortage.

(5) The Legislature further finds that the state can help alleviate the problem of shortages in veterinary services for livestock in rural areas.

Sec. 3. Section 71-5652, Reissue Revised Statutes of Nebraska, is amended to read:

71-5652 The purposes of the Rural Health Systems and Professional Incentive Act are to (1) create the Nebraska Rural Health Advisory Commission and establish its powers and duties, (2) establish a student loan program that will provide financial incentives to medical, dental, master's level and doctorate-level mental health, and physician assistant students who agree to practice their profession in a designated health profession shortage area within Nebraska, (3) establish a loan repayment program that will provide financial incentives to medical residents who agree to practice their profession in a designated health profession shortage area within Nebraska, ~~and~~ (4) establish a loan repayment program that will require community matching funds and will provide financial incentives to eligible health professionals who agree to practice their profession in a designated health profession shortage area within Nebraska, and (5) establish a loan repayment program to provide financial incentives to eligible veterinarians who agree to provide at least fifty percent of their veterinary services to livestock in rural areas within Nebraska.

Sec. 4. Section 71-5653, Reissue Revised Statutes of Nebraska, is

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amended to read:

71-5653 For purposes of the Rural Health Systems and Professional Incentive Act:

(1) Approved medical specialty means family practice, general practice, general internal medicine, general pediatrics, general surgery, obstetrics/gynecology, and psychiatry;

(2) Approved dental specialty means general practice, pediatric dentistry, and oral surgery;

(3) Approved mental health practice program means an approved educational program consisting of a master's or doctorate degree with the focus being primarily therapeutic mental health and meeting the educational requirements for licensure in mental health practice or psychology by the department;

(4) Commission means the Nebraska Rural Health Advisory Commission;

(5) Department means the Division of Public Health of the Department of Health and Human Services;

(6) Doctorate-level mental health student means a graduate student enrolled in or accepted for enrollment in an approved mental health practice program leading to a doctorate degree and meeting the educational requirements for licensure in psychology by the department;

(7) Full-time practice means a minimum of forty hours per week;

(8) Health care means both somatic and mental health care services;

(9)(a) Livestock means a domesticated animal kept in an agricultural setting (i) for the labor provided by such animal or (ii) to produce products for consumption or use; and

(b) Livestock does not include any (i) dog, (ii) cat, or (iii) animal kept for the purpose of being a pet;

(10) ~~(9)~~ Master's level mental health student means a graduate student enrolled in or accepted for enrollment in an approved mental health practice program leading to a master's degree and meeting the educational requirements for licensure in mental health practice by the

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department;

(11) ~~(10)~~ Office means the Office of Rural Health;

(12) ~~(11)~~ Part-time practice means less than full-time practice but at least twenty hours per week;

(13) ~~(12)~~ Qualified educational debts means government and commercial student-loan loans obtained by students for postsecondary education tuition, other educational expenses, and reasonable living expenses, as determined by the department, but does not include loans received under the act; and

(14) ~~(13)~~ Rural means located within any county in Nebraska having a population of less than fifteen thousand inhabitants and not included within a metropolitan statistical area as defined by the United States Department of Commerce, Bureau of the Census.

Sec. 5. Section 71-5654, Reissue Revised Statutes of Nebraska, is amended to read:

71-5654 The Nebraska Rural Health Advisory Commission is hereby created as the direct and only successor to the Commission on Rural Health Manpower. The Nebraska Rural Health Advisory Commission shall consist of fourteen ~~thirteen~~ members as follows:

(1) The Director of Public Health of the Division of Public Health or his or her designee and another representative of the Department of Health and Human Services; and

(2)(a) Twelve ~~(2) Eleven~~ members to be appointed by the Governor with the advice and consent of the Legislature as follows:

(i) ~~(a)~~ One representative of each medical school located in the state involved in training family physicians and one physician in family practice residency training; and

(ii) ~~(b)~~ From rural areas one physician, one consumer representative, one hospital administrator, one nursing home administrator, one nurse, one physician assistant, one mental health practitioner or psychologist licensed under the requirements of section

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38-3114 or the equivalent thereof, ~~and~~ one dentist, and one veterinarian.

(b) All appointed members ~~Members~~ shall serve for terms of three years. When a vacancy occurs, appointment to fill the vacancy shall be made for the balance of the term. All appointed members shall be citizens and residents of Nebraska. The appointed membership of the commission shall, to the extent possible, represent the three congressional districts equally.

Sec. 6. Section 71-5655, Reissue Revised Statutes of Nebraska, is amended to read:

71-5655 The purposes ~~purpose~~ of the commission shall be (1) to advise the department, the Legislature, the Governor, the University of Nebraska, and the citizens of Nebraska regarding all aspects of rural health care and rural veterinary services and (2) to advise the office regarding the administration of the Rural Health Systems and Professional Incentive Act.

Sec. 7. Section 71-5661, Revised Statutes Supplement, 2023, is amended to read:

71-5661 (1) The financial incentives provided by the Rural Health Systems and Professional Incentive Act shall consist of (a) student loans to eligible students for attendance at an eligible school as determined pursuant to section 71-5662, (b) the repayment of qualified educational debts owed by physicians and psychiatrists in an approved medical specialty residency program in Nebraska as determined pursuant to section 71-5662, and (c) the repayment of qualified educational debts owed by eligible health professionals and veterinarians as determined pursuant to section 71-5662. Funds for such incentives shall be appropriated from the General Fund to the department for such purposes.

(2) The Rural Health Professional Incentive Fund is created. The fund shall be used to carry out the purposes of the act, except that transfers may be made from the fund to the General Fund at the direction of the Legislature. Money credited pursuant to section 71-5670.01 and

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payments received pursuant to sections 71-5666, 71-5668, and 71-5669.01 and section 12 of this act shall be remitted to the State Treasurer for credit to the Rural Health Professional Incentive Fund. Any money in the fund available for investment shall be invested by the state investment officer pursuant to the Nebraska Capital Expansion Act and the Nebraska State Funds Investment Act.

Sec. 8. Section 71-5662, Revised Statutes Supplement, 2023, is amended to read:

71-5662 (1) To be eligible for a student loan under the Rural Health Systems and Professional Incentive Act, an applicant or a recipient shall be enrolled or accepted for enrollment in an accredited medical or dental education program or physician assistant education program or an approved mental health practice program in Nebraska.

(2) To be eligible for the medical resident incentive under the act, an applicant or a recipient shall be enrolled or accepted for enrollment in an approved medical specialty residency program in Nebraska.

(3) To be eligible for loan repayment under the act, an applicant or a recipient shall be:

(a) A ~~a~~ pharmacist, a dentist, a physical therapist, an occupational therapist, a mental health practitioner, a psychologist licensed under the requirements of section 38-3114 or the equivalent thereof, a nurse practitioner, a physician assistant, a psychiatrist, or a physician in an approved specialty and shall be licensed to practice in Nebraska, not be enrolled in a residency program, not be practicing under a provisional or temporary license, and enter practice in a designated health profession shortage area in Nebraska; or ~~.~~

(b) A veterinarian licensed under the Veterinary Medicine and Surgery Practice Act whose patients serviced in his or her practice are composed of not less than fifty percent livestock in rural areas within Nebraska. Each head of livestock counts as a separate patient.

Sec. 9. Section 71-5663, Revised Statutes Supplement, 2023, is

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amended to read:

71-5663 (1) The amount of financial assistance provided through student loans pursuant to the Rural Health Systems and Professional Incentive Act shall be limited to thirty thousand dollars for each recipient for each academic year and, except as provided in subdivision (4)(a) of this section, shall not exceed one hundred twenty thousand dollars per medical, dental, or doctorate-level mental health student or thirty thousand dollars per master's level mental health or physician assistant student.

(2) The amount of financial assistance provided through the medical resident incentive program pursuant to the act shall be limited to forty thousand dollars for each recipient for each year of residency and, except as provided in subdivision (4)(b) of this section, shall not exceed one hundred twenty thousand dollars.

(3) The amount of financial assistance provided by the state through loan repayments pursuant to the act for:

(a) Physicians ~~for physicians~~, psychiatrists, dentists, and psychologists is ~~shall be~~ limited to thirty thousand dollars per recipient per year of full-time practice in a designated health profession shortage area and, except as provided in subdivision (4)(c) of this section, shall not exceed ninety thousand dollars per recipient; ~~and~~

(b) Physician ~~for physician~~ assistants, nurse practitioners, pharmacists, physical therapists, occupational therapists, and mental health practitioners is ~~shall be~~ limited to fifteen thousand dollars per recipient per year of full-time practice in a designated health profession shortage area and, except as provided in subdivision (4)(c) of this section, shall not exceed forty-five thousand dollars per recipient; and ~~.~~

(c) Veterinarians is limited to thirty thousand dollars per recipient per year of full-time practice and shall not exceed ninety thousand dollars per recipient.

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(4)(a) The total amount of financial assistance provided through student loans for a doctorate-level mental health student or master's level mental health student shall be the full amount of such loans for a person who practices psychiatry, psychology, or mental health practice:

(i) For at least five years in a designated health profession shortage area; and

(ii) If all or a majority of such practice consists of the treatment of members of the community supervision population.

(b) The total amount of financial assistance provided through the medical resident incentive program for a psychiatrist shall be the full amount of such psychiatrist's qualified educational debts if such person practices psychiatry:

(i) For at least five years in a designated health profession shortage area; and

(ii) If all or a majority of such practice consists of the treatment of members of the community supervision population.

(c) The total amount of financial assistance provided through loan repayments pursuant to the act for psychiatrists, psychologists, and mental health practitioners shall be the full amount of such person's qualified educational debts if such person practices psychiatry, psychology, or mental health practice:

(i) For at least five years in a designated health profession shortage area; and

(ii) If all or a majority of such practice consists of the treatment of members of the community supervision population.

(5) For purposes of this section, community supervision population means persons on probation, post-release supervision, and pretrial release.

Sec. 10. Section 71-5664, Reissue Revised Statutes of Nebraska, is amended to read:

71-5664 (1)(a) The ~~In screening applicants for financial~~

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~~incentives, the~~ commission shall consider the following factors when screening applicants who are not veterinarians for financial incentives:

(i) ~~(1)~~ Motivation to practice in a health profession shortage area in Nebraska;

(ii) ~~(2)~~ Motivation and preference toward an approved specialty; and

(iii) ~~(3)~~ Other factors that would influence a choice to practice in a health profession shortage area in Nebraska.

(b) The commission shall select recipients who are most likely to practice in a health profession shortage area in Nebraska.

(2) The commission shall consider the following factors when screening applicants who are veterinarians for financial incentives:

(a) The percentage of patients serviced by the veterinarian that are livestock in rural areas within Nebraska at the time of application for financial incentives;

(b) Motivation and preference of the veterinarian to service livestock in rural areas within Nebraska; and

(c) Other factors that would influence the veterinarian to service livestock in rural areas within Nebraska.

Sec. 11. Section 71-5668, Revised Statutes Supplement, 2023, is amended to read:

71-5668 Each loan repayment recipient who is not a veterinarian shall execute an agreement with the department and a local entity. Such agreement is ~~shall be~~ exempt from the requirements of sections 73-501 to 73-510 and shall include, at a minimum, the following terms:

(1) The loan repayment recipient agrees to practice his or her profession, and a physician, psychiatrist, dentist, nurse practitioner, or physician assistant also agrees to practice an approved specialty, in a designated health profession shortage area for at least three years, or the period required by subdivision (4)(c) of section 71-5663, and to accept medicaid patients in his or her practice;

(2) In consideration of the agreement by the recipient, the State of

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Nebraska and a local entity within the designated health profession shortage area will provide equal funding for the repayment of the recipient's qualified educational debts except as provided in subdivision (5) of this section, in amounts up to thirty thousand dollars per year per recipient for physicians, psychiatrists, dentists, and psychologists and up to fifteen thousand dollars per year per recipient for physician assistants, nurse practitioners, pharmacists, physical therapists, occupational therapists, and mental health practitioners toward qualified educational debts for up to three years or a longer period as required by subdivision (4)(c) of section 71-5663. The department shall make payments directly to the recipient;

(3) If the loan repayment recipient discontinues practice in the shortage area prior to completion of the three-year requirement or the period required by subdivision (4)(c) of section 71-5663, as applicable, the recipient shall repay to the state one hundred fifty percent of the total amount of funds provided to the recipient for loan repayment with interest at a rate of eight percent simple interest per year from the date of default. Upon repayment by the recipient to the department, the department shall reimburse the local entity its share of the funds which shall not be more than the local entity's share paid to the loan repayment recipient;

(4) Any practice or payment obligation incurred by the loan repayment recipient under the loan repayment program is canceled in the event of the loan repayment recipient's total and permanent disability or death;

(5) For a loan repayment recipient seeking benefits under subdivision (4)(c) of section 71-5663, the recipient agrees to such other terms as the department deems appropriate; and

(6) Beginning on July 1, 2022, any agreements entered into by December 31, 2024, shall first use federal funds from the federal American Rescue Plan Act of 2021 for the purposes of repaying qualified

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educational debts prior to using any state or local funds. Agreements using federal funds from the federal American Rescue Plan Act of 2021 shall not require equal funding from a local entity. Any federal funds from the act committed to agreements during this time period shall be used by December 31, 2026.

Sec. 12. Each loan repayment recipient who is a veterinarian shall execute an agreement with the department. Such agreement is exempt from the requirements of sections 73-501 to 73-510 and shall include, at a minimum, the following terms:

(1) The loan repayment recipient agrees (a) to practice his or her profession for at least three years in rural areas within Nebraska and (b) that no less than fifty percent of the patients that will be serviced in his or her practice for each year of the agreement will be livestock in rural areas within Nebraska. For purposes of the agreement, each head of livestock counts as a separate patient;

(2) The State of Nebraska will provide funding for the repayment of the recipient's qualified educational debts in amounts up to thirty thousand dollars per year per recipient. Such repayment shall occur after each year of the three years of service provided pursuant to the agreement. The department shall make payments directly to the recipient;

(3) Prior to completion of the three-year requirement, if the loan repayment recipient discontinues his or her veterinary practice in rural areas within Nebraska or the percentage of patients serviced in his or her practice that were livestock in rural areas within Nebraska was not at least fifty percent of total patients in the most recent year under the agreement, the recipient shall repay to the department one hundred fifty percent of the total amount of money provided to the recipient for loan repayment with interest at a rate of eight percent simple interest per year from the date of default. The department shall remit money received under this section in accordance with section 71-5661; and

(4) Any practice or payment obligation incurred by the loan

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repayment recipient under the loan repayment program is canceled in the event of the loan repayment recipient's total and permanent disability or death.

Sec. 13. Original sections 71-5650, 71-5651, 71-5652, 71-5653, 71-5654, 71-5655, and 71-5664, Reissue Revised Statutes of Nebraska, and sections 71-5661, 71-5662, 71-5663, and 71-5668, Revised Statutes Supplement, 2023, are repealed.

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

December 12, 2023

Dear Rachael,

The data request made on December 12, 2023, by Jenny Obermier, RN of York General Hospital, York County, Nebraska is complete. She requested to evaluate the number of General Surgeons practicing in York County, as she was aware of some turnover in this specialty . After consulting our data collection service, Health Professions Tracking Service (HPTS), it was determined/confirmed that there is now .5 FTE's in York County practicing in General Surgery. This is a decrease of 1.5 physician FTE since 2022.

Dr. Daniel Growney, MD has left the state
Dr. Ye Ye, MD is practicing 2 days a week in York County (.4 FTE)
Dr. David Voight is practicing 4 hours a week in York County (.1 FTE)

The 2022 recorded population for York County, Nebraska is 14,125. With the reduction of 1.5 General Surgeons, the patient to provider ratio increases from 7,062/1 to 28,250/1.

The ratio threshold that determines shortage for General Surgeons is 10,200/1. The calculation of 28,250/1 exceeds this threshold. I suggest recommendation of approval to add York County as a state shortage area in General Surgery.

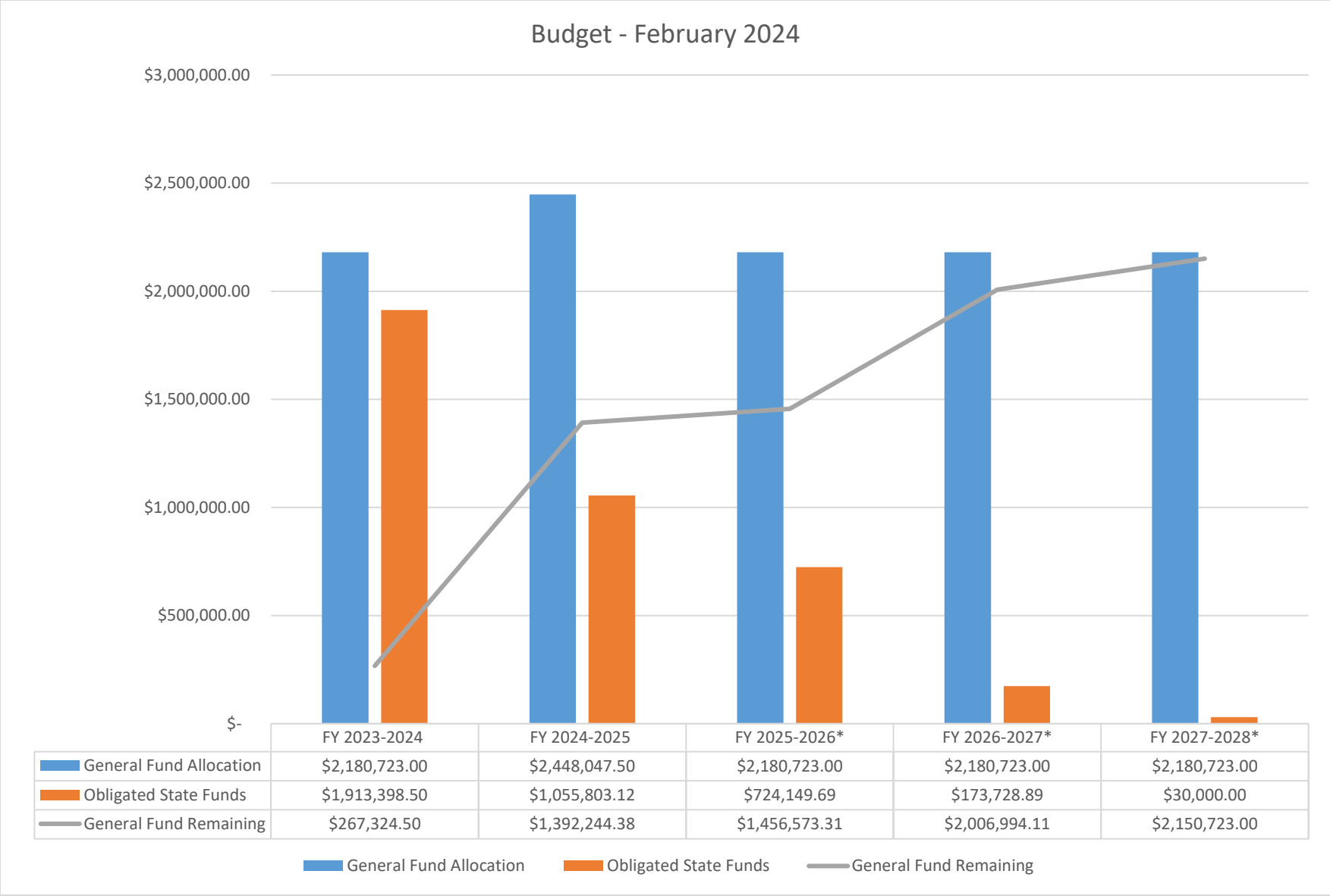
Sincerely,

Heidi Peirce

Heid Peirce
Primary Care Office Director
Nebraska Department of Health and Human Services
301 Centennial Mall South, 6th Floor
Lincoln, NE 68509

AGENDA ITEM #5C

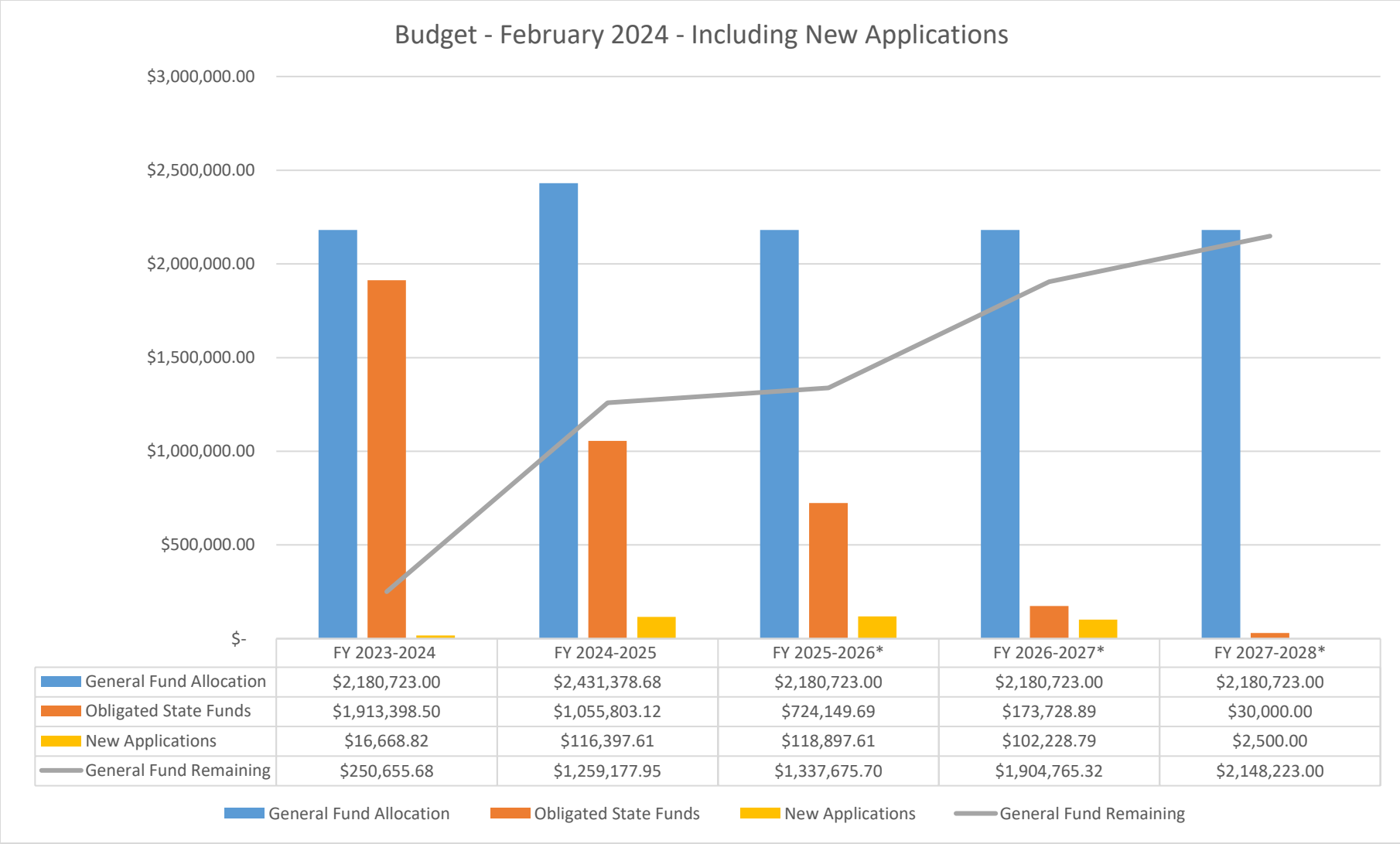
February 2024



	FY 2023-2024	FY 2024-2025	FY 2025-2026*	FY 2026-2027*	FY 2027-2028*
General Fund Allocation	$2,180,723.00	$2,448,047.50	$2,180,723.00	$2,180,723.00	$2,180,723.00
Obligated State Funds	$1,913,398.50	$1,055,803.12	$724,149.69	$173,728.89	$30,000.00
General Fund Remaining	$267,324.50	$1,392,244.38	$1,456,573.31	$2,006,994.11	$2,150,723.00

*general fund allocation is projected for FY2025-26 and on

February 2024



	FY 2023-2024	FY 2024-2025	FY 2025-2026*	FY 2026-2027*	FY 2027-2028*
General Fund Allocation	$2,180,723.00	$2,431,378.68	$2,180,723.00	$2,180,723.00	$2,180,723.00
Obligated State Funds	$1,913,398.50	$1,055,803.12	$724,149.69	$173,728.89	$30,000.00
New Applications	$16,668.82	$116,397.61	$118,897.61	$102,228.79	$2,500.00
General Fund Remaining	$250,655.68	$1,259,177.95	$1,337,675.70	$1,904,765.32	$2,148,223.00

* general fund allocation is projected for FY2025-26 and on