[LR363]

The Committee on Health and Human Services met at 8:30 a.m. on Friday, October 24, 2008, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LR363 and subject of Community Services Block Grant. Senators present: Joel Johnson, Chairperson; Tim Gay Vice Chairperson; Tom Hansen; Gwen Howard; Dave Pankonin; and Arnie Stuthman. Senators absent: Philip Erdman. []

SENATOR JOHNSON: It is a few minutes past starting time, so let's go ahead and get started this morning. This is the second day of hearings related to LR363. And this was to identify a study or an interim study to identify powers and duties of the Department of Health and Human Services and to prioritize programs and services and to examine funding for these programs and services. The...did somebody just leave you off, Senator Stuthman? (Laughter) []

SENATOR STUTHMAN: They wouldn't take me at the first place. (Laughter) []

SENATOR JOHNSON: So...but the first order of business this morning is the Community Services Block Grant hearing. But before we get into that, let's do it just a little bit different this morning. Instead of my introducing people, let's just start with Senator Tom Hansen and we'll go around the table. []

SENATOR HANSEN: Good morning. My name is Tom Hansen. I'm from District 42 which is Lincoln County, largest town there is North Platte. Glad to be here. Glad to have you all here []

SENATOR STUTHMAN: Arnie Stuthman from Platte Center, District 22, which is the Columbus area. I claim Platte Center because that's the home of General Grunther. []

ERIN MACK: I'm Erin Mack. I'm the committee clerk. []

SENATOR JOHNSON: And I took care of General Grunther's brother once at the Omaha VA. (Laugh) Jeff. []

JEFF SANTEMA: Good morning. My name is Jeff Santema, committee counsel. []

SENATOR GAY: Tim Gay, District 14, Papillion-La Vista. []

SENATOR PANKONIN: Good morning. I'm Dave Pankonin, District 2, which is mainly Cass County, so part of Sarpy and Nebraska City area. []

SENATOR JOHNSON: And one other thing about Platte Center is that they had someone who played for Buffalo in the National Football League for, what, 18 years. []

SENATOR STUTHMAN: Oh, you mean Torczon. []

SENATOR JOHNSON: Yeah, LaVerne Torczon and was quite awhile ago, but he was a darn good die (inaudible). At any rate, so with that you're the first batter. []

TODD RECKLING: (Exhibits 1 and 2) Good morning, Senator Johnson and members of the Health and Human Services Committee. My name is Todd Reckling, R-e-c-k-l-i-n-g. And I'm the policy section administrator for the Division of Children and Family Services within the Department of Health and Human Services. I'm here today to report to you about Nebraska's state plan for Community Services Block Grant funds. You each have a copy of the state plan and a handout providing you examples of programs provided through these funds. You'll see on your handout that we served over 90,000 people last year and some of the types of activities and programs funded as well as numbers served. This periodic public reporting is just one requirement of the federal statute allocating these funds. Community action programs were created back in 1964, as part of President Lyndon Johnson's "War on Poverty." Community Services Block Grant, or

CSBG funds, are federal funds distributed to the states and earmarked by federal law for distribution to the community action agencies. Funding to the states is determined by a formula which includes: (1) the number of public assistance participants in the state; (2) the number of unemployed in the state; and (3) the number of children in the state who live in households with income below the poverty level. Today, there is a network of over 1,000 community action agencies that exist across the U.S. Nebraska's nine community action agencies serve all 93 counties in Nebraska. The board for each community action agency is composed of one-third low-income representatives, one-third elected officials or their representative and one-third private sector representatives who live within that community action service area. The local board of each community action agency is responsible for the planning, management and operation of that agency. And the state is then responsible for monitoring and oversight of the agencies to assure compliance with federal and state laws and regulations. Federal authorization for CSBG actually ended on September 30, 2006. Although the President's budget proposal has eliminated funding to CSBG each year the Congressional budget has included it. This fiscal year for 2008 allocation for CSBG funds to Nebraska was just a little over $4.5 million. It's anticipated that the program will be in a continuing resolution through March of '09. It is unclear when the program will be reauthorized. Federal law then requires that at least 90 percent of the CSBG funds be distributed to Nebraska's nine community action agencies. The funds are then divided among the nine agencies in Nebraska by a state formula that's calculated using a base formula and the poverty population in each of the community action service areas. The state CSBG formula and a service area map are located on pages 9 and 10 of the larger state plan that you also received. The state may then use up to 5 percent. I just want you to know offhand that Nebraska does not even use 3 percent for administrative funds of the grant, and the remaining funds are then distributed back for program and services and provider technical support to community action agencies. They also are used to support new statewide innovative antipoverty initiatives, emergency needs or to support unforeseen future needs of the state's community action agencies. Page 13 of the state plan that you also have has a listing of the community action agencies, the

counties that they serve and the actual allocation that's received by each. The Community Services Block Grant establishes a funding base for the community action agencies enabling them to leverage other funding sources. Last year the CSBG dollars that were received enabled Nebraska's nine community action agencies to actually leverage an average of $17 in other federal, state and local dollars. Thank you for allowing me the time to present on the Nebraska's Community Services Block Grant state plan to you today and to provide you a small sampling of what those agencies are doing for our state. I invite you to review the plan, and if you're not acquainted with the local agency in your area to become familiar with that. Appreciate the opportunity of talking to you today. And would be happy to answer any questions that you might have. []

SENATOR JOHNSON: Thank you, Todd. Let me first introduce Senator Howard who has joined us as well. Now, any questions of the committee of Todd regarding this? Must have done a great job, Todd. Thank you. []

TODD RECKLING: Thank you, appreciate your time today. []

SENATOR JOHNSON: You bet, thank you. Well, we'll actually get started a couple of minutes early if we've got everybody here that we need. And I hope that you don't get to sip on that and finish it before (laugh) you leave. At any rate, what we want to get into first here is the Division of Behavioral Health. []

SCOT ADAMS: Good morning, Senator Johnson and members of the committee. Thank you very much for this opportunity to have conversation with you today about the Division of Behavioral Health as part of the Department of Health and Human Services conversation with you about its work, priorities, progress and challenges. I'm really excited to be here because I think there are good things going on in behavioral health in the state of Nebraska. We have, of course, another hearing on a particular aspect of behavioral health--the implementation of LB1083 through the LR338 process later this

fall. But I hope to be able to provide sort of an overview of all the behavioral health activities and works today as part of the overview of Health and Human Services. So I'm excited to be here and look forward to a good conversation. As others have done, I wanted to present you sort of the organizational chart of the Division of Behavioral Health. At one point, it said that we had somewhere around 990 employees throughout. Most of those are employed in regional centers. And while that was a number that was true on July of '07, our numbers have gone down significantly with reduction of services, especially at the Hastings Regional Center over time. The people who are here, I think, are solid folks. Some are new. And I would direct your attention in particular to the Children's Behavioral Health Unit, with Maya Chilese as the newest member really of our team. Maya heads up the office for Children's Behavioral Health, a Governor's initiative in an organizing effort within the division and within the department to focus attention on the Children's Behavioral Health services. I would also draw your attention to the Office of Consumer Affairs. Dan Powers currently serves as the interim director of that office and represents a direct line of input and advice and conversation with regard to consumer interests to me and therefore to the division. We are in the process of finding a permanent member to fill that position. Joel McCleary was the first member to hold that, the first person to hold that. And he resigned to take a position with the Department of Corrections earlier this year. The process for filling that position is one in which I have asked a variety of consumer organizations to come together and to help through being part of the review team. So that the review team, formed by consumers, will review all the applications and recommend three names to me for this discretionary position. I've had positive conversations and reception about that so far and look forward to that process. And hope that by the end of the year we'll be able to have names for consideration. I do know that at present we have at least 28 applications for the position, which I think indicates high interest in the position, and also indicates the importance of the position to the division overall. There are some key guiding principles that I want to stress at the very outset of my remarks. And that is we believe that wellness and recovery are possible. And these are very important words, I think, to the Division of Behavioral Health. Oftentimes, I think we approach the issue of behavioral

health from the point of view of problems or danger or safety or those kinds of things. And I think it's important that we look at the bright side of these illnesses and these conditions--and that is recovery. People do, in fact, recover, get better, fully participate in society. And so the investments made and the costs expended in terms of persons with mental health, substance abuse and gambling disorders are important, I think, investments for the state. We also believe that safety, dignity and recovery, again, are real and tangible kinds of things in people's lives and in communities. The next slide will talk a little bit about the structure or the flow of money. And you can see that about 73 percent of the revenues are General Fund revenues between operations and aid; cash--representing both tobacco fund money as well as lottery proceeds from the gambling or excuse me, for the gambling program side--represents roughly 11 percent of the funds; federal money is about 16 percent, for a total of around $168 million spent in behavioral health services between operations at the regional center and community-based services. []

SENATOR JOHNSON: Scot, could I interrupt you for just a second. []

SCOT ADAMS: Sure. []

SENATOR JOHNSON: On this, one of the goals and one we're starting to make progress, one of the goals with LB1083 was to make it so that we had greater access to federal funds by switching to community-based services and so on from the institutional, where there was essentially no help. Are we starting to make progress in that area? []

SCOT ADAMS: We absolutely are. There is no question that there are more Medicaid dollars involved into the system today, if you will, than there has been before. Medicaid will not pay for care if a person is at a regional center by virtue of federal rules, but will in smaller, community-based provider locations. In the beginning there were a few million dollars that were spent with regard to Medicaid services that were matched by the state. And in this current budget there's roughly $8.9 million of General Fund match

toward the Medicaid dollars in the current fiscal year. That's a significant increase, probably about a three- to fourfold increase in that. Now the interesting dynamic that is at play here is this is not a continuum where it is a straight line from go as fast as you can to as much Medicaid as you can because if the state were to use all of its behavioral health General Fund money matching Medicaid, there is a significant and large proportion of the population that is not Medicaid eligible. So General Funds are still a necessary requirement, thus there is a question of balance. What's the right amount of federal Medicaid services in there while allowing for sufficiency of the behavioral health General Fund dollars for those who are not Medicaid eligible. So it's a question of balance. And that question is still, I think, being teased out. While this is the largest amount of match money ever provided before from the Division of Behavioral Health, we're not quite sure what the right number is. We think it's probably in this area, but we're still at a point where I think that we're teasing that out a little bit. []

SENATOR JOHNSON: Thank you. []

SCOT ADAMS: You bet. []

SENATOR GAY: Scot. []

SCOT ADAMS: Yes, sir. []

SENATOR GAY: To follow up on that. So when you say this is where we've been going, how many years are you talking about? []

SCOT ADAMS: Really, behavioral health reform came into play most significantly and most dramatically and most recently with LB1083 that went into effect July 1 of 2004. []

SENATOR GAY: So back before 2004, go back a little further because I'm familiar with LB1083. But prior to that, though, what was our...how much were we spending on

federal funds or percentage? Do you know, ballpark? []

SCOT ADAMS: You know I don't know that number offhand. But I can sure find that out for you. []

SENATOR GAY: Okay. And then in the future then or when you look at those General Funds, and I know you come from the nonprofit sector and I think that's a good benefit. But are you doing partnerships? Are you going to get into that later or... []

SCOT ADAMS: Well, we absolutely have a variety of partnerships. The Division of Behavioral Health on the community services section is limited to 25 staff. So we have a variety of different partnerships with which we do work. The most notable of those partnerships are with the behavioral health regions. And I will talk more about that shortly here. The regions in turn then contract with individual providers for the delivery of services. Most of those are not-for-profit organizations, though in some regions and in some parts of the state the regions themselves are a provider of service as well. []

SENATOR GAY: But we've had partnerships, what I'm talking about is private individual partnerships. If somebody wants to inject some money into a program that they can be matched, I've seen...we're seeing more and more of that where good Nebraskans want to gift and then it's matched. Is that in the future going to continue? []

SCOT ADAMS: Yeah. I think throughout the behavioral health system you see inspiring examples of private sector individuals stepping forward to help out with behavioral health issues overall. Let me give you just a couple of examples. Perhaps the most note worthy and stunning is with regard to the Lasting Hope Recovery Center in Omaha, a new 64-bed psychiatric hospital that was spurred into creation and redevelopment of an existing hospital with the help of Ken Stinson, Rhonda Hawks and others who raised in excess of $25 million of private money for the renovation of that facility and other Region 4 facilities associated with behavioral health reform. That's pretty dramatic--$25

million of private money going to this topic. A second example would be the Kim Foundation, a statewide organization that has interest in promoting awareness about mental health and behavioral health issues, operates a Web site, has a radio show, provides direct funding for operations of different services across the state in terms of awareness campaigns and other kinds of things. I think it's another outstanding example of private sector involvement. []

SENATOR GAY: Do you think that will continue into the future is what I'm saying? Not that...is that what we're planning on in the future to budget, I mean, partnerships like that. []

SCOT ADAMS: I think fundamentally the nature of nonprofits is that government, typically, always comes up a bit short of what the nonprofit need is in terms of operations or capital and things like that. And so we have, I think, in America a system by which nonprofits necessarily involve the private sector, whether that's through United Way funding for operations or other organizations like that, that raise money on behalf of particular services. Especially in the area of capital improvements, I think, nonprofits generally rely on the private sector to tell their story with passion, with success, with data to be able to demonstrate making a difference. I think in Omaha again you're seeing some of that arising with regard to recent interest in a ten-year plan to end homelessness. Father Schlegel and Creighton University are strongly behind that effort. That will necessarily involve issues related to behavioral health kinds of concerns. So there are a great many kinds of things that the private sector has to offer, to play and to be part of that, I think, are ongoing and important. That will continue on into the future. One last element that I think is important is that recently Congress passed mental health parity legislation, which speaks to the private insurance sector with regard to making sure that whatever benefits are offered for healthcare plans are also the same benefits offered for mental health and substance abuse services, if that optional service--mental health and substance abuse, is provided in the policy. So that's another example, I think, of private sector involvement in the ongoing operations of behavioral health

services. []

SENATOR JOHNSON: I think Senator Stuthman had a... []

SENATOR STUTHMAN: Thank you, Senator Johnson. Scot, in going from the regional setting of the mental health and going to the community-based providers, and by doing that with LB1083, you know, we can continue to get the federal aid for that portion of it. []

SCOT ADAMS: Yes. []

SENATOR STUTHMAN: Are we supplying enough money to provide the services in the community-based setting for the mental health or behavioral health or are we to a point where we're starving out those community-based providers where they can't afford to do that process? []

SCOT ADAMS: You know, there will, of course, today be, I suspect, a variety of opinion about that question. My position is this--we spend roughly $180 million in a state of 1.7 million people. We are in a continuing moment of evolution in a radical transformation of the system from reliance upon regional center care, institutional care to community-based care. There are a variety of dynamics at play--mental health parity being an example of a recent one just within the last couple of weeks--that have come into the picture that will have, we hope, a positive impact on that. The original promise with regard to LB1083 and the transfer of regional center operating dollars was to send $25.8 million to the community. That was the discussion, the slides, the briefing papers, that was the promise. It's our position that we have sent about $30 million to the community as a result of that. And so we think we have exceeded the original promise. The reason for that was that the loss...LB1083 specified whatever services were closed, those operating funds should go to the community. So we think we have exceeded the original vision, if you will, and are in accord with the law. And I think that a variety of

those kinds of factors, including private sector investment, are dynamics yet to play out. []

SENATOR STUTHMAN: Okay, thank you. []

SENATOR GAY: So when you say that it would match those operating funds in the transition, is that when we see the slide that says completion of LB1083? And then we always hear it followed up by it's not ever completed. And I agree with that statement. Is that what you're basing those slides on then? []

SCOT ADAMS: Yeah, the premise of the slide that says we have closed the chapter on LB1083 reform is intended to say that all of the money of the original plan has gone to the communities. That that was a particular series of steps, dynamics, tough, tough arm wrestling at times between paradigm shifts, professional opinion, consumer involvement and all of that work eventuated in the transfer of $30 million to community-based services. That's a significant moment and one that, I think, had a particular set of dynamics and needs to play out. And that chapter has come to a close with the movement of the money to the community, as well as the completion of the term of the Behavioral Health Oversight Commission, the first one that came to natural sunset last June 30th. So those are the two criteria that I even vote for that statement. I do want to say that there's lots of work yet to be done. This is a long story with a long history. And, Doctor, probably you know better than many, boy, there's a lot we don't know about this field in terms of that. And so there will be a continuing story for a good, long time. []

SENATOR HOWARD: Scot, one thing I'm hearing from my district, Lasting Hope is in my district, even though Senator Synowiecki always claims it's his, is that they're having trouble getting psychiatrists, that there is a shortage of psychiatrists to work in these facilities. I was just wondering if you'd heard that too? []

SCOT ADAMS: Yes. The shortage of psychiatrists is a nationwide problem. It's my

understanding that outside of the state of New York, every state is a designated psychiatry shortage state. We have particular challenges here in Nebraska, I think, with regard to nonrural, nonmetro areas. But as you point out, even in Omaha Lasting Hope has had trouble coming up in a timely fashion all the necessary docs to be able to staff adequately. So that's an ongoing situation, an ongoing challenge that the entire nation faces. At one time, I think psychiatrists sort of ruled the roost, if you will, and were the king person, I guess I should say kingpin of the treatment team. And that has defused for a variety of reasons and I think positive reasons in lots of ways. But the particular role and function of the psychiatrist still is critical to the treatment team overall, especially in hospital-based care. There are other methods of care that rely less upon psychiatry--recovery movements that rely on peers, psych rehab programs that rely on different social psych models, that kind of thing. But especially in the medical model, hospital-based care that's a critical issue right now. []

SENATOR HOWARD: Thank you. []

SCOT ADAMS: You bet. Okay. Well, this slide is intended to sort of show some of the before and after effects of LB1083 and monies to the community. So it continues the conversation that we had just recently. So in fiscal year '04, July through June of '04 those were the amounts the regions had. And then in the current fiscal year these are the contractual amounts. These increases to regions then range from 23 percent to 89 percent increases in terms of revenues from...over the four-year period. Let me take a moment to explain "other" because it sort of jumps out and stands out there because it's not noted in the '04 year. In the '04 numbers you had some monies that were in regional contracts to match the Medicaid dollars that were there. So the regions did not pay those, they actually ended up giving them back to the state. They offered a way to help regions to monitor overall usage. A change in process is such that because of the significance of the dollars, the match money is now taken out directly from the Division of Behavioral Health's budget before it ever goes to the regions. So we have a bit of an apples and oranges. What that would mean concretely is that the numbers in the '04

column would go down a little bit in the '04 period because of the match monies. So the percentages of increase actually would go up. The $15.3 million is composed of about $6.5 million for the Lasting Hope Recovery Center itself. And so that is a direct contract between the state of Nebraska and Lasting Hope. We intend that that will go to Region 4 at some point in time, our hope is by July 1 of '09. But right now, today it is a community-based service not in the region, which is why I wanted to identify it as "other" rather than simply to lump it into Region 2. The rest of that amount is the Medicaid match, which is about $8 million, $8.5 million, $8 million, $9 million for Medicaid match. So those two numbers together form the "other" category, again indicating sort of the dramatic growth in Medicaid match over time. []

SENATOR HANSEN: Scot, I have one question, especially about Region 2. That's quite an increase from '04 to '09, projected. And numbers of people served or clientele reflect that number? []

SCOT ADAMS: You know we'll have a little bit more in a moment, though not by region. I'd be happy to get that,... []

SENATOR HANSEN: Okay. []

SCOT ADAMS: ...I believe we can get that by region. But I can give statewide numbers. The short answer to your question is, yes, every region has had a fairly dramatic increase in the number of persons served. In fact I think one of the unintended consequences that has occurred or the unforeseen consequence that has occurred over the course of LB1083, if you recall, the original legislation was intended to move people out of regional centers into community-based care and to keep people from going into regional centers, diverting them and treating them in the community. That, I think, by most people's estimates would have numbered hundreds, maybe a thousand, maybe mid-1,500 kinds of things. And what we have indicated, what our data indicated is that we have had 9,000 new unique admissions over the four-year period. So there

has been an increase. []

SENATOR STUTHMAN: Scot, that was the question that I had, kind of between Region 3 and 4. Region 3 had just about doubled from '04 to '09, and Region 4 about 50 percent increase. []

SCOT ADAMS: Um-hum. []

SENATOR STUTHMAN: And, you know, and yeah, you said you'd have some information as to how that was addressed, if it's... []

SCOT ADAMS: Each region, in the early days of LB1083, because of the nature of the implementation and the need to downsize regional center operations for monies to come up, we sort of went from west to east in terms of the implementation. And so I, II and III, for instance, sort of got on earlier and services were developed as Hastings then began its decline as their source of support. I should also note that again, sort of in the nature of the language of the chapter issue of LB1083 here, that Region 1 in particular, the Scottsbluff area has been at this far longer than LB1083. They had reduced their reliance on regional center care by necessity. It's just a long drive from Scottsbluff to either Hastings or Norfolk. And they had learned to care for their own well before the emphasis and the energy and the oomph of LB1083 law, if you will. And so their system was in better condition, if you will, better placement. So dynamics like that were factors that came into play. []

SENATOR JOHNSON: As a matter of fact, I think it would be a fair statement to make that Region 1, the Scottsbluff area in general, is the Godfather, if you will, of LB1083 because it actually...legislation came out of the performance of the Region 1 or Scottsbluff area, that they had successfully done this on their own. []

SCOT ADAMS: I think that's correct to say, Senator. I think that there was the sense of

hope and the "can-do-ness" that was an important element that was fused into LB1083 that was certainly based there in part. []

SENATOR GAY: Scot, on this, since we're talking about this Region 6 then, is there any issues still that they haven't got all the dollars they thought they were going to get from transfer patients? Because there for a couple of years we had... []

SCOT ADAMS: Yeah, that's a... []

SENATOR GAY: ...we had the patients, but they said the money didn't follow the patient. []

SCOT ADAMS: Yeah. Yeah. The...yeah, this goes off into a piece of things that is an important consideration. The vision of behavioral health has long held a formula for the distribution of funds. That formula is weighted three-quarters toward population and one-quarter toward poverty. The thought being that if you have a collection of poorer counties there ought to be greater state support in some ways to assist in that factor. So we use federal guidelines for both poverty level by county, as well as the population and the census and the updates and that kind of thing. With this distribution in fiscal year '09, we are within 1.5 percent point of rightness among all the regions. Some are a little higher, some are a little lower, but we're within about 1.5, .6 of where they should be if we were absolutely, strictly following the formula. And the error rate or the variance rate, if you will, really is the result of sort of some historic items and some things like the Scottsbluff area and just different areas that have come into play, human intervention over time. We did, by the way, revisit that formula with the regions this year. And one of the options was to sort of do the fruit basket upset and just use the formula, redistribute. And there was a strong consensus that that would not be fair to regions that have developed a network of services premised on the original distribution, and that this was a reasonably fair distribution. The next slide, I think, is also an important slide. What you have here is then the distribution of funds by major category. And I would draw your

attention to the green area, up at the top, first of all, which is the Norfolk Regional Center, which is funded entirely through the LB1199 formula for sex offender treatment. This is true, even though there are still 26 persons with mental health issues today at the Norfolk Regional Center. A decision was made two years ago, by the Unicameral, to fund all of the Norfolk Regional Center operations by sex offender funds. The orange, "orangish," I guess it looks sort of beige up there, is the regional center operations--Lincoln and Hastings Regional Center. That represents, with Norfolk, about 38 percent of all of the dollars available. So that the three regional center hospitals expend about 38 percent of the funds allocated to the Division of Behavioral Health. The largest area, community aid to regions, are the sum of the contracts available to the regions for services. And the other community aid also then are services that are provided to community organizations for behavioral health services. Things like the Medicaid match, the ASO contract, gambling contracts which is also part of the Division of Behavioral Health, though oftentimes sort of forgotten as part of what we do, and contracts directly with tribes for services on the reservations and for folks of Native American backgrounds. The Behavioral Health Administration amount is 1.3 percent of the dollars given to the Division of Behavioral Health. Now with regard to the next slide, this is I think to your question, Senator Hansen, again on the statewide level, about a 67 percent increase in the number of persons served between '04 and '07, composed both of mental health and substance abuse services here. There are people who are identified as having co-occurring disorders. For purposes of simplicity, we threw all of those into the mental health category. So there's a rough...there's a bit of a measurement there in that. But we wanted to sort of show the differences between the two. And the big number, the important number really is the 55,379 persons served with regard to those services. []

SENATOR PANKONIN: Scot, I may stop you there. []

SCOT ADAMS: Yeah. []

SENATOR PANKONIN: Just a couple of things. One goes back to your opening guiding principles. And I think it ties into this a little bit. We believe the wellness and recovery are possible. And we're seeing this larger number, now (inaudible) I appreciate that. And I think it's important that we do focus on it because of the numbers and the fact that these people can contribute and, hopefully, recover, and I think a large percentage can. We know it's a lot more complicated situation than a lot of times a physical ailment. But I've got...had some involvement with community of Alliance over the last year, and they do great work. And I think that's kind of their motto as well. So I appreciate that. But, and I've been curious over the last year in knowing that we're seeing, and Senator Stuthman mentioned that in his area, in the Columbus area, that the numbers are up. You know, why is that? I've been thinking, you know, is it environmental, societal? Lot of folks were undiagnosed with these issues before? Why are we seeing mental health issues? And part of it is it should be that way, that people are acknowledging that this is another situation that's part of life and it shouldn't be stigmatized. We all probably have some tendencies that way or at different times in our life. Why do you think we're seeing the numbers go up? []

SCOT ADAMS: Yeah. I think that's a great question and when I first saw the dramatic increase in admissions it was a question that jumps off the page, jumped off the page at me. And I think there are two or three reasons that help to begin to explain. Although I'm not aware of any definitive answer that says, you know, that and this and that's it. I think in Nebraska in particular, when we had the conversation around LB1083, there was a lot of controversy about that topic. Concomitant with that there were forces on both sides of the question, if you will, that had a great deal of media attention. The Kim Foundation, as an example, as one of the proponents of behavioral health reform, initiated a statewide media campaign raising awareness with regard to mental health disordered. And, I think, when you spend attention and time and effort on an area to raise awareness you have effect. Secondly, I think there are have been other larger efforts, national efforts to destigmatize things. Groups like NAMI and the Mental Health Association that have national impact and constituencies, I think, are examples of folks

trying at larger levels, with media and also with other groups and efforts to destigmatize and make it more okay to seek treatment. That's a good thing. And I want to say fundamentally I think that the increase is a good thing that people are coming forward to seek help. I think that's an important factor. I think another reason, though, that is perhaps more subtle than all that is more of us know somebody, than we used to, that's in recovery. Individuals who are in recovery are more willing to say, yeah, I've gone to treatment for therapy or I'm in recovery or yeah, I used to drink too much and not anymore. A whole host of things make it far more reasonable and personal to see a person in recovery next door is my neighbor, dating my daughter, an employee of mine, those kinds of things, where it has just become a more visible on a very concrete level. That spins off a greater willingness for others to do that. I think one of the greatest opportunities we have are people in recovery talking about recovery to help others who are nervous and scared about taking that first step. I would offer a fourth factor, too, that I think has, though not quite as much on point, I still think contributes to this. And that is the entire conversation and development and evolution, if you will, of the gambling situation in Nebraska. Along with all of those conversations was a very important conversation about problem gambling, about how much money should go into the lottery...from the lottery and other areas into treatment services. Well, again we're talking about treatment and recovery from a condition that's very like that. So while one person may hear the 1-800-BETS-OFF number, they know that there's help for that kind of thing. And that, I think, helps all of us to feel more easy about, you know, I'm not feeling good today for some other reason. But it helps us to take that step forward. And it also helps us all to sort of say, you know, there's help available. When I first got into this business, in the mid-seventies, back when we used rock and crayon to write, we...it was difficult for people. No one knew what to say, what to do, how to approach somebody, even though some others around the person may well clearly be able to see the effects of mental illness or an addiction or a gambling problem before the individual does. The advent of EAP programs and other kinds of things like the ones I've talked about, I think, have helped all of us to get better at that. And I think in Nebraska you've seen the crescendo with the lottery impact and the 800-BETS-OFF thing as well as the

discussions around LB1083 in particular. []

SENATOR PANKONIN: Well, I appreciate your work because it is important work. And I think, obviously, for individuals that are going through this process that need our help that also our whole state will be more productive and healthy and whatever if we can continue to make strides. So appreciate your work, it's important. []

SCOT ADAMS: Yeah, thank you. []

SENATOR HOWARD: And, Scot, just to take this just a little bit further. In the seventies, when you and I got into this, it wasn't that long ago...(laugh) []

SCOT ADAMS: Some days it feels like forever. []

SENATOR HOWARD: That's true. Anyone know the answer to this? But do you see any increase in a particular segment of the population, like an age group, like young adults or I've heard, too, that (inaudible) depressed seniors, for example. And I don't know if you're noticing anything that would give you some information about that. []

SCOT ADAMS: You know, Senator, I think the best that we can say about that is the evidence is inconclusive. My dissertation topic was on late onset alcoholism. That is to say people who go through their whole life drinking normally and then hit older age and then become alcoholic. Well, at the time I was at a point in my life where I had three young kids, going to school, not making any money, you know, that kind of stuff. And I thought, you got through all that stuff--sickness and deaths and job change and then you start drinking? I mean, that made no sense to me at all. And during the course of my studies what I found out was nobody much knows the reasons why for that particular phenomenon. They talk about stress. Oh, come on. You know there's a lot of stress at a lot of points of life. So what is it about the individual at a point in time? I think we are early in the research to be able to precisely answer your question. And I think some of

the variables that go into answering that question include the factor that we have more and more of an instantaneous society. We're expected to have an input and a response like that. We have no time to sort of absorb, make sense of it, accommodate it, reasons it out and respond as a person. We have to be hyper-responsive in all our ways or we're somehow odd or left behind. And that accumulation of that takes an impact, I think, on an individual's ability to adapt. So, I think, you got broad, general things like that. I think you have perhaps even things as odd as the foods that we eat. I think we're eating perhaps less healthy than we have in prior times and I think that can have an impact. So I think there are a variety of factors that come into play there. I'll be honest with you. There are so many and it depends a little bit on which expert and research line you're talking about. []

SENATOR HOWARD: Okay, thank you. []

SENATOR JOHNSON: Great. []

SCOT ADAMS: The next page then identifies the particular regions of the state with whom we are partners. As you saw, about $72 million or so goes directly to regions for the provision of services. Regions in turn then will contract with private providers or deliver services themselves. These regions were established originally back in the mid-seventies with LB302 and LB204, and have been reaffirmed in LB1083, and represent the major way through which we do work. []

SENATOR GAY: Scot, I've got a question on that. []

SCOT ADAMS: Yes, sir. []

SENATOR GAY: How do you communicate, when we talked about communication yesterday earlier, how do you communicate with these regional directors or hold them accountable or make sure we're all working together for the same goal? So let's say

Region 1 isn't doing something (inaudible), and maybe they need to, than Region 6, let's say, because we're a diverse state, different needs. But I think a lot of these would be common problems. But how does the communication go between you and them? []

SCOT ADAMS: Sure. Communication and accountability are addressed in a number of different ways. First of all, we have a relatively specific and lengthy contractual arrangement with the governing board, that is to say county commissioners, and the Division of Behavioral Health. In that contract are specified priorities, uses of funds, the types of services to be funded, reporting times, reporting requirements, those kinds of things. And so there is that document. And if any of you are interested in the contract for your area, please let me know, I'd be happy to give you a copy of that so that you can see what goes into that. In addition to that, we have a weekly conversation with the regions and largely around the emergency system coordination but also offers a time for communication about other topics of interest and items that are going on. We have an eyeball-to-eyeball meeting once a month with the regional administrators and the Division of Behavioral Health staff. And quarterly we involve a larger network of persons in that as well in terms of more people from the regional staff and more people from the divisional staff. So we can sort of do some of the strategic planning in goings on. Coming up, on November 20, we anticipate a fairly significant day-long planning event as well to help us move forward with regard to sort of some of the major elements of the next chapter of behavioral health reform. And so we have those kinds of convenings as well. And let me give you a particular example. With the distribution of funds that the Legislature directed us to do last session, we distributed $17.1 million to the regions on May 29. That was sort of an unusual distribution because we were just told to get the money out. It was the accumulation of unused monies over the course of multiple fiscal years. With that then we sent directions with regard toward its use, which focused in on the emergency system and moving people from regional centers and diverting people from going into regional centers as high priorities for use of those funds. Those priorities were in every one of the six letters. There were also some individualized elements to the letters, recognizing the difference of locality and region to region. But all of them

were focused in on those priority issues of be moving people from regional centers and diverting persons from regional center care. Okay? Okay. In terms of priorities I think that perhaps the most important thing is to achieve the new balance of the regional center hospitals within a community-based environment. This is the paradigm shift, if you will. Previously, the state of Nebraska relied on regional centers as their core stopgap service. That really has moved to the communities. And so the new role and function of regional centers within a community-based care is important. The emergency services system at the local level is important. I suspect that if you people as representatives here questions, it may oftentimes come from sheriffs and law enforcement with regard to some difficulties. Some of that is...some of that, frankly, is culture change. It used to be easy to drop somebody off at a regional center, keep the motor running. We no longer do that. And it's a more intense process that can involve peers, mobile crisis teams and others, as well as law enforcement who retains the authority to place a person in emergency protective custody. But it may take some more time. We think that the increased number of beds, both in Omaha, Norfolk and across the state, have alleviated the access problem. But on any given day there may be some stuffing, but there is opportunity for spillover into other resources. So that coordinating emergency services remains a very high priority with the Division of Behavioral Health. Integrating children's behavioral health is also a Governor initiative and an important focus, trying to bring together the resources of the state to focusing onto the particular needs of children's behavioral health. And then administering and managing non-Medicaid public behavioral health system is important. The next page then talks about other priorities of the Division of Behavioral Health. And the state leadership is a shared one with regions and consumers as the role of mental health and substance abuse planning, contracting of oversight, management information. Consumer involvement is one of those glass half full, glass half empty kinds of things. On the one hand, there has never been more consumer involvement at all levels, as required by LB1083. On the other hand, I think we have opportunities to increase that still further. And I think that that model and that focus of consumers is an important one to help shape behavioral health. Other important priorities include federal grants management.

In particular, we have a substance abuse block grant of about $7 million or $8 million, mental health block grant of around $2 million and a data infrastructure grant to help us in various areas. There are other federal grants that also come into the division. Disaster preparedness and response is an effort that is coordinated with regions. And we have had, unfortunately, some instances where that has come into play. And I think it has worked rather rapidly and come into place rather well in most instances. We continue to learn. I would hope that this would be a piece of our work that would get rusty because of nonuse, but I suspect that that will be the case from time to time, given the human condition. Housing is also an important point. LB40 was an important piece of legislation some years back, I believe 2005. And you'll see a number coming up that we last year served in excess of 700, nearly 800 persons in supported housing, persons who might otherwise be in regional centers or higher level of institutional care were it not for that. In terms of progress with regard to...yes, sir. []

SENATOR GAY: Scot, I've got a question back on your priorities. You talked about the emergency...I got a letter, and I've got a lunch lined up Monday with our county sheriff and police chief of Sarpy County about the EPC problem or what they perceive as a problem. You say it's a priority, and I know it is and it's a difficult situation. But do you have a plan for that now that you could get to me or others or when you say it's a priority, what's being done on that? []

SCOT ADAMS: In the Sarpy County area there are two particular responses that I think are major, forefront kinds of things. One, Lasting Hope Recovery Center is a bed resource for EPC. They have not been at capacity in terms of 64-beds, which is their planned capacity. And so that is a resource that can continue to grow and come on. There concern, as Senator Howard noted, was the ability to have full psychiatric coverage to move into all 64 beds. Secondly, Region 6 has developed in Sarpy and Cass Counties recently the mobile crisis teams. But this has been a relatively recent affair within the last year to 18 months in terms of the development of that service. And so I suspect that all of the T's have not been crossed, all the I's not dotted. Region 6, for

a variety of reasons, was among the later regions to develop this mobile crisis team. But initial reports are very positive about their effect in terms of being able to sort of calm down a situation, divert EPC admissions and those kinds of things. []

SENATOR GAY: Okay. Well, you mentioned Region 6. This is...the letter I received is not a meeting with our people. The letter I received is from the Speaker of the Legislature, and it was Norfolk as well. So I think it's a statewide problem and maybe this is just being corrected. I don't think it's one region. Region 6 is by far the largest region, so there is more going on, I suppose, there. But this was from Speaker Flood, a letter to me to...and him and I are both looking into it. So it must be a problem up in the Norfolk area, too, because they went up to Norfolk with the Norfolk chief. So, I mean, is it...you don't perceive it as a problem statewide then? []

SCOT ADAMS: Well, not it certainly is...because it's a priority of the division, it remains sort of an area of continuing attention and focus. Each region has had slightly different response and reaction. In the Region 4 area, as an example, Faith Regional, in the calendar year '08, has developed additional...ten additional beds in that area for a response. And so there has been some growth of the system in the Region 4 area to address that. And so that's a relatively recent development with regard to some of those things. In other parts of the state, any time an EPC occurs it can be a time-consuming affair, it can also be a fairly traumatic affair for all persons involved because of the level of energy and emotion involved in that. Over the last four years we have had a decrease of about 11 percent in Emergency Protective Custody actions, so there has been a general decline of EPCs, which I think is positive for law enforcement, positive also for the consumer overall as additional services have been developed. []

SENATOR GAY: Well, the we don't...last question on this, then we'll move on. But, I guess, you know...are you seeing then that they just feel...they feel they spend too much time on it? They probably just...well, I'm not going to speak for them. But they feel they're spending an awful lot of time on it. Are you telling me that you're seeing the

process is just complex, it's going to take time? []

SCOT ADAMS: Well, I think I would say that to some degree yes, it is a complex problem. It is not a broken bone and put them on a board and send them on in. []

SENATOR GAY: Yeah. []

SCOT ADAMS: It will take more time. However, this is also an issue that requires a great deal of coordination in working out at the regional level. We have developed funds and provided funds to the regions with the EPC notion and the emergency system as our top priority. So implementation of that becomes a question involving both the region and local law enforcement in each of the counties, each of the cities in working those relations out. There have been some very positive kinds of signs. This week I spoke with Senator Adams, who had had some concerns with regard to that and reported recent times, gosh, things seem to be working pretty darn well; gave kudos to Region 5 for helping to work out relationships in that area. I think we are at the point, now that those funds have gone to the regions for the development of these services with that as a priority, we're probably at the point of we're having to work out the particular unique relationships between county and city law enforcement processes and the particular regional services, which will vary a bit from county to county. So there's a great deal of leg work, if you will, that has yet to go on, I think. []

SENATOR GAY: All right. []

SCOT ADAMS: So I don't mean to minimize it in any way. []

SENATOR GAY: No, no, it's a complex deal. []

SCOT ADAMS: It remains a priority of the division. Funds have been allocated with that as a priority. And I think there's still more yet to be done in that area. []

SENATOR HANSEN: Scot, one final remark about (inaudible) in one of those meetings in Region 2 where the police or the county sheriff was the final determinant whether that person... []

SCOT ADAMS: Yes. []

SENATOR HANSEN: ...whether a person is...goes into emergency protective custody or not. Is that ever going to change? Do we need to change that? Does Region 2 need to have a bigger involvement in that, because we were there and we talked to a person who was put on a bus and sent to Lincoln and never got to his final destination because they wouldn't go through the process. []

SCOT ADAMS: Yeah. You know I...the question of changing the authority vested in law enforcement for that, I think, is a question for all of you to struggle with. My opinion is this, the question of placing somebody in an EPC hold is a question of legal rights in a country that treasurers freedom of the individual. I would personally be nervous if others than that authority chain were given authority to hold me against my will. And certainly this is a situation where a combination of points of view are important and come into play. They ought to have the advantage of a doc and medical healthcare and social work and a variety of different professions. But I think that the legal question of holding somebody against their will is one that is in the law enforcement or criminal justice system. []

SENATOR HANSEN: Okay, thank you. []

SENATOR JOHNSON: I guess, one thing that comes to mind a little bit, Tom, is that in Australia and another country, are two now, they have a first responder course that's being developed. And, I guess, I wonder if there wouldn't be a place for this in something that we might think about in the future of...since our sheriffs and so on are

put in the position of often being the first responders, that maybe this might be a concept that we might consider. []

SENATOR GAY: Joel, could I follow up on that? []

SENATOR JOHNSON: Sure. []

SENATOR GAY: At Lasting Hope, you know, I asked them to...you know, they do have a training with Omaha police. And then I said, well, was that being done in other...it's a funding issue of, you know, there's only so much money. And these counties just don't have the money, it's a budgetary thing. So if we want to look into that it would have to be put into Scot's budget or something. I mean, just to train somebody when they come across this situation how to handle it. So it's probably...we need to look at ourselves a little bit to fix that problem. []

SCOT ADAMS: To that I would also add that the training you were referring to in Omaha is known as CIT training, Crisis Intervention Training. It helps law enforcement understand how to enter into a situation, respond appropriately and that kind of thing. That's the short version. The Division of Behavioral Health has been successful in obtaining federal funds from the Department of Justice for justice behavioral health initiatives. We, in the last actually maybe month or so, have just received notice of a three-year grant involvement with the Department of Justice for these kinds of issues. One of the goals is to try to look at the opportunity to replicate that kind of training in other departments across the state. There are other elements to this justice mental health grant that I think will be important and sort of help with the overall question of both EPC as well as mental health and the law enforcement areas, if you will, where they jointly come together. []

SENATOR GAY: How much is the grant for? []

SCOT ADAMS: Quarter million dollars. []

SENATOR JOHNSON: All right. Thank you. []

SCOT ADAMS: All right. Speaking to items related to progress, and we've talked about the new consumers already, about 9,000 persons throughout the system. We have closed 232 adult and 16 adolescent mental health beds at regional centers. All adult services at Hastings Regional Center are closed. At Hastings only 40 beds remain of chemical dependency treatment; those serve strictly the Kearney YRTC population. At Norfolk we have three units of sex offenders available, and we have about 26 persons with mental health conditions that within the next year to two years we expect to move to the community. As a result we are not anticipating moving more folks there at this time, though that may be necessary, depending on the flow and composition of Lincoln from time to time. I'd mentioned that we have redirected $30 million of regional center operational money to community-based care and we've talked about Lasting Hope. Other key indicators of some change, success and progress, I think, rest with consumer participation and the system. As I said, this can be viewed as glass half full, glass half empty. But I think never before has there been as much involvement as there is today. I'm especially proud that there is in our statute the Office of Consumer Affairs, which is an important element that I have great hopes for in its next iteration. And also, each of the regions have regional consumer specialists whose job is to participate in the planning activities of the region, so that the consumers voice is there. Secondly, to assist consumers in any way possible and to help train consumers in different ways, especially in terms of recovery. I think it's also important to note that our regional centers are focused on safety issues. As more and more people are treated in the community, those folks coming to regional centers will be among the most difficult and most challenging patients in the state of Nebraska. We have taken a number of steps to improve safety at the regional centers. And the bottom line is that over the last four years the incidence of peer abuse and staff involvements and injuries, any measure of safety has improved over time. Other items with regard to progress is, of course, the

establishment of the Office of Children's Behavioral Health, about a year and a half ago. Our children's behavioral health plan was submitted with the cooperation, support and work of other divisions of the Department of Health and Human Services. So there really is a departmental plan for children and adolescents. It's been on the Web site since January of '08 and I think represents a positive vision for children's behavioral health. And I mentioned earlier the housing assistance program. There are a couple statistics there that indicate its success. Again, I want to just reiterate the importance of housing as a critical component in the overall recovery of persons from behavioral health. You have to have some place to land and call home, to feel safe and to be able to move out in your life from there. And so that's an important component. Other activities of progress we have met across the state, Senator Hansen, as you mentioned, we met in all of the regions with regard to the emergency protective custody situation, continue to have that as an important element and focus of the division moving forward. And, I think, some continuing work and progress is being seen there with the mobile crisis team, the decrease in EPCs and refinement of procedures. (Inaudible) form network is an important element that takes a look at the dramatic impact that treatment can have on a person, the type of treatment can have, issues like restraint and seclusion and how that can be so impacting and damaging to folks in an effort to continually improve not only the efforts with regard to the state, but also in the community with regard to techniques and procedures. The LB95 program is a program that you may be aware of. And let me just mention that I think this also is an important program. If a person has been committed for behavioral healthcare to the regional center or diverted, they are eligible for medications that we will provide to the person, doctors prescription, doctors order, that kind of thing. But LB95 spends nearly $3 million per year on medications given to individuals who otherwise would not be able to afford them. This is not an insignificant program. Finally, on this page, and I might just mention that we will be having a new Web site, basically called the Network of Care. I do not have the final address yet to be able to tell you about this. We hope to have the beta version of this available in the December time frame. We hope to have it live and going in February. This is, I think, an extraordinary Web site that will be consumer friendly and

positive for persons wanting to seek information about behavioral health. Some things that are part of this Web site, as an example to share with you why I think it's a good thing, there are over 9,000 articles written in simple language, in one-page summaries, on behavioral health topics--medications, treatment of choice, varying treatments, a whole bunch of things written so that you can understand them, and linked back to whether or not you want to go in-depth through the original research, you know. But at least it's simplified and summarized. There will be the map of the state with the regions, akin to what you saw before. And if you click on your county all of the services in that county will come up. If you need MapQuest, MapQuest will tell you how to get from where you are to that service right away so that all the services will be available immediately. A third component that I think is especially encouraging is that there will be an opportunity for what's called "My Folder", an element on this Web site where a person can place their WRAP plan, W-R-A-P, Wellness Recovery Action Plan. So when a person is in the state of health and good position they develop the plan for when times aren't so good--who do I want to talk to; who do I not (laugh) want to talk to; how do I want to be approached; what do you do with my dog in case I have to go to the hospital, things like that are all in this document to help the person plan ahead for the tough times. That can be up there. It is protected by code and available to people in time of crisis. I think this will go a long ways. And it will be available, potentially, for law enforcement, as an example, to help them understand how better to address and treat this person at that point in their time. So this Web site, I think, holds potential to have dramatic improvement and offer new ways of allowing technology to help others. The final section here then is really some of the challenges that we face in behavioral health. The forensic psychiatric services are an area that many of you may have heard of recently with regard to people ordered to the Lincoln Regional Center, held in jails for some period of time. There are three areas of forensic medicine in the area of psychiatry that we interact with the courts. Evaluation is the first one. Dr. Scott Moore currently goes to the jail when a judge says, I need an evaluation of this person. So all across the state of Nebraska he travels to the jail and evaluates the person and produces that within a very brief time, usually within a week of being called. Services to

restore a person to sanity is the language, but to be able to participate in their defense is the second level of service. And oftentimes that is an inpatient stay at the regional center. And those people, typically, come in and out relatively quickly, measured in weeks rather than months. The goal there is to help them get to trial, to see if they are able to participate in their defense. And then the last one is also known...in treatment is also known as "not responsible by reason of insanity." This is after a trial has been held and the person has been found to be not responsible for the crime they are accused of because of insanity. Then they are sent to the regional center for treatment. Typically, that's for a very long time, though not always, but usually longer than the restoration folks. We are working to allocate additional resources in the area of forensics. We expect to be able to manage better and be more responsive to the courts. We have been working with the Supreme Court and representatives of the courts to work through protocols and process to establish a smoother working relationship for this population of people. So it remains an item of concern and focus with us. And we have had, I think, some recent positive interactions and successes to help things move along. Again, you see the coordinating emergency access as a continuing challenge. It's an important part of what we are thinking about with regard to EPC, supporting community hospitals, those kinds of things. We think that the role of the regional center will be increasingly one in which we will take the people who are most troublesome, most violent, to be able to free-up community resources, to be able to respond more routinely in a greater flow fashion for the bulk of the cases that community hospitals and resources will see. There are special populations of people with co-occurring disabilities, if you will, that are particularly difficult, from time to time, to work with and to place into community settings--persons with developmental disabilities, older adults, transitional age youth, persons in assisted living facilities all represent areas--groups of persons that we have great concern for if we are to be able to sustain easily in the community. We have had instances where providers have just been unwilling to accept folks because of multiple issues. I think that's a training issue, part of it is a culture issue. It's an area that we want to continue to work with regions and providers on as we all get better. And the a final challenge that I want to speak to you is really to say that there has been intense focus,

the last four years, on mental health reform. And the focus was getting people out of regional centers, into communities and money to the community and that kind of thing for mental illness. And that was important, laudable work. One of the hallmarks, I think, of this next chapter of behavioral health reform will be upon integration, integration of the populations that have co-occurring disorders, integration of addictions along with mental health disorders, and integration of people into the community to a fuller extent. And so the integration question is...it will be a continuing challenge that I think defines the next chapter in behavioral health reform. I very much appreciate your time and attention today. I appreciate the lively questions and back forth and am open to other questions that you might have. []

SENATOR GAY: I've got one. Scot, when you talk about community services, we as a state you're working with the regions, they work with the community providers who understand the system. But how do you...I mean, in some...in anything some are better than others and there's a competition amongst even nonprofits and you work in that business. But how do you...how do we judge who's doing a good job? That we're spending dollars wisely and a patient goes in and they're being treated, in ongoing treatment, how do you determine quality? []

SCOT ADAMS: Yeah. I would offer you three or four responses to that question. First of all, we require programs above $75,000 to be accredited institutions. So it would be national standard with regard to the delivery of care. And so an external national body has said they're doing it, they're doing it well or they're not and there is a plan of correction to improve to those levels. So I think that's an important consideration. Secondly, the Division of Behavioral Health directly and through regions conducts three kinds of evaluations of programs: We require fiscal audits; we conduct program fidelity audits, and we conduct unit of service audits so that we can see that the services are actually being delivered in individual client records and that those meet minimum thresholds of standards of care. A third way in which we seek to have the issue of quality and accountability is that we'll be moving toward performance-based contracts in

the next fiscal year. You heard that as part of Chris Peterson's overview. That's a direction that the department overall is heading toward. And this is not going to cross every T or dot every I at that sort of mega level. But it will begin to talk about what are the important components of system quality that we can move to over time. So this is the beginning of an effort in that regard that will identify valuable and important outcomes that we need participants to adhere to and to move toward. And so I think that's a third worry that quality will be improved and enhanced. Fourthly, I think that there is an opportunity simply for the conversation. The paradigm shift that has occurred over the last four years of behavioral health reform has had a lot of different subconversations that have happened. And we really have not had the opportunity to come (laugh) together, all together and say, what have you learned, community of Alliance, a leader? What have you learned, Catholic Charities, from your side? What have you learned, Cirrus House in Scottsbluff? And we need to have more of that kind of convening to come together to be able to share the individual kinds of things. It's in that atmosphere that, I think, true quality can improve. What I can say to you though, sir, is as I have gone across this state and visited many of the treatment programs, I am really very, very impressed with the community-based providers in terms of the level of care, the attention to detail, the emphasis on the consumer and the individual. There is individualized care more than I had expected to see. I'm very impressed with that. []

SENATOR GAY: Thanks. []

SENATOR PANKONIN: Thank you, Senator Johnson. Scot, I had seen, and this was in October, release from SAMHSA, the federal agency. SAMHSA awards over $146 million in grants for child mental health services. And this was a competitive process, I assume. And there was, for example, Oklahoma had a couple of entities that...two different ones, the state of Washington two different ones. I think there is 18 on here. And, I guess, the questions are twofold. Do we apply for these things? And do we have a process to apply for these as they come up or in... []

SCOT ADAMS: Yeah. Um... []

SENATOR PANKONIN: And this isn't a gotcha question,... []

SCOT ADAMS: Yeah, no, yeah. []

SENATOR PANKONIN: ...it's just curious about with all the reorganization, all the things going on which, and I sure understand, and I think for the whole HHS system there's been so much change. And part of it, as you mentioned, we need to let it settle down, work our plan and then try to get this cross-information together from what's working within the system, because there is a lot of good things going. But I was curious about this one in particular. There's a lot of money here. Do we have a plan or do we have a system in place? []

SCOT ADAMS: We have...we have been successful...we do apply for grants. We were successful with the justice mental health grant with the Department of Justice, as an example. We recently applied with others for a system of care grant from SAMHSA. We were not successful with that, just notified about that. We have...and then other programs, though, at the individual provider level have made application and been successful. As an example, St. Monica's, in Lincoln, a program that treats women and their children at the same time, has received a grant, support for their operations, as has Heartland Family Service, in the Omaha area, for that. So... []

SENATOR PANKONIN: So you feel we are going after them. We're not going to get everyone, I understand. []

SCOT ADAMS: We're not going to get every one. []

SENATOR PANKONIN: But you think the process is in place to... []

SCOT ADAMS: Yeah. I...the...we are going after the ones that we think are reasonably strategically of benefit to the state. []

SENATOR PANKONIN: Applicable and... []

SCOT ADAMS: Yeah, exactly. []

SENATOR PANKONIN: ...right. []

SCOT ADAMS: So...and that's both at the provider level. For instance, we participate with letters of support with those two private agencies. And sometimes we lead the effort in that regard too. []

SENATOR PANKONIN: Good, because obviously, if we can we should. Okay. []

SCOT ADAMS: Yeah, yeah. []

SENATOR HOWARD: Well, I just have one final question. And I really appreciate your, I don't know if stability is the word, but you always seem to have this handled. (Laugh) It's nice to hear and I'm sure not always the case. []

SCOT ADAMS: You're kidding. (Laughter) I mean, oh good. (Laughter) []

SENATOR HOWARD: But it is...you do seem to...you just take it on. I've had conversations with Rhonda Hawks. She's done such a great job with the Lasting Hope facility. And I remember early on she and I talked. And I said, you know, this is a big undertaking, it's very major. But she has operated with a lot of hope. We've had conversations, ongoing conversations about something similar for adolescents, for children. Do you see that as something that we could move toward in the future? []

SCOT ADAMS: A particular center? []

SENATOR HOWARD: Well, that sort of partnership with that commitment, whether it be with Rhonda or someone else to look toward that. Obviously, we have a need for it. []

SCOT ADAMS: Let me first say again that I am struck, stunned, inspired by the people in the private sector who have come forward to be part of this. My whole career has been with being in behavioral health, started off in alcoholism and drug abuse and inclusive of mental health services at some time and that kind of stuff. So I've been mired in this stuff for a long time. And most of the time people of my career, people have tried to run from and hide from awareness of that kind of thing. You had to be quiet about it. So I...my heart really is thrilled when I see people of substance, status in the community standing across the state stand up and say, we need to do some things here. The involvement of the entire state and the private sector in particular resolving issues like this and problems that people face, I think, is an important element. Would I love to see that? I would love to see it. Is a particular center, like Lasting Hope is a particular center, the right answer? You know, I don't know if that's the right answer or not to be honest with you. I think that reasonable people can disagree as to what the right thing to do is. But I want to make sure that that conversation with private individuals and with universities and with providers continues to occur. And that the involvement of the consumer is a very important element in all of that. []

SENATOR HOWARD: Okay, good. []

SENATOR JOHNSON: Senator Howard and Scot, one of the things, and I'll kind of tell the committee here at the same time, is you know I think that a very important part of this is that we keep looking into these different areas. And one of the places, for instance, with what you're talking about is Boys Town has got quite a good national reputation. So we are in the process of setting up a visit of this committee to Boys Town as an example of looking into those different areas. So... []

SCOT ADAMS: Okay. Thank you. []

SENATOR JOHNSON: Anything else that anyone can think of? Thank you very much. []

SCOT ADAMS: Thank you very much. I appreciate your service and your attention to this topic. []

SENATOR JOHNSON: Well, we've only been going about an hour and fifteen minutes here or so. So let's not take a break at this time. Let's just proceed with public comments about...and as much as we can, let's stick to the topic as addressed by previous speaker here because we will, with each of the topics, and the other two topics are the Division of Children and Family Services, and then Developmental Disabilities. So if your comments are particular to those areas, it would probably work best, but we deliberately wanted to do it in this fashion so that we got significant public comment. And so let's just proceed with that. Let's relate it as much as we can to Scot Adam's comments on behavioral health. So do we have anybody that would like to speak at this time? Good morning and welcome. []

J. ROCK JOHNSON: Good morning, thank you. My name is J. Rock Johnson, that's initial J, Rock R-o-c-k, Johnson J-o-h-n-s-o-n. I've worked as an advocate and as a consultant for about two decades here in Nebraska and at the national level. For example, I served on the Planning Board for the Surgeon General's landmark report on mental health. I was elected to several terms on the national NAMI Board of Directors and other national boards of directors, consultant work in addition to that. There were several items that were brought up, and I just want to make a comment upon them. Senator Gay had talked about the public-private partnerships, which certainly there has been excellent examples that we have had. One of the concerns about that is, how do we in this fairly new area of gifting and partnership, how do we have oversight of that? How do we have accountability? How do we have ways to really work together and to

do evaluation and planning, also the question, again Senator Gay's concern, around law enforcement EPCs, emergency protective custody. One of the ways that can be dealt with is upstream, if you will, there's a little story. The person walking along the canal and hearing people drowning, rescuing them and rescuing them finally turned around and starting walking the other way; said, well, where are you going? Well, I'm going upstream to see whose throwing them in. And we've also heard another way of putting that is we're willing to pay for the fence...not pay for the fence at the top of the cliff but for the ambulance at the bottom. It's a little along the lines of you don't have time to do it right but we always have time to do it over. So this, I think, is a fundamental, philosophical approach. We have been an institutionalized state and we've been able to benefit from the learnings of other states in their 30-year deinstitutionalization process. But moving to the community, it also means moving into, as we discussed, consumer operated services programs which have been shown by resource to be very effective in conjunction with traditional mental health services. The consumer operated services in most states were funded by the Medicaid rehab option because it had flexibility. In our state, in 1994, the Legislature did direct the then state public health authority, mental health authority, DPI, and the Medicaid program to apply for this Medicaid rehab option. As a result, the services that were being funded by general funds in behavioral health were transferred over to Medicaid and they have not, you know, been used in...as a vehicle for change. The relationship having to be directed by the Legislature, I think, has improved considerably and coming now under the same state agency. However, there are some real problems with people with psychiatric illnesses they're having and one was referenced yesterday and that was the excess morbidity and mortality, as we say in the medical profession, which is people who have a psychiatric label. In the last ten years, they're excess mortality has increased by about 15 years. People with a mental illness die on the average 15 years before the rest of the population, actually it's 25 when you add up the previous numbers. So this is a very significant disparity. And as we look to the fact that many people with psychiatric disabilities are receiving care through the Medicaid services, these SAMHSA, the Substance Abuse Mental Health Service Administration, has joined with other federal partners and in July released a

report on reimbursement of mental health services in primary care. And I'll put that here as item 1 for the record, which gives a link to that report, and this came out in September, the 22nd of September. It's reimbursement of normal services and primary care settings with billing codes. So there's efforts that are being made to connect the fact of primary care and behavioral health care. They're not really separate and it's not that they're complementary, but they have to be joined together. Now as we look at the new opportunities that are offered there's one and CMS really foreshadowed this for about the last year and a half, it's called 1915(i). It's a home and community-based state plan offer on self-direction which gives individuals some responsibility for making their own plan so that they can, you know, could move out of being recipients of service and dependent upon that. There's going to be a training in self-direction in mental health that's coming up on the 6th of November. Now I know that this information has been shared previously with the division and with the department about a year and a half ago and looking at this coming up. I'm concerned that if we have only a very, kind of narrow view, and if our goal is to cap Medicaid and we can't see any farther than that and it becomes a kind of a knee-jerk reaction, there are opportunities out here that we're not going to be able to take advantage of, as that kind of innovation that was discussed yesterday. Perhaps we need to spend some money and focus on this. []

J.ROCK JOHNSON: And in that same category is the medical insurance for workers with disabilities, which also was referenced yesterday, as an opportunity for people to pay a premium in order to get Medicaid care but to get into the work force. And the expectation is, once a person is able to get off benefits and into the work force and as are able to pay these premiums because, as we know, there's lessening amount of employer insurance out there. These people are going to stay in the work force and we need that kind and quality of worker out there. So as I'm looking at the relationship between behavorial help and Medicaid having once been forced, in a sense, by this Legislature to cooperatively work together, now within the same department I would expect to see more of that. But it also requires a willingness to reach out, get this information and work collaboratively together because we can keep people from dying,

we could help people have productive lives, we can help people go to work. One of the things that I didn't hear discussed under veterans as well as, I may have missed this point in the behavorial health presentation, is planning. We tend to plan on the runner at the last minute and the veterans are going to be welcoming people who have higher level of disability and needs at an earlier age, I believe, because of the Iraq and Afghanistani wars and we really didn't see a discussion of planning. So I would just add an action planning process. It's only one page but it's something to look through and think about and to be monitoring. The last item that I want to share with you is, next to last, the National Council on Disability has previously issued a report called "From Privileges to Rights." People labeled with psychiatric disabilities speak for themselves and includes policy recommendations with every chapter. They're working on "National Disability Policy: A Progress Report" and I hope that that kind of information will be coming back into the legislative process. Albert Einstein said after the dropping of the Atom bomb that everything has changed but our way of thinking. And what's changed with people with disabilities and with people particularly with psychiatric disabilities, is people can and do recover. We've had a structure of federal benefits that's, as an unintended consequence, surely, that has tracked people. And so there have to be creative ways, track people out of the work place and who do want to work. There have to be creative ways to make those changes. The final item I bring to your attention would be the potential of developing, possibly, a pharmaceutical cash fund that could be used and focused upon the needs of people with psychiatric disabilities. There have been two Attorneys Generals lawsuits that have been settled. I can say, specifically, the first one which we had the information about this summer had to do with Bristol Myers Squibb and had to do with Medicaid fraud. So those settlements, I understand, just go back into the general fund, but I would say that the medications that people take all say, mechanism of action unknown. The second suit, successful suit, was with Eli Lilly and I think that there are other suits that are out there, and I think that there will continue to be more. So it's just something that I put out as a potential way to fund some of these changes. I thank you for your consideration and appreciate the interest that's shown and your ability to work collaboratively with the executive branch. Thank you. [LR363]

SENATOR JOHNSON: J. Rock, it's always a pleasure to have you here. You give such thoughtful considerations. Do we have any questions around the table? I've got a few here, but let other people go first. Well, let me just make a comment or two, and we had touched on a couple of things that I think are kind of important. Then, one, is that earlier we talked about the, even in the Omaha Metro area where you would think that there would be enough psychiatrists, there aren't. However, we are not going to be able to manufacture psychiatrists ad lib here in the foreseeable future. And you've really kind of touched on other things in the past and touched a little bit on it today and that is, that there is a team approach that I think is important that we must remember. And that one of the things is, and again you've mentioned this in the past and didn't touch on it particularly today, and that is the help of one consumer to another. And it dawned on me that we really do this with the 12-step program of, that's present in Alcoholics Anonymous. And that a person who has been able to get out of the depths of the alcoholism reaches back to the person who still is in the depths and helps him out. And you've kind of referred to that indirectly of doing the same thing with psychiatric patients that they're able to help each other as well and help the whole concept. And I think that you're to be complimented for recognizing this and that perhaps the rest of us should recognize that a little bit more. One of the other things about that is, we've become aware of shortages of all types of workers in the psychiatric field and it's almost universal but I recently saw an example of something that the people doing it are very happy about. And I'm aware of a pediatric office of half a dozen pediatricians who bring in about equivalent of a half-time psychologist right in their pediatric office, and they are just as pleased as can be with this approach. But we need to, as I see, expand all of this where the psychiatrist and thinking only of that terms are not the answer. And again, I think you're a great stimulus for this concept that it has to be a team approach, including the consumer himself. I guess one of the other things, that if we have other people comment either here on this issue or others, is this, it seems we've got to find some way. I'm a great believer in work. I think it's good for the people that work and particularly in the psychiatric arena. That here, as soon as we get them to a place where

they can be employed and do good work and start earning a living, we take their medicines away from them. And so, they are financially better off not working and getting the medications. We've got to find some way to integrate this so that the medications continue, the help continues other than the medications, etcetera, and yet allow these people to earn a living and contribute to society. So excuse me for rambling, but I think you've given me a lot of these ideas in the past and I just want to kind of emphasize them here with you present. [LR363]

J.ROCK JOHNSON: May I respond briefly to this? [LR363]

SENATOR JOHNSON: Yes. [LR363]

J.ROCK JOHNSON: Serving on the surgeon general report, one of the findings of that report was the importance and the evidence that self-help works, mutual aid. So that was a new finding to be brought forward and at the very highest levels of our government. Serving on the planning board was Larry Fricks, who was the office of Consumer Affairs person with Georgia. He immediately went back, talked to their Medicaid director and folks and created the certified peer specialist training and position, which included a requirement that after so many people in a program, that they had to have a certified peer specialist. And this was Medicaid billable and they're large numbers of, large amount that was billed through Medicaid for the certified peer specialist. I believe there are about 22 states now that are utilizing this certified peer specialist mechanism through Medicaid. And your reference to the relationship to the 12-step programs in AA certainly laid a groundwork for the concept of recovery. It's only been in the last ten years or so that people have been talking about the fact that a person with a severe mental illness can recover. And what we really need is some barrier removal for these structural problems through the federal government's benefit program. That's been done by filing the Medicaid rehab option, for example. Although a person with a psych disability, it's the expectation that they will have also a substance abuse issue, not necessarily an addiction. So those two go together. Our problem is that

federal government says we can blend and braid that separate substance abuse, mental health funding. We can blend and braid it in terms of programs. We just have to report it separately. So that's another one of the barriers that we're looking at. I note that one of the first places that a working individual who has lived, experience with severe mental illness became a job requirement other than the...well, actually in addition to, because it was about at that same time was the ACT Teams. They required to have a peer specialist on it in order to meet the standards that had been developed. I want to just make one final comment about the relationship between behavorial health and Medicaid. I've spoken to the need, the disparity, the incredible disparity. Just when people are kind of getting how to manage their lives in their early mid-fifties, they die, on the average. The average age span in this country right now is 78 years, so the primary care and the behaviorial health needing to mesh and be complementary. And also for behavorial health and Medicaid to actually be able to work together is one thing, but to not work at cross purposes is another. I noted in the Medicaid presentation, that graduate medical education would be, the percentage would be brought down, and that was about $50,000. At the same time, we're talking about worker shortages and also how to change the medical education so it's more responsive to current needs. So that in addition to the other that was just rushed over of the mental health therapy visits being cut, we don't schedule crisis. You know, we need to be able to get in and get help. So those are areas in which we have come an awful long way but I think in moving forward, I also have a concern about it was said that the current Medicaid management information system did not allow the autism waiver to be included. I'm very concerned about the development of the Medicaid management information system that it include the various measurements that we might want to see and want to use, the domains, outcomes, and so forth, because you can't remedy a design defect. So as this is being done, I think it needs to include the people who have new needs for information and different needs than we have ever done as to outcomes and getting a life. Thank you. [LR363]

SENATOR JOHNSON: Again, thank you for your stimulating questions over this period

of time. Thank you. Do we have someone else? Good morning to you, sir. [LR363]

C.J. JOHNSON: Senator Johnson, members of the Health and Human Service Committee, my name is C. J. Johnson. I'm the...oh, J-o-h-n-s-o-n, I'm the regional administrator with the Region 5 Systems. First comment I just want to talk about is, in relation to some of the earlier questions on emergency protective custody, and I completely agree with J. Rock. In fact in a meeting the other day I said, you know, the thing that I get so scared about is that we're really at a critical point in behavorial health reform, where since 2001, actually, when tobacco settlement funds were first distributed to the behavorial health regions and then through the shift that we've so focused on the emergency system, and we needed to. I mean, quite frankly, it was out of control in a lot of ways and then shifting the reduction in the state hospital beds and taking that money and going into community was very critical. And a lot of that money actually was spent to beef up the emergency system, which includes, and that's where it gets complex, you have emergency protective custody ills, which law enforcement is responsible for. And I'll just say, my opinion is, that's where it should stay for the very same reason Scot Adams listed it. This is a point in somebody's life where due to a mental health condition, an acute mental health condition, they have to be determined whether they're a danger to themselves or others right at that point. And it really is kind of a criminal justice issue where somebody basically is being arrested, and then over a 72-hour period of time is given an opportunity to have an evaluation to stabilize before any other determination is made. So it really is about taking somebody's rights away for at least 72 hours of their life. And then we get into hospitals and crisis centers, etcetera, etcetera, etcetera, and the emergency system. What I want to say is, I do get somewhat concerned when people say the emergency system is failing or broken at this point. The reality is, it's working very well when you look at the statistics. There's been a huge reduction in emergency protective custody holds. There's been a dramatic decrease in the number of people who are even placed on a inpatient commitment once they are EPC'd. For example, in Region 5 Systems, in Regions 5 geographic area, four years ago of all the individuals who were placed on emergency protective custody hold, 24

percent of those individuals then subsequently were placed on an inpatient commitment and would have to go to a state hospital. To this day, even...we've not only reduced our number of EPCs, but only 12 percent of those individuals, when they are placed on an emergency protective custody hold, are deemed to need ongoing inpatient care after a three-day period of time. So we've made significant strides in making more community services available for individuals at that point, and we've greatly reduced the need for state hospital care. A lot of times when you do hear law enforcement particularly expressing their concern, I've been in this field a long time and trust me, when you're having to deal with an individual who is going through an acute mental health episode, and I've been in psychiatric hospitals, etcetera, it is a very traumatic event for the individual as well as anybody that's involved in that. And then, subsequently, when you have to maybe transport that person an hour or two to a hospital, that can be very challenging. What I would encourage you all to do, when you hear this kind of stuff, is really try to narrow it down. What is it their concern is? For example, in Region 5, one of the complaints four years ago was law enforcement, when they did have to make that determination to place him in emergency protection hold, they would have to themselves start calling around trying to find a bed space for those individuals. One of the things that we accomplish in Region 5, and it was actually in collaboration with Lancaster County, which then benefited our rural counties in our region, was actually to create a 24-hour line available 365 days a week that is staffed with individuals who specifically know how many crisis beds are open in our crisis center, how many hospital beds are available in our hospital, how many beds are available at Cornhusker Place, which is our detox center, and that way when a law enforcement officer does pick somebody up on emergency protection custody hold, and they've made that determination, because that's what they do, then they call that one number, a single number that's staffed all the time, and they say, this is the situation. This person is either in need of detox, even though I've EPC'd them, or they have a medical condition or, you know, to bring them to the crisis center, that person at that point can directly tell the law enforcement officer, this is the facility you need to take that person to and there's a bed available for that person. The law enforcement that we've found, find that to be

wonderful, you know, because they're not calling around. The other issue that we've faced with...oh, sure. [LR363]

SENATOR GAY: C. J., was that funded entirely by Lancaster County? [LR363]

C.J. JOHNSON: Yes, Lancaster County funded that through their crisis center and then we made it available to all our law enforcement in our region as a part of that throughout all the rural counties as well. [LR363]

SENATOR GAY: And do the other counties, they don't fund any of it because we've got Otoe. I looked at your region, it's fairly large, but so just Lancaster upon themselves funded this thing. [LR363]

C.J. JOHNSON: Yes, and part of that... [LR363]

SENATOR GAY: Was this through a grant or direct funds, do you know? [LR363]

C.J. JOHNSON: It's through their direct funds and part of that is because you have to recognize, well, in Region 5 even though it's different, we're kind of lucky because Lancaster County is, you know, significantly in a large county with a large population and we're a lot of times, when they have a need, you know, we're able to work with Lancaster County to hub that out to our rural counties. They had a need for this phone call as well because 82 percent of all their emergency protective custody calls that we experienced in our region actually are in Lancaster County itself, and those law enforcement officers including Lincoln Police were saying, we don't want to have to call around either, so. [LR363]

SENATOR GAY: So Lincoln and Lancaster. [LR363]

C. J. JOHNSON: Yeah, so we're able to build that. [LR363]

SENATOR STUTHMAN: Mr. Johnson, is this practice by any other regions? I was not...I'm not aware, you know. I'm from Region 4 and our law enforcement they... [LR363]

C.J. JOHNSON: I couldn't specifically comment on that. I'm just sharing what we're doing right now. [LR363]

SENATOR STUTHMAN: What you have, what you have, because I think our region they've got to call around and they call around half the night trying to find a place. [LR363]

C.J. JOHNSON: Yeah, and I don't know, I don't know. [LR363]

SENATOR STUTHMAN: Okay, thank you. [LR363]

C.J. JOHNSON: The other issue for law enforcement, quite frankly, is transportation. And this isn't an issue of a failed system in any way. The reality is at this point is, from my understanding, is that state law and regulation require that law enforcement be the one who transports somebody once an emergency protective custody hold be placed. Which means if you are in Richardson County in our region, that means you're going to be out of your county an hour to an hour and a half both ways just taking the person up to the crisis center, which is okay. The crisis center is okay. It's just the transportation issue. Then in subsequent mental health board hearings they have to drive back up, okay, and pick that individual up and then drive back to their county. One of the things that could greatly help, is if we could change any state law or regulations that require that it has to specifically be a law enforcement officer to transport that individual once they've been placed on emergency protective custody. If we could subcontract or use other resources without that particular conflict, we could do that and therefore, when an emergency protective custody was held somewhere else in the rural area, we could,

you know, have a contract where somebody else could do the actual transporting for law enforcement, so they wouldn't have to leave their county. Now different regions have tried this in different ways, but there's always issues around liability and because of the way the law reads and all that. So if we could just maybe address that, we could do a lot to help law enforcement relations in emergencies. So subsequently, the reason I went into this is, and Senator Gay this was, you were saying you were having a meeting, I don't want us to once again get to a point where we have funding and then we have to throw it at the emergency system. We really are, we need to look at where we're at. And as J. Rock said, we need to take this money. We're kind of at a point now, we've invested in these high-end services. We really need to take, kind of, the remaining money we're getting and put it at the front end where we're really helping individuals way before they have an acute mental health crisis, developing those wrap plans, really empowering consumers for that self-care, and so it's really about putting that money towards the fence on the cliff versus paying for the ambulance now. And so I just say it because I don't want another waive of reaction because of what law enforcement is saying when a couple of things could be done fairly quickly, I think, to help their concerns in relation to emergency protective custody holds. [LR363]

SENATOR GAY: C. J., if you've got a chance, send me any or other information on that, because what you're saying, I commend Lancaster County for doing that, is the county needs to step up and they can solve their own problem, I think, from what I'm hearing so far from people. But I like the way they did that, and Sarpy County is much the same way with one county and five community, we have five different law enforcement agencies in one county so they could work together is what you're saying. And so if you have any information, would you send it... [LR363]

C.J. JOHNSON: Well, yeah, a lot of times it's just a matter of what's their issue. To me, if it's calling around to try to find bed space, it does seem to me there could be a collaborative way so that only a single phone call needs to be made to help them with that, you know. [LR363]

SENATOR GAY: But they need to take proactive, yeah...thank you. [LR363]

C.J. JOHNSON: Um, the last piece I just want to quickly comment on. In the earlier presentation there was discussion around the funding as it came out over behavioral health reform. And, you know, during the process when the funding has all been distributed, which we've now received letters of all the funding being distributed, there is a disparity based on the formula that Scot Adams talked about earlier, to Regions 5, 6 and 4. And I do appreciate the fact that when we talk about percentages, it's only a little bit of percentage here, a little bit of percentage there. I do want to point out that when we are talking about that underfunding based on that formula, Regions 4, 5 and 6 constitute 75 percent of the population in the state. And therefore, when we're talking about 1 to 2 percent of the overall funding, we are talking about a couple million dollars that those, that 75 percent of the people did not receive, basically funding for, ongoing funding to build up more services. So there is some disparity there. You know, I've had some conversation with some other senators regarding, well, let's try and right size the regions, hold the other regions harmless. But the reality is, to do that is about a $12 million price tag. And we can all guess that nobody wants to go after $12 million, although, why not, is what I say. But the other thing we heard about earlier today was the Medicaid match that was developed through behavioral health reform. Ironically, most of that $8.9 million that was discussed earlier that is being taken from public health through the division behavorial health and moved into Medicaid, actually was to increase substance abuse services throughout the regions or to increase Medicaid match for substance abuse services, which was not specific to mental health services, although there are so many people that have dual diagnosis that at some level that makes sense. One of the things that I would ask for consideration at this time is because that money was pulled out of there for substance abuse services, that there be some consideration to really take a look at an alternative funding source rather than existing funds that we've been using for the last couple of years. But look at an alternative funding source. Again, I mentioned in talking to some senators, increasing

tax on alcohol. Well, I got the look I always get when I say increasing tax. But I was encouraged by saying, how about if we found some current funding strings that are already there that we could look at. For those earlier, for the housing, if you recall LB40 took stamp tax funds that were already being generated, but carved out a section of those stamp tax funds specifically for individuals with mental health conditions and low socioeconomic situations. That program has been extremely successful. It did not increase any tax base but it simply used money that was already being generated for affordable housing to be specifically for mental health issues. I would encourage possibly looking at our current alcohol tax and not necessarily increasing it, but the current state statute simply says that the alcohol tax that is generated is put into general fund. It would seem to make sense at some level, possibly, that we could look at that and actually carve it out to act as the match that is currently being used for Medicaid substance abuse services. Because, again, a $40 investment gets $60 in return on that, and then we could take that money that we pulled out of the division of behavorial health to act as that match, and actually then reinvest it to the regions, but at that time reinvest it to continue to try and right size the current allocations that are being to the regions so that we can actually get the money closer to 75 percent of the population that currently is basically underfunded in relation to behavorial health services. So with that, I'll answer any other questions. And if not, trust that we all have a good day. [LR363]

SENATOR JOHNSON: You know, I kind of like trivia and one of the things is, George Washington one of his first crisis when he was President was the whiskey rebellion, and because people were avoiding paying taxes on the whiskey that they were making, and so on. And I can't remember the exact percentages but the taxes on the whiskey in Washington's day, that they made sure they collected, make it so that they dwarf the taxes on alcohol today. It's, the taxes then were many, many times what it is today, so. I have to leave and I just want to let people know that there are different things that we have to show up for and so I have turned the morning over to our Vice Chair here. I hope to see you a little bit later in the day, so. Thank you very much. Any questions of...thank you very much. [LR363]

SENATOR GAY: Thank you, Senator Johnson. Are there any public comments regarding behavorial health? If not, I think, could we take 5 minutes? Let's start, we'll start about...let's start at 10:45, take a 10 minute break, and then we'll give Todd our full attention. [LR363]

BREAK: []

SENATOR GAY: All right, we'll get started and move on, and next on the agenda is Division of Children and Family Services. Todd Landry is here to discuss his department. The plan is this. I know this is an issue near and dear to many people's hearts and there's going to be a lot of questions and we want to allow time for public comment as well. It's about 10:45 a.m. Todd will probably take a half an hour, guessing, on his proposal. We'll try to hold our questions until the end and jot them down, so we'll try to be in interest of you. And then we'll ask our questions, but I just wanted to say, we'll have time for public input after lunch. Are we going to meet back at....at 1:30 p.m. that would be, so there's going to be plenty of time if anyone from the public wants to visit or ask questions, so. That's the game plan and then we'll follow up later in the day on the Division of Developmental Disabilities, so. Todd, welcome. [LR363]

TODD LANDRY: Thank you, Senator Gay. My name is Todd Landry, L-a-n-d-r-y, the director of the Division of Children and Family Services. Thank you for the opportunity to be with you today. In the area, or the Division of Children and Family Services, we have four main programmatic components of my division, child welfare, the office of juvenile services, economic and family assistance, and child support enforcement. As it relates to our organizational chart, we are largely aligned along and geographic basis with five service areas each led by an administrator, and a policy section led Todd Reckling. You met Todd this morning during the CSBG testimony. Budgetarily, we have a total appropriation amount of approximately half a billion dollars. As you can see on this slide, about 60 percent of that is in general, or cash, or general funds, with about 40

percent in federal funds. From the perspective of how we're organized as a state, I have all of the service areas that report within this division that includes the lion's share of all the offices around the state of Nebraska. We have the five different geographic service areas. They're shown here in different colors on the map. Each one of them have a number of offices providing services to those communities. I'd like to just give you a brief run down of how each of the programmatic areas are funded. In the area of the child welfare, we have a budgeted total of about $163 million. You'll notice that the lion's share of that is in general funds, about 85 percent in general funds, about 13 percent in federal funds, and a small amount in cash. The office of juvenile services, which includes the YRTC'S, as well as the parole and the direct commit arenas, have a similar breakdown of funding, about 85 percent general, about 11 percent federal, and about 4 percent cash. Economic assistance, you'll see that the funding mix is quite different. In this case, 45 percent general funds and 54 percent on federal funds. These are programs that many of you are well aware of such as the food stamp program, or as the federal government is now calling it, the supplemental nutrition assistance program, the aid to dependent children, or the TANF dollars, ABD, as well as energy assistance. And in the child support enforcement area, even more federal fund participation in this area, 67 percent in federal funds and 33 percent in general funds. We have several pages and the next several pages in your handout are on our priorities, and the first two should look very familiar to you. These are the first two of the Governor's top ten priorities for the Department of Health and Human Services to improve on the federal CFSR review, and to accelerate the reform of the child welfare system. As it relates to the CFSR, our on-site review date was completed in July of this year. We're still awaiting our courtesy copy of the final report. That will likely come, hopefully, by the end of the year, and then our program improvement plan will be due 90 days after receiving that courtesy copy. No state has passed, as you heard Chris talk about yesterday, the CFSR. Nebraska will certainly not be in the position of passing as no states are expected to pass this second round as well as no passing in the first round. Accelerating the reform of the child welfare system was a key component of the Governor's priorities, that we have a couple of the notes there of key achievements that we've made, including the implementation

of our safety intervention system, and the implementation of safety and in-home services reform. Senator Stuthman yesterday mentioned the situation or the question of, how do we work on not only accelerating children out of the system but also to only appropriately bring into the system the children who are unsafe and need our services. And the NSIS system is specifically designed, in cooperation with eight other states and at National Resource Center, to ensure that we're only bringing in children into the child welfare system who are truly needing it and who are in an unsafe situation. Yesterday, Chris talked about our goals in reducing the number of state wards. On the first page, we already talked about our CFSR outcomes of safety permanency and well-being. Those are our true outcomes, but we also have a number of measures that let us know how we're getting there. And one of those is in the reduction of state wards. Our goal is to reduce from 7,000, which is where we were at the beginning of the year, to 5,000 in 2012. And we have made quite a bit of progress as Chris mentioned yesterday. 2007 marked the second consecutive year in which the number of children safely exiting state care surpassed the number of children entering care. And that's a key component of looking at, obviously, how we're doing on reducing our total number of state wards. Serving children and youth on an in-home basis versus an out-of-home basis is a key component of our plan that we introduced in January. We have a slide that demonstrates that a little bit further in the presentation, as well as a slide on that service array that is mentioned on the next bullet point. In our office of juvenile services we have identified eight key solutions to help us to improve the service offerings to juvenile delinquents in our state, and some of those are listed there for you. I mentioned a moment ago the service array. This is the pyramid diagram that we've been using since January to illustrate what we're trying to truly achieve as it relates to our services in the Division of Children and Family Services as well as, obviously, some overlap there with the Division of Behavorial Health. As you can see on this slide, it is weighted as we would like to see it weighted, towards more children and family served in the lower end of the pyramid, fewer children served in the upper end of the pyramid. When we looked at this pyramid before, we recognized that over the past several years, the state had focused most of its efforts on the upper end of this pyramid and less efforts on the lower

end of the pyramid, specifically in-home and safety services were really, and the reform of in-home and safety services were really designed to implement improvements in the lines there shown as early intervention and biological family with wraparound services. That is an area that we had historically not paid as much attention to and before you can really get the results of implementing the upper end of this pyramid, we had to make sure that there was sufficient resources and focus on the lower end of the pyramid. And so this diagram really goes a long way toward showing you what we want the future of our division and services to look like. Along with that, we have our slide that we also released in January that illustrates the number of children that we're serving on an out-of-home basis versus an in-home basis. As of January of this year, we're serving about 70 percent of kids on an out-of-home basis, about 30 percent on an in-home basis. We really want to flip that triangle around. We want to serve more kids safety on an in-home basis versus an out-of-home basis. Generally, the research has been very clear that children that can be safety served in-home achieve better outcomes than children being served on an out-of-home basis. I'm happy to report that while it's only been a few months since initiating this shift, and this design shift, we already are seeing the results of these efforts and already we can report that as of last month, we were serving 65 percent of kids out-of-home and 35 percent in-home, already a 5 percent shift in that relatively short period of time. Other goals we relate to our child support enforcement program and increasing our paternity establishment rate in order to meet the federal benchmark. The next goal really goes to the heart of what CFS is all about. Building and collaborating and having strong partnerships. This area more than any other, I think, that I've ever been involved in, interfaces and interacts with more other entities than we could ever imagine. Certainly, courts are involved, are tribes, law enforcements, county attorneys, guardians ad litem, parents and families, the youth themselves, as well as other advocates, and the list goes on and on. One of the ways that we have tried to build and do a better job of building these partnerships is with the implementation of my Partner's Council, which started last September or October after I joined the department. Partner's Council includes members from all of the key association groups such as CAFCON, NABHO, NEAHSC. It also includes

representatives from the CASA organization, the Nebraska Foster and Adoptive Parents Organization, the courts, the Legislature. You have a representative from your committee on that Partners Council, as well as key advocacy groups such as Nebraska Appleseed and Voices for Children, just to name a few. But building those relationships is, obviously, very critical to us. Our goals also have to do with conducting business with transparency. And we'll talk very specifically about this as it relates to our COMPASS system and being able to be very clear in representing the work that we're doing and the work that we're focusing on in child welfare. In our food stamp area the focus has to always be on accuracy rate and negative error rate while still implementing that program on an efficient basis. And the TANF work participation rate, which I know many of you have worked with and are familiar with, increasing that TANF work participation rate to meet or exceed the federal benchmark is absolutely vital to us to ensure that we do not have any type of financial penalty on our TANF dollars in the future. The next few slides I'd like to do is take each of our four areas in order and tell you a little bit about the progress that we've made in each of those four key areas, as well as the significant challenges that we continue to face. In reducing the number of state wards, we're happy to be able to announce that we've safely reduced that number by 15 percent since our all-time high of 2006. At the same time that's enabled us to reduce workers' caseload and over the whole statewide perspective, on a statewide average, obviously, there's differences from service area to service area. We've been able to reduce those caseloads from 129 percent of the CWLA standard to 103 percent of that standard. Effective July 1, we contracted with five lead agencies to provide a continuum of safety and in-home services to children and families. That's dramatically different when previously we had 100 or more providers for different services and different components in different parts of the state as opposed to the full continuum of services that needed to be provided. As I mentioned, there's already been a 5 percent increase in the number of children being served in their home versus out-of-home in just the first few months that we implemented our strategies. And it's good news that we remain number one in the nation in establishing permanency for children in foster care for long periods of time. That is one of the four key federal measures in outcomes for permanency that all states

are measured on. We continue to be number one in the country on that measure. This graph visually shows the reduction in the total number of state wards from our high of 7,800 in April of 2006 to the 6,600 number that we have as of the end of last month. It's also important to note, that while that is a significant decrease, we also have reduced the number of kids in out-of-home care. And our number of kids in out-of-home care, which is a component of this larger number, is now at the lowest number that we've had in eight years. And that means, we have fewer kids in out-of-home care in any time over the last eight year period, and that's also excellent news. We've managed to increase the number of finalized adoptions. Senator Stuthman yesterday mentioned the question, as I said before, of accelerating the kids out of the system safely as well as ensuring that only the kids who need our services come into the system. One of the best ways that we can accelerate the kids out of the system is to safely move them to permanency, if they can't go back home, into a safe adoptive relationship. We've increased the number of finalized adoptions by 57 percent over the last four years and the last three years we've received federal adoption incentive bonus awards. We've also funded pre-hearing conferences in collaboration with the courts and "Through the Eyes of a Child" initiative to front-load the services as much as possible when a kid does come into our system and has to be involved in the court's process. And we have certainly increased transparency through our COMPASS system. This graph shows the number of adoptions finalized by calendar year and, as you can see, we've had steady increases over the past several years to our all-time high last year, 462 adoptions. Through last month of this year, I can report that we're already over 360 adoptions for this calendar year, so we're well on track to meet or exceed these same numbers in the current calendar year. I've mentioned a couple of times our COMPASS system. COMPASS is a system, a transparency tool that we rolled out. It's visible for anyone who has access to the internet. It's out there on our Web site and it's updated on a monthly basis. This tool allows us to show you very clearly in the child welfare area on the six key safety and permanency measures that the federal government measures all states on. And as you can see on this measure, we're coming very close or meeting the federal benchmark in several areas. In particular, the fifth gauge that you see there,

permanency for children in foster care, that 149.3 rating leads the country in that measure. So we're doing an excellent job of achieving permanency for kids in foster care for long periods of time. I'd also like to point out the second gauge. One of the first, the first two gauges focus on safety. The second gauge is absence of maltreatment in foster care. The federal benchmark is 99.68 per cent. That, as you all can tell, is a very, very high benchmark to reach. We currently are meeting 99.60 percent and on a monthly basis, you'll see this number fluctuate between about 99.6 and about 99.75. But it's excellent news for the kids who are in our foster care system that they're not having any maltreatment while in our system. And the last one I'd point out on this slide is timeliness of adoption. Composite score there of 106.2, the federal benchmark is 106.4. We are incredibly close in meeting our timeliness of adoption measures that the federal government specifies. That number has dramatically increased in the past several months. When we first started looking at this when I came to the department about a year and a half ago, that number was hovering in the 80's, and the fact that we've been able to dramatically improve our performance in that area gives us a lot of hope. At the same time I will also tell you that the very last measure on placement stability, and the third measure on timeliness and permanency of reunification, are our biggest concerns right now. We need to dramatically improve our performance in both of those areas and are working hard to do so and our reform efforts are really tailored towards hitting those two areas that we know we need to meet. Continuing on in progress in child welfare, developing a community independent living plan for youth in the Omaha area. Senator Gay, I think you mentioned areas and questions about public private partnership. This is a great example of one. We're partnering with the Sherwood Foundation, the Scott Foundation, the Nebraska Children and Families Foundation in order to leverage private dollars and public dollars in a joint effort to address the needs of youth in our Omaha area who are aging out of the foster care system. If this program is successful and has already been recognized by the Jim Casey Youth initiatives, which is a national organization, is one of their eight co-investing sites in the nation, if it's successful, we look forward to being able to implement this successful model across the rest of the state. We've also developed a statewide child abuse prevention plan in collaboration

with NCFF, and the Child Abuse Prevention Fund Board, and working closely with the courts "Through the Eyes of a Child Initiative." Despite that progress, we have, and, of course, probably will always have challenges in these areas. We continue to have a higher rate of children in out-of-home care than other states even though we've reduced it to a low that we haven't seen in eight years. We still know that we're higher than most other states around the country. And as we move towards serving more kids on an in-home basis versus an out-of-home basis, we expect that the next time CWLA does this survey, and obviously they haven't done one in a few years, but the next time that they do that, we'll see a dramatic improvement in Nebraska's standing. Improving on the federal CFSR outcomes remains a key challenge for us. While we're doing very well in some of those areas, we know we have a ways to go in others. And perhaps the biggest ones are the last two bullet points or dashes on this slide. Placement stability, which is a measure of children moving within the foster care system. We know right now that children move too often when they come into our system, and it's a big component of the framework recommendations for out-of-home reform that we've put together. Timely reunification of a child is also critical. Federal guidelines is, that if you're going to reunify, the guideline is to do that within 12-month period of time. That, obviously, can be a challenge in some cases but we look forward to being able to achieve that goal through a more effective in-home services and up-front services such as those that we've put in place with our in-home and safety services reform. That ties right into the next challenge of keeping kids safely in their own homes and reducing the number of removals. This is something that we've already talked about. It's a key challenge for us and is a major shift in the way the department and the division is doing business. Continuing to reduce the number of state wards, it will always be critical for us to make sure we're doing that in a safe manner. And one of the things we carefully look at, is the number of kids who are reentering the system after we have placed them back home or into an adoptive family. And the good news for all of us right now is, while we have seen our total number of state wards drop, while we've seen our out-of-home placement numbers decrease, at the same time we have not seen any kind of increase, in fact a little bit of a decrease, in the number of reentries of kids coming back into the system. So right now

with those to date of points combined tell me, is, for a lack of a better term, we're having a bit of our cake and eating it too. We're able to safely reduce those kids and those kids are able to safely stay at home. The last challenge is one that's absolutely vital as we move forward is improving upon oversight of programs, contract monitoring, and over all accountability. As we continue to work and partner more with our community based providers, we also have to make sure that we have very strong and effective oversight. One of the things that's helping us tremendously in our new in-home and safety contracts, are two pieces. These were the first contracts in our state that we've ever done that had true performance based outcomes with incentives and disincentives built into the contracts. And if you want to see exactly what those look like, they're on our Web site. Anyone can go out there and take a look at them. And you can see specifically the measures that we have out there and what those incentives and disincentives are, if they achieve or do not achieve those outcomes. In addition, beginning next year after we have six months of the new contracts, we're going to be posting their results on those key measures on the Web site just like we post our COMPASS measures as a state. Those performance measures are going to be posted on the Web site for everyone to see how these agencies are doing. We'll jump now to progress in our office of juvenile services and we've made several steps forward as part of the eight solutions that we identified at the end of last year. We opened for the first time in April of this year a new Youth Links triage center, which is specifically designed for needs of kids in the juvenile delinquency area. Again, we've done this initially in Douglas and Sarpy Counties and we're watching those outcomes very closely and if it's successful, it's a model that we can expand out to the rest of the state. The effort here at the Youth Links program is all about and we're doing this in conjunction with Heartland Family Services and Boys Town are our partners on this project, is to enable a way for juvenile delinquents to have a safe effective place without necessarily having to go to high cost detention services. So there's day treatment services, there's residential services, there's also partial care services that enable us to serve those kids more effectively with engagement of the family as opposed to the high cost alternative of detention. Our youth level of service case management inventory is a tool that we

developed in and joint implementation with juvenile probation as a way of accessing the risk and needs of delinquent and serious offense youth. Our YRTCs', both at Kearney and Geneva, are accredited by the American Correctional Association. In order to maintain accreditation you must meet 90 percent or better compliance with 454 best practice standards. Geneva just went through their reaccreditation review, and our initial results from that are they met the standard 453 out of those 454 standards. That's great news for us. It means we're meeting those high standards of accreditation. Also at YRTC, Geneva, we've developed a comprehensive curriculum for girls who are committed there, who are pregnant or who already have children. The mothers and babies program is an innovative solution to help those particular youth. We have some significant challenges in our OJS area and juvenile services. Clearly, juvenile crimes and behaviors have increased in severity over the past several years. For many of you, or myself, we may remember when we were high schoolers or teenagers and we got into a disagreement, if it escalated to violence, it probably escalated to fisticuffs. Today, if things escalate to violence, more often it's happening that that's escalating to violence with blades and sometimes, unfortunately, with guns and other weapons. That level of behavior in those juvenile crimes are certainly increasing in severity and it's a challenge for all of us in this system. There has been a shortage of reentry programs for youth into their home communities after they have completed their stay at YRTCs. The Youth Links program is designed, in part, to help us with that so that there can be a reintegration component for the time that youth are going...before youth go back home. Again, if successful and our outcome show good success, that's a model that we may be able to expand to the rest of the state. And continuing growth in our OJS population, implementing the eight proposed policy and practice changes that we've identified quickly enough to address this growing population, is an ongoing challenge for us. Now I showed you the total number of state wards that have increased by about 15 percent over the past two or so years. What I can tell you is most of that decrease, in fact all of that decrease, has occurred in our child welfare area for children who have been abused and neglected. Our juvenile delinquency component of that population has actually gone up slightly, so it is a key concern for us going forward. Continuing with

challenges in our OJS area, implementing recommendations from national consultants for our programming at our YRTCs. This is really a significant step forward for us. Our YRTC programs, particularly at Kearney, are transitioning from a former correctional model to more of a cognitive base model that has gotten good results in other states in the country, such as Missouri, and some other states. So we are changing that programming. We had hired some national consultants to help us look at those programming options and they're the ones who have helped us identify these cognitive based programming changes that we're beginning to put in place. And last, developing, building and staffing the new 24-bed secure care and 48-bed chemical dependency facility in 2011 will be a challenge for us. We're hopeful that we'll be successful in our funding request for this $18 million project. I know we talked a little bit about that program yesterday during Chris' testimony. Let me move now to economic assistance. We've made some great progress and some success in this area. Our food stamp program was number one in the nation for negative error rate, number two in the nation for lowest active error rate in the past federal fiscal year. Currently in 2008, we've maintained our number one rating for the lowest negative error rate and we're currently eighth in the country for the lowest active error rate category. In our TANF program were fifth in rating in success in the workforce. We're also sixth in family formation and stability, tenth in job retention are just a few of the measures of our success in our TANF area. We have some challenges in our economic assistance area, one that we'll talk about a little bit more later in the presentation, is how do we continue to leverage technology to not only increase client accessibility, but also increase agency efficiency, and drive down our cost of doing business. Our taxpayers demand it, they deserve it, and we have a plan in place to address that. We also have to make sure we're increasing our monitoring through our supervisory case reviews in order to improve our program, performance, and to maintain those successful accuracy numbers that we showed you on the previous slide. In our child support enforcement area, we're fifth nationally in the collection of current support orders and sixteenth nationally in the collection of past due support, both ratings reflecting the high level of success that we've had in our child support enforcement area. It may shock you to see that we have

processed over $263 million in collection in 2007. That's an increase of over 4 percent versus the prior year and as of August, on a monthly basis, we're collecting $5.3 million on a month-to-month comparison over the previous year. Nearly 99 percent of the collections are processed and returned back to the custodial parent, or I should say returned to the custodial parent or sent to the custodial parent, within the two-day federal time limit in August. That's a tremendous accomplishment in ensuring that the dollars that the custodial parents need in support of those kids are getting in their hands as fast as possible. One thing that's helped us on that, is 94 percent of child support payments are now being made electronically as of last month. That doesn't just mean that the dollars are getting to the custodian parents more quickly, it also means that we can continue to hold down our costs in doing that business as we do it more and more electronically and less by paper. Just to give you a feel for where we are program case number wise. We've already talked about our state ward count and our food stamp program. We serve about 52,000 households a month. That's up just over a percent versus a year ago. In our ADC and TANF number we have a case count of nearly 8,600 families, that's down 5 percent from a year ago. Childcare is up about 4 percent. We've got about 17,000, 17,000 to 18,000 families receiving childcare subsidy and in the Medicaid area, we have a slight increase in eligible persons of about .74 percent. You may be curious why Medicaid is on here. You've obviously already heard from Vivian on Medicaid policy and Medicaid payments. One thing to keep in mind, of course, is while she's in charge of policy and payments, it is my division that's in charge of eligibility determination. So eligibility determination is part of the responsibility of my division. As we move forward, I've talked a lot in the last several minutes about our challenges as well as the success that we've had. Hopefully, tried to paint a bit of a picture for you in scope and scale of the division. But it's now time to spend just a few minutes talking about where we're going in the future and why we have to change the way we're doing business. There's some real key factors, some key infrastructure or underlying factors of why we have to continue to change how we're doing business. One, public demand for easy access to service. We cannot rely on an old model of doing business that relied upon us showing up at an office five days a week from 8 to 5 and expecting everyone to

show up during that time period. People want to be able to access our services electronically, they want to be able to access it on a 24-hour, seven day a week basis. Improved accountability is absolutely vital. As we go forward, our taxpayers demanded and they deserved that we're being at a high level and meeting the highest levels of standards and accountability and along with that is improved outcomes. An outcome focus in our contracts, in the work that we do with our own staff, and in the expectations that we have for ourselves and others is absolutely vital. And everything that we're doing in our contracts has to do with making sure that solid outcomes, usually tied to federal outcomes, is going to be key as we go forward. Making efficiency gains is absolutely vital. The taxpayers, again, expect that we're going to provide these services at the lowest possible cost to them and that's what efficiency is all about. And the last thing I'd like to briefly talk about is a changing dynamic in our workforce, a changing dynamic in our division is our changing workforce. At the end of last year, we took all 2,000 employees that I have in my division and we just mapped out what their ages are on a large spreadsheet. And what we found when we did that, is nearly 50 percent, nearly 50 percent of our staff, are eligible to retire now or in the next five years. Half of our staff have the opportunity to potentially be leaving our state employment in the next five years. Put more simply or in a different way in order to replace all those people, unless we change the way we're doing business, we'd have to hire on average about 260 people a year for the next five years. Right now we struggle to recruit, hire, and train about 160 people a year. There is no way, in my opinion, unless we change how we're doing business, that we can continue to operate the way we have in the past. What that means for us is putting in place some big changes within our division. Some very big changes, and you know what, before I even get into those changes I want to recognize and appreciate, along with big change, comes big anxiety. Whenever you put into place change, it's going to cause a lot of concern, a lot of anxiety. That goes for our own staff within the division, it goes for our providers, it goes for others that we interrelate with such as the courts and other entities. Along with change comes that anxiety and we have to address that as we go forward. The best way that we can address it is through communication and that's one of the things we're trying very hard

to do, particularly with our staff and our key providers and contractors is to make sure we're communicating this as much as we possibly can and get their input along the way. I'd like to give you two key examples of major reform efforts that my division is going through. One, is out-of-home reform, and the other one is ACCESSNebraska. At the beginning of September, we released framework recommendations for out-of-home care. These were recommendations that were at, for lack of a better term, of 40,000 or 50,000 foot view. We knew it didn't have all the details in it. We didn't want to put all the details in it because we wanted to get the benefit of input and feedback from our staff, from providers, from advocates, from the courts and judges, and others. But I've captured here on the next couple of slides or so what those framework recommendations indicated. First, it builds upon the concept of our current safety and in-home services contract. To not only include in-home services, but also nontreatment out-of-home services. So these are the non-Medicaid services. So when we go back to that pyramid, we're really talking now about not just the early intervention and the biofamily services, we are now talking about foster home services and group home services, so the non-Medicaid component. This is where the largest bulk of our dollars go to and it's key that we actually...and we know from our federal results that kids are moving too frequently from one placement to another and they're not getting out of the system as fast as we need them to, particularly on reunification. So the framework recommendations were really designed to attack those two key outcomes that we're not succeeding at the level that we need to. The framework recommendations would require contractors to assume the day-to-day functions of service planning, coordination of delivery services. And that would include coordination with treatment services. It would retain the responsibility of the division staff, state employees, for contract oversight, and contract monitoring. The recommendations will require contractors provide a complete continuum of all those nontreatment care and needs and a focus on using evidence based or promising practices, and we believe that the contracts must include financial incentives and disincentives for key outcomes related to safety, permanency and well-being. Again, these are very, very high level framework recommendations. If you want to see the detail of these, they're on our Web site and

have been since September 5. We've had the benefit of a significant number of community forums, phone conference calls with juvenile and district court judges, and others, to give us feedback on what they think about this. We're in the process of collecting all that information, putting it all together, and coming up with a formal plan that would answer many of those detailed questions that we were asked over the past few weeks. But there is no doubt in my mind, senators, that if we are ever going to meet those safety and permanency outcomes that the federal government expects us to meet, that we have to change the way we're doing business right now. We may be able, and I am sure we will, potentially disagree on how we get there. But the one thing I believe we can all agree upon is, we have to get there, and we have to achieve those safety and permanency measures. The second big area of reform that we have going on in my division is in the area of our economic assistance program, specifically ACCESSNebraska. I believe I've had the opportunity to meet with most of you, at least giving you a high level view of what ACCESSNebraska is about. It really is composed of three or four key components or phases. The first phase was a public Web site. Some residents can now access and electronically complete and submit an on-line application for services. That Web site also has an opportunity for the first time for individuals to fill out a quick five or ten minute screens of basic information so that they can screen themselves in or out so that they don't have to complete the whole application. They can do the quick screening tool to see if they might apply for these services. This is the first time that this state has ever had their economic assistance application on line. Before September 8, you had to literally go into one of our offices or call our offices and fill out that application by hand. It's a key step in us moving forward. As we move forward with that Web site, you can see on this slide some of the future developments for the on-line application piece. But now we are also moving forward with the second phase with ACCESSNebraska, which is document imaging, which put simply is just the use of technology to scan, store and retrieve documents. We have a huge number of documentation requirements for people to demonstrate that they are, in fact, eligible for the services. In the past, we've gotten those from them, made copies, put them in files across our state. And as you can imagine, the amount of paper that has collected over

that amount of time is tremendous. By electronically storing this information, it's much more efficient way of keeping that information secure and safe. It also makes it possible for worker A to also have same access to that file as worker B in any part of the state that they may be in. And that then, makes it very possible for us to move into the third phase, which is the use of customer call centers instead of workers spread out through all the 50 plus offices that we have throughout the state. We are proposing to implement three to four call centers, locations to be determined, that would enable us to have a single contact telephone number, a statewide timely response to our constituents to enhance our communication and consistency. This program is very important. It's a key aspect of how we propose to achieve efficiency in our ACCESSNebraska project. By using call centers versus our individual offices and these other changes that we're proposing, we believe that we can, in fact, reduce our staffing requirement by 25 to 27 percent saving the state at the end of this project $8.5 million a year in operating dollars. The cost of implementing ACCESSNebraska is done using federal funds, no general fund dollars are being used for the implementation of ACCESSNebraska, $4.5 million federal bonus dollars and other participation of federal matching dollars are being used. The dollars though that will be saved ultimately, of course, are primarily state general funds. Two things I want to point out very quickly about the call centers that we've talked about with many of you. Two key aspects, while we don't know where they go, we do know two things that are absolute givens. All of the call centers will be located in the state of Nebraska, and the call centers will be staffed by state employees. Those are two of the measures and initiatives that we have going on in the division. We obviously have lots of others that we've referred to during this presentation. This strategic time line puts it all on one chart. So for those of you who skipped ahead to the end, you probably said, you know, you could have just showed us the one slide, but instead I thought it might be beneficial to put a little bit into context of where we're going. But this one slide really does graphically show over the next five years what our goals and aims are within the division of children and family services. These are not easy goals to meet. These are extremely difficult goals that we're trying to meet, but we have a fundamental belief that we're going to set high goals for ourselves and we're going to aggressively go after

them. And I want to take a final moment to say thank you to all of you on this committee and the other legislators that you serve with. I also want to thank my fellow directors and all of the staff in the Department of Health and Human Services and most importantly, all of our key partners, the courts, our providers, advocates and others, most importantly the families that we have the privilege of working with. We cannot have achieved the success that we have achieved so far without their important roles and important day-to-day work and we know we won't be able to achieve it in the future without their help. So with that, senators, I thank you for giving me the chance to go through that presentation, and I'm guessing that you may have a question or two. [LR363]

SENATOR GAY: All right, thanks Todd, and thanks fellow senators for patience. I'm sure there's questions and we'll ask those again. What we'll do, it's 11:30 a.m., we'll go until noon and then we'll break but we want to make sure there's plenty of time for questions. So let's start with individual senator's questions. Any questions from the committee? Senator Stuthman. [LR363]

SENATOR STUTHMAN: Thank you, Senator Gay. Todd, on your reducing of the state boards, and I really appreciate that, that is something truly, I think, is something we need to do. Has there been any consideration of the fact that people that enter, you know, that are...well, they are state wards. They're not state wards but then they're turned over to the state. Because of the fact and I've gotten quite a few of constituent calls that, you know, they're trying to get services and they can't get services because they don't qualify, but if you turn your kid over to be a state ward, then this child can get some services. Is there anything where there can be services provided while those same type of ones that they're only given because they're a state ward, that they could be utilized while they're not a state ward and still be a family member. Can there be anything worked out that that time frame or time line or financial stability or whatever it is that makes the fact that we can only provide these services if they are a state ward and you have to turn the kid over. Can we change that part of it? [LR363]

TODD LANDRY: Senator Stuthman, I think it's a good question and one that I've heard asked by several others in the community. One of the things that we looked at over the past year, is how many kids really fall in that category. How many kids have the courts determined that the sole reason that they're coming into care is become of access of services. There's a special adjudication code, as I'm sure you're familiar with in the courts, a no-fault determination made by the courts to determine that. And so the courts make that determination, we don't. What I can tell you is that of our total number of state wards, 1 percent of the kids fall into that no-fault determination. So 1 percent of the kids, the judges have said, are in our system because of no fault of the parents or others. Having said that, we also recognize that there are a number of kids out there who may be unsafe and who need these services. As part of our safety and in-home contract and our safety and in-home reform, we specifically wanted to address those. Keep in mind, the key question that we as a state must make, and our staff make on a daily basis, is a key question of safety. Is the child safe or is the child unsafe. Our NSIS system that I briefly referred to is a outstanding tool, in my opinion, that we developed in collaboration with eight other states in the country and a National Resource Center on child abuse investigations in order to determine accurately and quantifiably, is the child safe or is the child unsafe. If the child is safe, they should not be in our system. We can refer them to other services that may be available in the community, etcetera. But if the child is safe, that is the key question that we, as a state, I believe, must ask and that's the key question that determines whether a child comes in for services with us or does not. If the child is unsafe, though, that is when we should be providing services. Now in many cases, and I believe an increasing number as we go forward, we'll be providing those services on a basis with the family on a noncourt involved basis. Doesn't mean they have to become court involved and have to become state wards. It does mean that we have to quantifiably be able to show that the kids are unsafe. But if they're unsafe and they can safely be maintained in their home and the family is willing to partner with us to work on these services and issues, then, yes, those are the kids that we want to serve. And if we can do that without court involvement, so much the better. That's good for us. It's good for the family. It's certainly good for our limit of resources in the court system

as well. That's the direction that we're going in. That's what we've been pushing towards for the past year and a half since we first began to implement this in the western service area. And then we moved it across to the eastern part of the state, but that's the direction we're going in. Now, I should mention and finish trying to answer your question by saying if a child is safe, then those services for the family need to be provided by the community. The key question is safety. [LR363]

SENATOR STUTHMAN: Is that part of the reason why the number of state wards are coming down, or is it the fact that a lot of them are aging out? [LR363]

TODD LANDRY: I think the biggest reasons, the number of kids aging out has remained relatively stable over the past couple of years. The biggest reason our numbers have come down have to do with the number of kids who are exiting the system more quickly, such as through adoption. The increase, the raw increase in the number of adoptions, as I showed you on that slide, as well as the fact that I believe we are doing a better job, and this is a newer impact, we're doing a better job of addressing those safety issues on a voluntary basis as opposed to a court involved state ward shift basis. [LR363]

SENATOR STUTHMAN: Okay, thank you. [LR363]

SENATOR GAY: Senator Howard. [LR363]

SENATOR HOWARD: Senator Stuthman asked such a good question and I think there's a little more to it that would be helpful to know. And Todd explained it well in that a child comes into the system basically due to safety needs but the 1 percent of the filings that are not due to...well, basically due to special needs would in many cases be, it's a dependency filing is what it's called. And in many cases, it's a situation where the parents insurance has run out and they need to turn to the state for assistance and in those cases, and I think you would agree with me with this, I would ask you to analyze this if you have a different viewpoint on it. But in those cases, the parents do give up

their control over decision making, which is a double-edged sword because the state still has a responsibility for being financially prudent but at the same time the child is in need of services. So I think that's an area that I would ask for the department to really look at critically to see how families can access this without becoming in, for lack of another word, estranged from their child, estranged from the responsibility of parenting that child. So do you see this happening in the future that there can be more of a meshing of this so that parents don't reach that desperate state? [LR363]

TODD LANDRY: Well, I think for that small percentage of the cases--and I believe you, you know, I think I would agree with your characterization of it--I think for those small percentage of the cases, we'll need to continue to look at ways that we can hopefully minimize the number of kids who are in the situation where they have to do that. By the same token, there may be certain situations where there is no alternative other than the child being made a state ward. So while I think we can continue to work towards reducing that number and looking at innovative ways that we can work with families avoid that, I think there will always be some need for that and I think there will always be some situations where that situation has to occur. [LR363]

SENATOR GAY: Senator Pankonin. [LR363]

SENATOR PANKONIN: Thank you, Senator Gay. Todd, appreciate your time today and your report. And as I've told you privately and really all the folks in HHS have some challenging jobs, yours is right up there and appreciate your efforts, your public service that is involved very sincerely. I'm curious about ACCESSNebraska. Obviously, you started September 8 with phase one and for those of us, whether personal life business, when you make these changes, and how's it going? How is the first six weeks or couple months or whatever we're looking at here? [LR363]

TODD LANDRY: Well, thanks for that. The first couple of months and first, really, six weeks that we've had the application on-line has gone remarkably well. You may have

noticed that we started that out and we launched it on September 8 without a whole lot of fanfare. We did that very specifically because we wanted to make sure (laugh) that everything was going to be working very well, and now we're getting out the word more and partnering with many community organizations to make computer terminals available where their clients are so that they don't have to come to us or anywhere else. I can tell you that we have had hundreds of applications submitted electronically. The very first application came in from Ord, Nebraska. I think it's as much as half of the applications that we've received electronically have come in after work hours or on weekends, which again I think is a good reflection of the ability of the application to be available when families are ready to apply or individuals are ready to apply as opposed to when we're going to be in the office. So I think the process has gone very, very well so far, very smoothly. We've had, as I said, a large number of applications that have come in electronically and the work there seems to be going well. The next two phases, with document imaging and the call centers, are obviously bigger changes and that's where we're going to see more impact. Those changes really won't begin to go into effect until next calendar year, actually next fiscal year. Document imaging will be the next big piece that we put out there. That will happen and it's scheduled to happen November of 2009, with the call centers then becoming operational in the summer of 2010. So we've got quite a long way and quite a lot of planning and work to do, but part of that is intentional and that's from learning from the results of Utah and Florida and other states who have done this. One of the things that they said is leave yourself a significant amount of planning time and implementation time for this project, particularly as it relates to those call centers, because that is going to change some training in how our staff actually do their jobs. As opposed to having a set caseload of X number of cases, they're now going to have to be able to address a question that comes from any part of the state from any kind of any of the cases that may be there, and so it's going to change how we train our own staff in that process. I have a lot of hope for it. I believe the first step with our electronic application went exceptionally smoothly because of the work that our staff did in partnership with others in the community, so I'm hopeful as we go forward. One of the questions that has been asked, so I'll take a chance to address it

now, is, well, wait a second, what does this mean for accuracy. What is this really going to do for your accuracy? Because we've led the nation in some of those accuracy areas. One of the things I will tell you is during this change process I anticipate some reduction in our accuracy rates. You can't, I think, implement a change of this magnitude without having some of that happen during the transition period. But once fully implemented, I believe we're going to be at or above where we are right now. An example I'll give is Florida. Florida, during their implementation time period, had a very poor accuracy rate, very poor accuracy rate. And we're fortunate that we've learned from some of the things that they can offer us in that so ours doesn't dip to that level. But currently, and you may remember the slide that I said in our current fiscal year of 2008 we're eighth nationally in our active error rate. Florida is number three. So it gives me a lot of hope of where we're going in the future. [LR363]

SENATOR PANKONIN: On this phase one, do you have a feedback situation to where the citizens we serve and/or your staff, folks that are working with this, have input on some of the things that may be glitches that happen usually in these sorts of things? Have you...have a system in place? [LR363]

TODD LANDRY: We do. We have a specific work team on that and as we form more work teams we're getting that feedback from the field. There's also, on every single one of the pages, when a person is going through the application process, there's a help button. And so that help button is manned on a working day basis and so we can respond to their questions immediately, and those, the people who are manning that number, are also keeping a list of common issues and commonalities among the calls that are coming in and we're making, virtually, daily changes and tweaks to that on-line application as we go forward. [LR363]

SENATOR PANKONIN: My last comment is just, when we've looked at the budget for your area at over a half a billion dollars, obviously this is a huge responsibility in itself, as you've said, and...but yet we know, too, our citizens need help in this area and our

most vulnerable citizens are our children, young children. So appreciate your efforts and we need to continue to get better, as I know you want to. [LR363]

TODD LANDRY: Well, that's exactly what we're trying to do and my focus will always be on key outcomes, and that's why I'm putting so much emphasis on those COMPASS measures of safety and permanency. We can look at lots of different things on a singular, case-by-case basis, or even, you know, 10 or 15 cases, but those measures up there reflect the thousands of cases that we're dealing with, all 6,600 state wards, not just those but the 12,000 or so calls and cases that we handle on any given year. So that's really what we're trying to focus on and that's what we're keeping a close eye on. So I appreciate your comments and I'll let Vivianne know that she may have the largest checkbook but I'm not terribly far behind her. [LR363]

SENATOR PANKONIN: Close. [LR363]

SENATOR GAY: Senator Hansen. [LR363]

SENATOR HANSEN: Thank you. Todd, on page 93 and 94 you talk about the framework for the out-of-home care reform, and you're asking for contractors to carry out more of the day-to-day transactions that go on. You ask for contractors to provide the continuum of nontreatment care. When Director Peterson talked yesterday, the number one goal she had was accountability, and my question is who is going to show up for the accountability for the contractors if we're going to give them more responsibility? [LR363]

TODD LANDRY: Well, yeah, I think it's an outstanding question. I think that's why you have to have the contracts that are performance based, number one, so that there are effective incentives and disincentives built into every single one of the contracts. It's what we've started with our in-home and safety contracts. It's what we intend to pursue with our out-of-home contracts as well. So that's number one. You got to have the

contract written right. Otherwise, how are you going to hold anybody accountable? If the contract is not there to begin with, it's going to not work. And I'm not saying our contracts are perfect, but I'm absolutely delighted in where we are right now with our in-home contracts. The second way I'd answer that question is you may remember when we changed the way we do our in-home and safety contracts, we went from over 100 providers down to 5 providers that cover various portions of those five service areas. That's absolutely critical as well. If we have over a hundred or we have hundreds of contracts, it's very, very difficult to get a high level of oversight and accountability on every one of those, especially if there's no uniformity among them. And so reducing it to a smaller number of contracts makes it much easier for us to manage and hold those contractors accountable. Now what that means is some people get upset about that because some of those hundred-plus contractors were not, obviously, you know, some of the five lead contractors that we ended up with, and I can appreciate that. But from a statewide perspective, we had to reduce the total number of contractors, uniformity of the contracts, and put those performance-based measures in them. And then the third piece is the oversight component. That is a piece that is not an area that the department has done particularly well in--I'll speak specifically for my division--has not done particularly well in. When we reorganized last September, we specifically created within the central policy section a continuous quality improvement unit or area, and that area is specifically responsible for oversight of these contracts, as well as some of our other key outcome measures. It's the first time we've ever had it. As we go forward with these contracts, one of the things that will change is some of the responsibilities of some of our staff. So our staff, instead of, for example, doing some of the day-to-day coordination work, putting out fires, recruiting foster families, whatever the case may be, their role is going to change and their role is now going to change towards more contract oversight and higher level decision making. That's going to enable us to free up those FTEs who are now doing some of those functions. This reform effort is intended to free up some of those FTEs to do that critical oversight and monitoring role that we need to have. [LR363]

SENATOR HANSEN: I would ask you to keep us informed on the oversight part of it, the accountability, the oversight, the whole thing, because I think it lies in the responsibility of the state senators, who okay this program and finance a portion of it, to be satisfied with the oversight. [LR363]

TODD LANDRY: It's absolutely essential. I'm looking forward to next when the session comes back into regular session and...or the Legislature comes back into regular session next year. At that time, that's going to be our first opportunity that we're going to have full transparency on these contracts. I'll give a lot of credit to our contractors who sign those contracts knowing that not only were there performance measures and incentives and disincentives built in there, they had to sign that contract knowing...and there's a particular, you know, contract clause that says we will post your results on the Web for everyone to see. They owned up to it. They said, yeah, that's what we're here for too; we're going to be held accountable to those levels too. So we're not going to hide anything. We're going to put it out there for everybody to see, just as we did with COMPASS. It was real clear for everyone to see where we were failing and where we were succeeding when we started that over a year ago and, as a result of it, Senator, guess what. Those measures have improved. [LR363]

SENATOR HANSEN: Thank you. [LR363]

SENATOR GAY: Senator Stuthman. [LR363]

SENATOR STUTHMAN: Thank you, Senator Gay. I want to talk a little bit about the YRTC programs and the challenges. One of the bullet points was implementing recommendations from the national consultants for improved programming. Now explain to me what you mean by programming. Is this the education portion of it? Is this job training or what do you have for these clients that are in Geneva and Kearney? [LR363]

TODD LANDRY: Uh-huh. Well, I'll use the example of Geneva, to begin with. In Geneva some time ago, and I don't know exactly how many months or years ago this was, but we implemented a specific curriculum there called the Journey, you know, the Journey curriculum, and that Journey curriculum requires, before a young lady leaves or gets discharged out of YRTC, except unless it's an age issue where our jurisdiction ends, she is required to work through that entire program that identifies what has contributed to the fact that she is where she is now. What part of her, cognitively, behaviorally, emotionally, etcetera, has to change for her not to, you know, not to repeat those damaging behaviors and what it is that has to change around her, such as in her family, the friends she associates with, etcetera, so that she doesn't repeat the same mistakes that were made in the past? That example of a program, and I'm glossing and putting it at a very high level, obviously, is an example of a cognitive, thinking-based program, as opposed to a program that simply said, you committed this law violation, you can't stay here in the community, we're punishing you, go and live at Geneva for six months and do your chores, etcetera, and when you're done you can come back home. That's the difference. At Kearney I will be the first to admit that our programming has lagged behind that at Geneva. Our programming at Kearney, while we have some counseling and therapy and those programing pieces in place, the programming doesn't have as strong a specific curriculum as Geneva's program does. That's the big change that we're putting in place. We recently hired Jana Peterson--Jana has been a administrator in our central service area on the child abuse/neglect side--specifically to head up that effort at Kearney to implement a new curriculum program for those male youth to have that same cognitive behavioral impact before they leave Kearney. Up to now, that programing at Kearney, while it has had some components in that in place, has not been a set, thorough curriculum that's research based, that's evidence based to get the results that we need. So that's what we're really trying to change, particularly at YRTC-Kearney. We're also making some changes at Geneva as well, but they're more of a fine tuning at Geneva as opposed to Kearney. I will tell you, I think that also shows up in, for lack of a better term, our recidivism numbers at the two campuses. Our recidivism number, and I'm working from memory here so please forgive me if I have to

get back with you with more specific details, but I believe our recidivism number at Geneva has been somewhere in the 8 to 9 percent. In other words, 8 to 9 percent of the girls that leave Geneva end up either coming back to Geneva or violating some condition of their liberty. That number is about double that at Kearney right now. Both of them are still pretty much in line with national averages, but we don't just want to hit at the national average. We want to certainly drive those numbers down as low as possible so that these kids come out of these two facilities addressing the issues that they have and becoming productive citizens in the future. [LR363]

SENATOR STUTHMAN: That's my main concern, you know, so that a greater percentage of the people, when they are released from there, you know, have some type of an education, have some type of a goal or profession that they would like to pursue so they can become an asset to the state instead of a liability. [LR363]

TODD LANDRY: Absolutely. And I will say at both campuses are our formal education component. Our high school education components remain in place and they continue to do a very fine job. We continue to make slight modifications in those programming areas, but both of those continue and that does include some of those other pieces, such as vocational training, vocational education, etcetera. [LR363]

SENATOR STUTHMAN: Okay. Thank you. [LR363]

SENATOR GAY: Any other questions from the committee? I don't see any. Thank you very much, Todd. And then...well, I guess we're 5 minutes to 12:00, so we'll adjourn till 1:30. But when we come back the plan is...I know many of you might want to speak on this issue or other issues so at 1:30 we'll allow you to do that. I'll say now and I'll repeat it prior if Joel is back, if we can limit those. I know many of you are advocates and you speak to us a lot and we want to hear from you, but let's limit it to specific issues, you know, whatever the case may be. So we'll do that at 1:30. All right. Yeah, how many people would like to speak at 1:30, just ball park, if you could raise your hand? So we

don't have a ton. I mean, I don't want to shut you down, but, you know, 5-10 minutes each. So okay, thank you. [LR363]

BREAK []

SENATOR JOHNSON: We'll get going with ours. The conversation with Senator Howard was she has the problem similar to what I alluded to this morning, is that sometimes we have commitments both places. So let's get her to hear as much here as we can and then she'll have to get to the other place where she needs to be. So with that, I believe that we are at the place where Todd Landry talked about the Division of Children and Family Services, and now I think that there were four or five people that indicated that they wanted to put in their comments on the record of where we're at with this. And we've had very helpful comments throughout the day. I've been very pleased and heard good reports from other people as well. So do we have some that would like to comment at this time? How many other people do we have? One, two, three, four or so. Okay. [LR363]

C.J. JOHNSON: Oops, I think I just made my cell phone want to go off. Sorry about that. Good afternoon. Hello again, Senator Johnson, members of the Health and Human Services Committee. Again, my name is C.J. Johnson, J-o-h-n-s-o-n. I'm the regional administrator with the Region 5 Systems, but I also want to state that I'm speaking in regards to these comments also as somebody who has been involved with children and families for the last 30 years. I've been a state employee. I've worked with psychiatric hospitals. I've done a variety of things over the years. I've been in private practice as well. I have three primary comments in relation to the testimony this morning, some of the questions. I'd first like to comment on the...Senator Howard, you had asked in regards to parents seeking services and the challenge there, and the response at that time was, well, that only 1 percent of those kind of cases are actually filed. I really had to ponder over the lunch hour how to try and say this nicely, but the reality is, and we should all...well, I guess I'll just say it. I think at some level that's a very naive comment

that only 1 percent in relation to that. The reality is--an, in fact, over the lunch hour I jumped on a bunch of Web sites like the United States Juvenile Justice Annual Report and some of those kind of things just to make sure I was going to say what I was going to say--the reality is, is most of the individuals, most children who end up in the Office of Juvenile Services here involved in delinquent behavior, many of the children who end up being state wards because of child abuse and neglect are a result of either themselves or their parents not getting treatment services for behavioral health conditions that they have, and that's just a fact. So we can't...you know, we can say only 1 percent of those parents actually seek services because they weren't able to...or make their children state wards because they weren't able to find the services, but the reality is, is a vast majority of all those children who eventually become state wards, in some capacity or another, have some kind behavioral health condition. Subsequently, they have some kind of behaviors which eventually get them involved, whether it be in juvenile justice, and their parents the same way. They may have behaviors associated with their unmet behavioral health conditions that may result in abusive behavior and neglectful behavior. So I just want to clarify that. And I think the other piece of that is I, you know, all the commotion around the safe haven law. I think that is just a reflection of that same thing. There just are not for children and families the availability of publicly funded services for those individuals who do not qualify through Medicaid or who do not have insurance or other funding sources. On our adult side, we actually provide pretty good, you know, availability of services. That's always underfunded, but we do actually provide services for people who aren't Medicaid eligible, who don't have insurance, who don't have any other resource to find those services. We provide those for the adults, but in our state we just simply do not provide funding for families and their subsequent children to get services unless they in fact are Medicaid eligible or in fact they do have to become state wards, or those services just really aren't readily available. My next comment is in relation to dollars. If you think back on this morning's...both the presentations, when we talked about LB1083 and behavioral health reform, that reform is primarily focused on adult services. It was reducing psychiatric hospital beds and then shifting the dollars through that savings to community-based services. And as Scot

Adams pointed out, an unintended consequence of that was when we shifted that $30 million into the communities not only were we able to move people out of psychiatric hospitals who had been there for years and years and years who didn't really need to be in those state hospitals, but we also were able to increase a considerable number of community services to serve literally thousands more Nebraskans by doing that shift. What I didn't notice in the second presentation on Child and Family Division about the reform efforts that they're going through is I did not see any dollar figures. I did not see any dollar figures which said, as we reduce the number of state wards, we are going to take the money that we are saving through not having to purchase services for those state wards and shift that into the communities to increase behavioral health services. I'm very concerned about that. The figure that we saw of a reduction of 1,000 state wards, based on my knowledge of the amount of services that are being provided at any given time, that's...we're talking about anywhere from $10 million to $15 million or plus of service savings right there alone for those state wards, and yet we have not heard that any of those dollars have been reinvested into the communities in any way to bring up behavioral health services for children and families. And, quite frankly, I did ask this question at one of the public hearings or the forums and, in fact, I even posed it to the thing of, based on the savings that will be dealt with from the reduction of state wards, will there have to be legislation introduced so that that money can be reappropriated from child welfare into the Behavioral Health Division so that those monies can be invested. I was told at that time that that would not be necessary to do that because we can just shift money from one place to another. That's concerning to me as well because that has not been my past experience. In fact, a number of years ago a collaboration was entered into by the regions with the Division of Child Welfare at that time to develop integrated care coordination units, or ICCUs. The intent of that was to not only provide services to families and state wards, but also was to try and prove that you could do that more efficiently. And in fact those ICCUs through the regions actually developed a over $6 million cost savings. Now what was...at that time when that was developed under the administration at that time the understanding was and the agreement was that any of those cost savings that occurred would be able to be

reinvested for development of behavioral health services for children. Under the current administration, however, two years ago, after numerous attempts by the regions to get approval to use that $6 million to start new behavioral health services for children, all of those requests were denied except in Region 3. In the Kearney area they did start an early intervention program with some of those dollars. However, two years ago we were involved that because the Legislature had appropriated those monies to child welfare, that in fact the behavioral health regions could not use that cost savings to develop those behavioral health services, which seems a contradiction to the earlier message I just said about the lack or the lack of need for legislative action. Subsequently, that $6 million dollars was reabsorbed into child welfare, which from my layman's opinion probably showed up as a budget savings in that and probably ended up in our Cash Reserves and, therefore, didn't go to help any children or families. And also the Region 3 early intervention program which was primarily focused on working with young children and families to prevent them from having to become state wards, they also had to quit that program because of that funding drawback. So I do have some concerns about that because I have yet to hear how the money saved by the reduction of state wards in the services, if or whether or not that's going to be reintroduced or reinvested into development community services for children and families. The third comment I have is, as I said earlier, we always have a tendency to invest in the ambulance at the bottom of the cliff rather than in the fence at the top, but I do want to let you know there are some programs out there that have already proven to be very effective in working with families and children with serious emotional disturbances. And I should point out that those children that go into those programs many times have higher risk scores than youth you actually find that are state wards in the juvenile justice system or in child welfare. For example, on a CAFAS score, 80 being a very high risk, these kids are going to be kicked out of school, out of their communities, out of their homes, the Professional Partner Programs which the regions administer, those children come in with CAFAS scores of around 80. In our ICCU program which works with state wards, those youth generally come in with an average of 50, so it's significantly...so the kids in the Professional Partner Programs are very high. These are all voluntary services

where the parents actually seek the support of the Professional Partner Programs and the goal is to help not only the kids stay in school, in their homes, in their communities, but also to keep them from becoming state wards. And these programs have been extremely effective over the last 13 years when they were first introduced in 1996 after a Governor's summit at that time. However, the problem is over the last 13 years those programs have not been expanded in any way. They've not received additional funding. I mean Region V alone, which constitutes the second largest region populationwise in the state, we only have the ability to serve at any given time, based on the original programs, 58 families at any given time, and so we're not really able to impact a lot of families at any given time. But those kind of programs are out there. I would ask that and really be looked at is as dollars are saved by not having to spend money on services for state wards, as they're being reduced, that that money is actually shifted into the development of behavioral health services and our communities so that our families and our children who need those kind of services, who don't have other forms of payment, have access to those. Not only will it continue to reduce our number of state wards, but it will have impact across the state. You won't have kids getting kicked out of schools. You'll decrease your juvenile justice involvement, and we've already heard today that the juvenile justice involvement or juvenile offender population has continued to go up in this state. I think it would have significant impact. And again, as I said earlier, it's not about increasing taxes, it's not about increasing funding. It's simply making sure that the money that is already appropriated to support children and families is simply reappropriated for a different purpose. So with that, I'll answer any questions. [LR363]

SENATOR JOHNSON: Yes, Senator Gay, go ahead. [LR363]

SENATOR GAY: Can you summarize how you came to $10 million to $15 million, how you came to that figure in savings? [LR363]

C.J. JOHNSON: Well, we operate the integrated care coordination unit, which is

working with state wards, and last year our service budget that we had set up for 300 families for that year, so it's 300 families at any given time, was $4 million. So within our budgeted amount that we had available was a $4 million budget for 300 families. So I just quick did the math. If you reduce state wards, you know, down to 1,000 families, then take 400 times that 300, you get $12 million, so that's where I came up with the figure of $10 million. [LR363]

SENATOR GAY: So it's a ball park, though, because there's probably some kind of...yeah, I can see your rationale. [LR363]

C.J. JOHNSON: Well, we...and we work, in the ICC, we work with families that were from child abuse/neglect, we worked with children that were involved in juvenile justice, we work with...so we had kind of a quite diverse grouping of state wards. So, yeah, it was kind of ball park figure, but I would say it's based on figures from the other ICCUs. [LR363]

SENATOR GAY: But we could ask. We could ask the same question, though, obviously, in saying how much would that save us, so...from our end. [LR363]

C.J. JOHNSON: Uh-huh. [LR363]

SENATOR GAY: I said you could make an estimate, but we could ask and find out exactly what that might be too. [LR363]

SENATOR JOHNSON: C.J., as always, very thoughtful. [LR363]

C.J. JOHNSON: Okay. Thank you. [LR363]

SENATOR JOHNSON: (Exhibit 4) Thank you. Why don't the next person come up, if you would, and while you're doing that I have a letter here from the March of Dimes

people and they specialize now in the birth defects and so on, but as I'm looking at it I had kind of smile across my face because I'm old enough to remember when this was for polio. And my wife, in fact, spent the night with one of her childhood girlfriends and the girlfriend woke up the next morning never to walk again, now in the last 60 years, because of polio. And so it's kind of nice that we do have some successes to see once in awhile. Thank you. [LR363]

SARAH HELVEY: That's great. Thank you. Good afternoon, Senator Johnson and members of the committee. My name is Sarah Helvey, H-e-l-v-e-y, and I'm an attorney and director of the child welfare program at Nebraska Appleseed, and I'm here to speak to this resolution with regard to foster care issues. And then I believe, following my testimony, my colleague, Erin Ching, C-h-i-n-g, who is here representing our low-income self-sufficiency program, may have a couple of comments with regard to economic assistance issues. So with that, I just want to...I actually want to begin by commending the department so, for the record, I'm looking to see if Todd's jaw has dropped. (Laugh) [LR363]

SENATOR JOHNSON: Watch out, Todd. (Laugh) [LR363]

SARAH HELVEY: It don't look like it is quite yet. But in all seriousness, you know, I guess I want to...I do want to commend them for what I think we have seen as a positive recognition now of some of the problems in the foster care system. For years we've been, you know, just simply trying to bring recognition to some of the shortcomings in the foster care system and I think we finally reached a point where the department is honestly acknowledging and talking about some of those shortcomings and really taking, by any measure, some pretty aggressive efforts at reform. Now we may disagree about what those reforms should be and what's the most effective way to structure them on behalf of children, but I think at least we found some common ground on the need to get serious about reform. And so I wanted to give credit to the department for that and also mention that I have really appreciated Todd Landry's openness in this process. I

think we've seen an important effort at transparency in the system and also a real effort to work with and receive input from advocates and community members, and I've been really pleased with that. We also share with the department and are pleased to see that they have, you know, are really focusing on reducing the number of state...children in out-of-home placement in Nebraska. And while again we may disagree with, you know, the details of how we're going about that, we share that goal with them and we're pleased to see that. I do want to offer just a few comments in terms of some issues that remain a focus or concern for Appleseed, and the first is just as the department implements existing...continues to implement existing contracts and considers additional contracts, I think we feel that we need to be careful that we're not simply shifting the burden to contracting agencies without providing the necessary resources to produce the kind of change and reform that is expected of them and is needed. And then we also reiterate concerns about oversight accountability and I think we were pleased to see that that's, you know, on the minds of both the committee and the department. I think you've heard those concerns repeatedly so as we move forward just want to keep that in everyone's mind, which seems that it is. Second, we have some...I guess some questions about a new policy of the department of funding treatment for parents in foster care cases, so by that I mean mental health treatment and substance abuse treatment primarily, almost exclusively through grants to private agencies through the regions, through the Division of Behavioral Health, rather than when necessary providing that through child welfare funding directly for court-ordered, again, treatment for parents in child welfare cases. And we believe this potentially creates a problem with the department's obligation to provide reasonable efforts, creates waiting lists for parents while kids wait in foster care, and really undermines efforts to get children returned safely to the home. Finally, we believe we need to look at existing gaps in our foster care system and behavioral health system which has been brought to light by this new safe haven law. I know there's going to be a hearing on that separately, but I just, you know, want to reiterate previous comments in terms of, you know, as Mr. Johnson said, there is more than 1 percent. Unmet behavioral health needs are an issue for almost all kids in the system and, you know, we need to, I think, have a real

commitment to look across systems--foster care, behavioral health--and even in our public benefits programs for some of those basic needs to create a system that meets the needs of all children and is adequately funded. So in conclusion again, I just want to, you know, say that we appreciate the department's willingness to recognize issues and work on our form, but we just urge the committee to, you know, to implement accountability into the process. I think we're really on the cusp of some pretty significant reforms, so it's, you know, time I think to take a really important look at that to ensure that the reforms will be successful, the most successful in improving the lives of children. [LR363]

SENATOR JOHNSON: Thank you. Any questions? Thank you very much. [LR363]

SARAH HELVEY: Thank you. [LR363]

SENATOR JOHNSON: Next, please. And good afternoon to you. [LR363]

ERIN CHING: Good afternoon, Senator Johnson, committee members. My name is Erin Ching, C-h-i-n-g, and I'm also a staff attorney at Nebraska Appleseed. I work in the low-income self-sufficiency department and I just have a few brief comments about ACCESSNebraska, which is the new on-line system for the financial assistance programs. I would also like to commend Director Landry and the department for making this new on-line application available. We think it's a great convenience for especially working recipients of public benefits. We do believe that it will make the department more efficient and save money and all of that is terrific. We're very happy about that. At the same time, we do have a few concerns, particularly as they go on to phase two and phase three of the ACCESSNebraska plans. Our first concern is the proposal to cut caseworkers. We've heard estimates of around 27 percent reduction of caseworkers, that's around 250, and our concern with that is the caseworkers are working at and above capacity right now. I believe they all have caseloads of over 100 families. They struggle to process paperwork on time. When clients call they can't always get a call

back promptly. And so to the extent that the on-line applications increase efficiency, we think that's great, but I'm worried that it won't increase efficiency enough to make up for this huge reduction in caseworkers that the department is proposing. I would also like to say that there's real value in experienced caseworkers so we hope that the call center will be staffed not just by state employees but by experienced income maintenance workers who understand these very complicated programs and how the rules work, rather than brand new employees. We have concerns for some of the special populations that are represented in the welfare population, and I know that the department is probably being thoughtful but we'd just like to list some of them out. Limited English proficiency people: I know right now that the on-line application is only in English. It sounds like they're proposing to offer it in Spanish and I think that's great. We're hoping that down the road there will be options for other language speakers as well. And the call center, my understanding is that that will be in English and I'm hoping there will be options for non-English speakers at the call center as well, particularly if the local offices are closing down and the call center and the on-line application are the only option for people applying for these programs, same with the physically and mentally disabled. Without the help of in-person caseworkers, it's going to be hard for certain people to use telephones and computers in order to access their benefits. And so we hope that there's accommodations made for the disabled community. Also, you know, there's some elderly rural folks who might not be comfortable using computers and call centers and so we hope that there will still remain an option for people who need it to be able to get in-person caseworker services as this plan moves forward. Finally, we have just a few picky legal detail concerns. We want to make sure that as community partners are starting to help people fill out applications, that they're getting some training on confidentiality, privacy, these kind of concerns. We want to make sure there's a clear answer as far as what the start date of an application is when it's submitted on-line. Is it the date that the person fills it in? Is it the date that the caseworker processes it? Because this affects people's due process rights. We're also wondering what happens when an incomplete application is submitted or when the computer crashes in the middle of an application being filled out. What are the rights of applicants in those

situations? So those are a few of our concerns but again over all we're very supportive of this plan. We're glad that the department is moving in a direction that increases access and efficiency, and I thank you all for your time. [LR363]

SENATOR JOHNSON: Thank you. Any questions? The reason you saw me smile when you talked about the computer crashing is ours did this past week and it cost a lot of money to replace it. [LR363]

ERIN CHING: Oh. Yeah. [LR363]

SENATOR JOHNSON: So anyhow, no, thank you very much for your comments. [LR363]

ERIN CHING: Right. [LR363]

SENATOR JOHNSON: Any questions? I see none, young lady. Thank you. Okay, anyone else? Okay. Thank you very much. Have a question? Oh. Well, let's move on. John, you ready, Division of Developmental Disabilities. And one of the things that, if I could, is again let's ask challenging questions and so on, but I would like this to become an overall discussion about the developmental disabilities field and not a discussion about the Beatrice situation. There is a separate committee that is spending hours and hours going into this and I think for us to have a brief meeting about that would not be very productive so I think we need to rely more on that committee for that particular thing. But fine to touch on it, but let's try and look at the whole field. John, welcome. [LR363]

JOHN WYVILL: Okay. Good afternoon, Chairman Johnson, members of the committee. My name is John Wyvill, W-y-v-i-l-l. I am the director of the Division of Developmental Disabilities. I'm responsible and accountable for the services of developmental disabilities in the state of Nebraska. And for your convenience, you have a PowerPoint

presentation that will be up on the screen, as well as a packet on your chart. The first thing that I would draw your attention to is the organization chart that we have for the Division of Developmental Disabilities and that will be the template for my discussions initially. If you look at the organizational chart, basically there's two components of developmental disability services in the state of Nebraska. Those are the community-based programs, which is under a new administrator named Tricia Mason. Those of you may recall Rene Ferdinand was the administrator and he took a job with Autism Center of Nebraska last year and we have did a national search and were able to recruit a individual named Ms. Mason to be service coordination. She came on board in September. Also in July of this last year...of this current year over 200 service coordination employees that were originally under Children and Family Services have been moved administratively under our direct command. They administer DD services in the community in the field. In addition, we have a program and planning and development unit which is commonly referred to as the central office or the Lincoln office. That falls under community-based services. On the right side of your organizational chart you will see two programs. One is the Bridges Program at Hastings, is under Ron Stegemann, the CEO. Since I've come on board, we've had several changes in staff at the facility. We have a new CEO, Ron Stegemann. We have a new medical director, Dr. Alfred Harrington. We have a new director of quality improvement, Angela Server. We have a new director of neighborhood services and we currently are actively doing a nationwide search for active treatment and we have someone in an acting capacity there. In addition, we have also have a new director of psychology and a...I think that's about it in terms of the changes. We've also changed organizational structure of the management at the facility. So from a year ago there have been several additional key members of the staff that now represent the face of developmental disability services in the state of Nebraska. Our plan at BSDC, as well at the agency, is very simple: skilled leadership in place, effective organizational structure, rightsizing BSDC, recruitment and retraining...recruitment and retention and training of staff, and successful community placement. In your next item, just for historical reference, you will see a census of the Beatrice State Developmental Center. That will give you kind of the

historical context of some of the challenges that are being faced at BSDC, as well as DD services as a whole. You will see that historically based on the records that we have. Way back in 1975, there were over 1,000 residents at the facility, and there's an attorney from Nebraska Advocacy Services named Bruce Mason that's still around that was part of/instrumental in an agreement I think called the Havelock v. Exon (phonetic) case, which helped get some people into the community and you'll see for several years that the population of the facility reduced till about 1982-83, and then it became constant for several years before the announcement of our rightsizing initiative in BSDC in December of last year. And as a point of reference, in October of...October of last year, October 1, I think census was around 332. Now today I think census is at 253. So you can see where that goes. On the next item on the page, corresponding, is just as an information item you will see community-based program for developmental disabilities, the number of people served. Going back to 1996 up to 2007-2008 you can see the gradual increase in the number of individuals being served in the community setting. In the next chart that you will have on that is just a basic thumbnail sketch of our budget for the Division of Developmental Disabilities. We will see funding sources from the federal government and the state, and that outlines...it's outlined roughly $94 million in General money and then you can see a combined total of $236,993.44 number up there, which represents overall at BSDC as well as community-based services. Giving you a big picture view of our strategic plan or the 25,000-foot view of our strategic plan in Division for Developmental Disabilities for the state of Nebraska in the future, obviously, BSDC will retain a vital role in serving people with developmental disabilities in Nebraska. We are working very hard to establish a more effective community-based delivery system. We are obviously always improving and looking at ways to more effectively and efficiently deliver services to our customers, and rightsizing BSDC to improve the level of services and worker/client ratios by transitioning some clients into the appropriate community-based services setting. Our priorities are fairly simply in Developmental Disabilities. We are continuing to rightsize the BSDC, we are facilitating the creation and improvement of community-based services, and successfully resolve uncertainties about federal funding with CMS as it relates to the facility. In terms of

progress in Developmental Disability Services, we have in July reached an agreement with the Department of Justice regarding the facility and that agreement is our working relationship with the Department of Justice as an independent expert on site that is assisting us. And, as you know from the press announcement from the Department of Justice, they have been very complimentary to our efforts and our commitment to making the changes necessary at the facility. We are making significant improvements in systems and processes for clients' protection at BSDC through enhanced quality oversight. We are moving in a new direction at BSDC by rightsizing, serving fewer people, through placement in community-based services, and we are working with local community to increase community access and involvement by BSDC clients. We have refined the community-based developmental disability services quality improvement plan to include 100 percent monitoring by service coordination and provider agencies monitored by the DHHS community-based services unit. We've had a 12.9 percent growth in community-based services without corresponding growth at BSDC from 2003 to 2008 through increased utilization of federal funds. And we have implemented a fifth Medicaid waiver choice, the community service waiver, a self-directed approach to serve delivery. The challenges in front of us in DD are fairly straightforward: Implementing the agreement with Department of Justice as it relates to BSDC, creating and improving community-based services, delivering quality services that address the behavioral needs of people served, and recruiting and retaining staff at BSDC. And that concludes my formal remarks and presentation and willing and able to answer any questions from members of the committee. [LR363]

SENATOR JOHNSON: Thank you, John. Senator Stuthman. [LR363]

SENATOR STUTHMAN: Thank you, Senator Johnson. John, you just stated, you know, you're trying to create and improve community-based services. Can you tell me a little bit about what is your intention on these community-based services? Is that private services or those services that are initiated by HHS? [LR363]

SENATOR JOHNSON: I kind of like your question, Arnie. If you would kind of expand on that a little bit of the different kind of services and so on that... [LR363]

JOHN WYVILL: Well, I've been working with a senator on another committee and I know exactly, I think, what he's driving at. Senator, that's a very good question. The community-based services that can be provided, I think there's about...there's multiple providers in a community that provide services in a residential setting. They can either provide services in a home, habilitation day services. And those are services that were either certified and licensed by the department, and that certification process goes through Developmental Disabilities and then through Public Health so that they can be certified and licensed. So we also, in part of that process, and there's several different levels here, for oversight for enhancing services, we can enhance it from a variety of different ways in our role in certification reviews: how our staff goes out and provides certification reviews of providers. The second way that we can do oversight is we do oversight and enhancement by our terms and conditions of the contract with each of those providers. I think I want to say it's 35 providers that have contracts with us and we monitor the relationship, so basically very similar to what you hard about in the other hearing about CMS, what condition to participation. In order to be a provider to us, there are certain conditions that they must meet, so that's another way that we work. In addition, we also have what's called critical incident reports. Critical incident reports are a mandated reporting requirement by providers. If they have an incident, they must report that to us within 24 hours and then follow up, in addition to any reporting requirement they might do to adult protective services or to the local law enforcement officials. And then we determine whether or not we investigate that and then follow up on it. And then it could be in terms of monitoring for quality assurance to make sure they're delivering what they're supposed to be doing; are they being accountable for the money, similar to the challenges of Autism Center. So those are a variety of different ways that we do that and we are always looking for ways to enhance that responsibility and, in fact, there's probably been some providers complaining that were even making it more difficult for them by enhanced contract oversight and our certification. But our

ultimate goal is the accountability, protection, and security of our clients that are entrusted in our care for services. So that's how we do enhance that. We continue to raise the bar in terms of our expectations for delivery of services. [LR363]

SENATOR STUTHMAN: And these are individuals or groups or private entities that contract with you to do the service... [LR363]

JOHN WYVILL: Yeah. [LR363]

SENATOR STUTHMAN: ...and do the day-to-day operations... [LR363]

JOHN WYVILL: That's correct. [LR363]

SENATOR STUTHMAN: ...for the developmental disabilities or whatever. And what you're doing then is just the oversight of it, of the contracted service. [LR363]

JOHN WYVILL: Yeah, contracted services and the certification of their license. [LR363]

SENATOR STUTHMAN: And the... [LR363]

JOHN WYVILL: Also Public Health, a separate division, also investigates them in a case of any potential abuse or neglect claims, or things that warrant them to go in, in addition to adult protective services or, if appropriate, children and...CPS, children protective services, too. [LR363]

SENATOR STUTHMAN: Are there a number of agencies that contract for services or are there agencies that contract and do it in a lot of different communities? [LR363]

JOHN WYVILL: We have several providers, for example, Mosaic, may be in several different settings and they may, for example, Mosaic may have...and I think they have

three ICF/MR facilities throughout the state in addition to other settings in which services may be delivered. Then we also have like you've heard Mr. Stormbecker (phonetic) testify from DSN, which is I think Disability Services Network. They have several different areas what they provide. They may have a group home or they may have a day service that they provide at a specific location. It varies throughout the state and through their roles we exercise our oversight by either contract management or by certification reviews, which we come in and do certification, and also we do quality reviews in which a private entity goes in and does a quality review and provide us with those reports. [LR363]

SENATOR STUTHMAN: Are there enough contract services to provide all the need for community-based or should there be more contract services available? [LR363]

JOHN WYVILL: We are working...we are working with several providers to expand capacity specifically for BSDC for those for community placement out there and, as we heard as always, is that it's either the service can be provided by an existing provider or they can go through a certification process and start anew and providing services with developmental disabilities is a very challenging environment and sometimes may not be conducive for a start-up company unless you have a situation which we have seen, is that individuals have worked for another provider and have said, we want to be our own boss, and then spin off and do their own thing. [LR363]

SENATOR STUTHMAN: Thank you. [LR363]

SENATOR JOHNSON: I would presume that the more challenging clients would be the toughest ones to provide the noninstitutional or community-based services. Is that correct or am I wrong? [LR363]

JOHN WYVILL: The most...there are several different challenges, Senator. [LR363]

SENATOR JOHNSON: Okay. If you would. [LR363]

JOHN WYVILL: There's a challenge, for example, for behavioral, the clients that have behavioral issues, and that might require different supervision levels and that can be a challenge in and of itself because we may have an individual that may be fine 360 days out of a year and then some environmental situation or something may trigger an episode that creates a challenge for the community provider and that can be very challenging on the individual. In addition, we also have those that may have some physical limitations or challenges in terms of proper feeding or proper care to make sure that they may not have pressure sores or other things. So it just depends on the...just depends on the individual, but those are very challenging. And then especially with the behavioral episodes with a provider, as we've heard in the other committee, that becomes a challenge and that sometimes can be very challenging on the staff in how they wrestle with dealing with that, wrestling with providing appropriate care while respecting the rights and dignities of those individuals. [LR363]

SENATOR JOHNSON: Thank you. Senator Gay. [LR363]

SENATOR GAY: Thanks. John, when you talking community-based services, earlier Helen was talking about regulation and licensure. Is that who... [LR363]

JOHN WYVILL: Yeah. [LR363]

SENATOR GAY: ...and her division. Are they the ones checking up on the contractors when we go out and we say... [LR363]

JOHN WYVILL: Okay. [LR363]

SENATOR GAY: ...(inaudible) community-based services? And we...and you said you follow up on them and make sure they're doing things correctly. How many people do

that? How many people are actively out making sure they're providing the services you want under the contract? [LR363]

JOHN WYVILL: Okay. [LR363]

SENATOR GAY: Inspectors I guess is (inaudible). [LR363]

JOHN WYVILL: I don't know the answer for Helen Meeks's group in Public Health but we can get that to you. But I do know who does it on our side. We have over 200 service coordinators throughout the state that have a caseload so some of the things that we do is we can do monitoring of individual clients. Just as a hypothetical, we had a provider that we were concerned about being maintained as an ongoing concern, so then we direct the service coordinators to monitor. They monitor individually and visit the clients to make sure that they're safe and they're being appropriately cared for while we were working with that provider so that we have...at a moment's notice, we can direct, based on information we receive, to have service coordination go into that home, into that provider, and is that is what would result in a contract. In addition, we also have our staff in the community-based unit up here can do either the certification reviews or anything else and they do their reviews also very similar role of a...of similar to CMS. So when you hear the providers talk, they think that they're being regulated quite fine, if you ask any one of them, but the issue is that we have service coordination that can visit with them and they work very closely with our Lincoln office and they can also monitor that. And then if there's some systems issues, that we can also start looking at them and see if we can...have to put them on probation and then they have to deliver specific items out of probation. For example, if it's a fiscal issue, there are certain things that we may have to do because that might be symptomatic of a bigger problem. If the bigger problem is they're having sloppy records, they may also have sloppy care in terms of that, and that's a very big concern for us, or just maybe a specific care issue, for example, a critical incident that comes to our attention or something that comes to our attention and we contact the provider and say what are you doing to address that. For

example, just as a hypothetical, someone can anonymously bring to our attention, you know, for example, everyone is on drugs at the living unit, you know? So if we get something like that, we obviously have to check it out, as well they go through adult protective services, and then we come to the providers (inaudible) and say, we've got this allegation, what are you doing about it, what are you doing, give us, you know, your response. And engaging on they may say, yeah, we heard that, here's what we did, here's what we've done. And then we might be satisfied. If not, then we start asking some more questions. And if there's more concerns then say, well, we're going to have to have a talk with you, and then we have to make determinations as to whether or not to terminate their contract, look for better places for our clients and things like that. So it just depends. It can change on a moment's notice, but we have several different layers that are in place to help address specific issues as they come up. [LR363]

SENATOR GAY: Okay. And then you talked about 200 service workers. How many cases is average for one of those workers? [LR363]

JOHN WYVILL: I have to get that precise number but I want to say it's a small number. But I can get that number to you. [LR363]

SENATOR GAY: Okay. It would be interesting to know of. And then also compare that to what the average caseload is around the country of other people doing this too. I always think, you know, sometimes these caseloads get out of control. I've got another question as well then. So I feel more confident about that. But then when we're looking...sounds like your department is looking to do what others are, to start outsourcing some of these duties, and then being the contractor and monitoring. We do a lot of that. But can you talk a little bit about the waiting list and kind of just in general? I think that's something that will be coming up that, you know, we need to discuss it. Your view of the waiting list, just give us...talk about the waiting list, I guess. I didn't hear anything about that. [LR363]

JOHN WYVILL: Okay. There are, in terms of individuals, they come to a service coordinator, they come to our agency asking for assistance because they may have a family member that has a developmental disability, and the first thing that they have to do is determine whether or not they're eligible for services. And if they're eligible for services, the next determination is whether or not they are a priority one, which is set forth in state law. Priority one means that if they're in danger, immediate danger of health, safety, welfare. If that is the case, we provide the appropriate services to that individual right now. If not, they sort of...they get in line with...and based on a time of their date of need, and then they're in line waiting for services for that, and that list is continually ongoing and changing. So some individuals on the waiting list are there for a period of time before their services are up unless there's an evaluation or an incident that creates a...creates a need for them to move up, and that underscores the challenge in developmental disabilities. It's sort of the other issues about how do we equitably distribute the appropriate amount of services to make sure our most vulnerable are being served, and that's what we do with our priority one funding, and then we serve the other individuals and then we go from there. [LR363]

SENATOR PANKONIN: So, John, understanding that that number changes and that those people can have different levels of needs and whatever, what approximately is that number, the waiting list? [LR363]

JOHN WYVILL: Senator, I have had that number and I...last Friday I had that number on the top of my head when I was in front of the other committee, and I can get that to you. I can give you the precise number. I have that. [LR363]

SENATOR PANKONIN: Okay. [LR363]

JOHN WYVILL: And I can just give you the copy of what I've shared with the Special Investigative Committee. [LR363]

SENATOR JOHNSON: Glad you can't remember things, too, John. (Laugh) I worry about myself sometimes. Any other questions? John, thank you very much and have a good day. [LR363]

JOHN WYVILL: Okay, thank you. Thank you for your time. [LR363]

SENATOR JOHNSON: And, Chris, do you want to go next or do you want to finish up the day? [LR363]

CHRIS PETERSON: If there are no comments. [LR363]

SENATOR GAY: Any public comments? [LR363]

SENATOR PANKONIN: Is there any other comments? [LR363]

SENATOR JOHNSON: Let's have a few comments and then let you finish. Would that be all right? [LR363]

CHRIS PETERSON: Okay. Great. [LR363]

SENATOR JOHNSON: Do we have anybody that would like to comment here today? Hey, there she comes. Great. [LR363]

MARY ANGUS: You are surprised to see me, I'm sure. [LR363]

SENATOR JOHNSON: No, we're glad to have you. [LR363]

MARY ANGUS: I brought up my computer. I hope you'll indulge me because I believe I have the numbers that you were giving us last week, so I would like to see if I can find that briefly for you, maybe after I've gone back. My name is Mary Angus, A-n-g-u-s, just

like the cow, and I'm the registered lobbyist for the Arc of Nebraska. The Arc of Nebraska is a support and advocacy organization for and with people with developmental disabilities, and it's affiliated with the Arc of the United States. I'm going to make sure that I don't get too much into the other committees. I represent the Arc also on the LR156, which is the wait list, and have testified in front of the investigatory committee. Those things are being done as we speak and I'll let that mostly be... [LR363]

SENATOR JOHNSON: Great. Thank you. [LR363]

MARY ANGUS: ...left to that. Mainly, a lot of my comments have to go to the fact that I believe we need and the Arc believes we need a unified system. [LR363]

SENATOR JOHNSON: Say again, please. [LR363]

MARY ANGUS: We need a unified system. What we've been hearing about is a variety of issues, such as the Medicaid, how that would fit in with developmental disabilities. We agree wholeheartedly with the Appleseed and their statements that people with disabilities in general and people with mobility impairments, language problems maybe aren't able to use the computers, would be definitely at a disadvantage. Currently, if you have a disability and you're up for a review, the caseworker actually can come to your home to facilitate that. Obviously, having call centers across the state and reducing it to three, rather than having local offices, would not allow that to happen. Additionally, people with disabilities--and we have amongst the developmental disability population we have people with mental illness, we have people with cerebral palsy, we also have people with a variety of issues, autism and other issues--many of them would be unable to complete an application on-line. Many of them would find it such a daunting task that they may not even finish. Many would not even try. We heard about Florida's use of the electronic eligibility review. I spoke approximately a year ago with one of their administrators in behavioral health and she said that it has been devastating to people

with disabilities, in particular those with mental health. That's the division she's in charge of. And so I would ask you to look further into what's going on in Florida before you, you know, take that into consideration. Going on from there, I would like to add that we've got the LR156 resolution on the waiting list, we've had Building Better Futures, we've had so many different plans and recommendations made over the years that have not been implemented, and the work of this committee and the work of the LR156 wait list work group, the work of the investigatory committee really relies on your ability and willingness to advocate for implementation of many of the recommendations which are going to many times be very similar, if not identical, to recommendations that have been made over at least the last ten years. What has been happening is those recommendations haven't been implemented and, therefore, the Legislature and the state are wasting money on those committees and task forces. We also have a little bit of a concern about continuing the oversight by the Legislature over HHS in general, and the Developmental Disabilities Division also. We see that there is, under Beatrice State Developmental Center, there is going to be federal oversight on the federal courts for the next five years, however, across the board we don't have that legislative oversight at this point, at least not to the extent that we feel would be necessary. I would respectfully submit that the division has not been able to show that it's able to do adequate oversight of either community-based or institutional-based services, as has been shown by some of the problems they've had with community services and with Beatrice and being unable to match the requirements under Medicaid for participation. The provider profiles, which are one of the ways that they will provide a look at how the community-based services are being carried out, the kind of quality there being carried out--I believe, Director, you mentioned that--is not necessarily looking at enough of the facilities. In the past, there have been a lot more people going out into the field and checking out a lot more of the service providers then is currently done, and it has been done by an independent group of people. In our case, at least part of that time, it was done by the Arc of Nebraska. And I'm not saying that we have a vested interest, but the fact of the matter was it was independent. And now going in-house, it is similar to the fox watching the chicken house. The communication issue was raised yesterday in

terms of how you're going to get updates, either on the MMIS or whatever particular area that you're looking at, and I would really recommend highly--and this is going to be recommended, I'm certain, by the other committees--that you maintain and produce a process for regular and open communication with the department and with the division, and that would include regular updates for you. I hate to add more work to this committee and to the Legislature, but our constituents trust the senate. We...our constituents trust the Legislature. And it is not that we don't trust Director Wyvill. It is not that we don't trust Ms. Peterson. (Laugh) She's smiling at me back here. She's going, oh yeah, right. It is that our constituents have faith in the people that they have elected to serve them in this Legislature. That really completes what I wanted to add. I think that unified system, looking at the way Medicaid is cutting funds, cutting services, is going to be really important to improving community services and rightsizing at BSDC. I'd be glad to answer any questions as to my best knowledge. [LR363]

SENATOR JOHNSON: Any questions around the table? [LR363]

MARY ANGUS: And I will go back to my seat and check on the number on the wait list for you so that you don't have to watch me check in my computer. [LR363]

SENATOR JOHNSON: Okay. The...let me ask you one question because, you know, I like people that come up and don't just give pat answers how everything is just great and all that. The people that come up with constructive criticisms are the ones I listen to, frankly. But let me ask you this, over all. [LR363]

MARY ANGUS: Uh-huh. [LR363]

SENATOR JOHNSON: Now we've been with the reorganization of HHS for about 16 months or so. [LR363]

MARY ANGUS: Uh-huh. [LR363]

SENATOR JOHNSON: Are we headed in the right direction from a administrative standpoint, in your opinion? Have we made progress? [LR363]

MARY ANGUS: In my opinion, I don't know that it has changed dramatically for in the field and the service provision as much. When I'm talking about a unified system, I'm talking about one that is easily working between behavioral health and developmental disabilities and children's services, the various divisions. Part of that, obviously, from what we've heard earlier, has been based on some federal ways that they dispense the money. However, it has been in the past and I believe it continues to be the case that it's difficult to integrate those services. I know that the Division of Behavioral Health is working on ways to provide better services for people with developmental disabilities. There are particular challenges to working with people with developmental disabilities. As a former therapist who worked with abused and then called handicapped children, it is difficult to make sure that you're using an approach that is more appropriate to the way that particular person understands the world. It's that way for everybody but even more so with folks with developmental disabilities. So I think that having a unified system and being aware of the impact of changes to Medicaid of various other programs--for instance, the money follows a person, which Director Wyvill has been using to help rightsize--that really has a very strong impact on our ability to serve people in the community well and if at all. So does that answer your question? [LR363]

SENATOR JOHNSON: I'm not... [LR363]

MARY ANGUS: My question is...my answer, I guess, is I really don't know. [LR363]

SENATOR JOHNSON: Okay. [LR363]

MARY ANGUS: But I'd like to see it more unified. [LR363]

SENATOR JOHNSON: Well, in...you know, like you say, we've only been at it for 16 months and so on as well,... [LR363]

MARY ANGUS: Uh-huh. Yeah. [LR363]

SENATOR JOHNSON: ...which isn't a very long period of time. [LR363]

MARY ANGUS: Yes, sir. [LR363]

SENATOR JOHNSON: And the gentleman who was here yesterday had...who had been a former legislator, 10-15 years ago, when the last change had stopped short of where we're at, thought that it would make a significant difference. So I was curious from your standpoint whether you had been able to see the improvement that he saw at this time. [LR363]

MARY ANGUS: Well, I think that this last reorganization was part of that long-term plan that began... [LR363]

SENATOR JOHNSON: Yeah. [LR363]

MARY ANGUS: ...that far back and so we're on that track. I'm not sure it's going to be able... [LR363]

SENATOR JOHNSON: Yeah, but this gentleman had been there for both. [LR363]

MARY ANGUS: Yes. (Laugh) [LR363]

SENATOR JOHNSON: And that's why I ask if, you know, from a practical standpoint, if you had been seeing this yet. [LR363]

MARY ANGUS: I guess one of the ways we've described it in different trainings is that it's...one of the women that was doing the training is from a ranch in the western part of the state and she said it's like the cattle chutes. You know, you get up one chute, which would be developmental disability services, and if you really need some over here--I think it may be less that way right now with the reorganization--but you got to back everybody up and then go back in this chute. So it's been really difficult to integrate those services, at least in practice. [LR363]

SENATOR JOHNSON: Yeah. All right. Any questions around the table? Thank you very much. [LR363]

MARY ANGUS: I appreciate your...I appreciate both the immense job that these folks have to do with regards to the DD services and your willingness to be so involved in the whole process. So thank you. [LR363]

SENATOR JOHNSON: Okay. Thank you. Anyone else? Saw the former committee Chair sitting out there and I thought he might get up and have something to say, but I guess not, so, Chris. [LR363]

CHRIS PETERSON: Okay. Thank you, senators. Senator Johnson and members of the HHS Committee, thank you very much for this opportunity to give you information about the Department of Health and Human Services. In, I think it was, August 20 of 2006, I took over as the director of services, and in September both the Thomas Fitzgerald and BSDC failed their surveys. In December, Dick Nelson left, and from January through I think March, Dr. Schaefer and I split up the agency and basically did crisis management. I daily gave thanks to the staff that we had because it's a huge, complex organization, just as you've heard just a small little bit of what we do today. I want to thank you for working with us and the administration on LB296 because I think you have seen over the last day and a half the expertise that we've been able to bring in, and I'm very, very proud of the directors that we have. We are large. We're 35 percent of the

General Fund total of the state budget. And we have a lot of energy. I think there's a new attitude, definitely from our part, and certainly a willingness and an openness to look at things. If you listen today, I picked up on ten themes I think that we had. Number one is we are focusing on the goals of the reorganization: accountability, accessibility, transparency, and clarity. We need to work smarter and we need to make sure that we work in conjunction with everybody else. The second is we have a role and a responsibility of the quality of care that we provide, and of the safety of our clients, and that always has to come first, the quality of care and the safety of those that we take care of. Third, I would say that the challenges of our work force, there is no getting around the fact that we're having a hard time hiring. We're having a hard time hiring, we're having a hard time retaining. We have people come to us. They apply. We can't keep them, for a variety of reasons, and it takes a whole network of things to change that--"mentoringship" looking with, as J. Rock talked about, people that have been in that situation helping you get through the day; changing our overtime hours so that the mandatory is not something that keeps people from applying; getting weekends off; training; getting to go to conferences. All of those are things that we are implementing to try to work through our overtime and staffing issues, as well as looking at the culture. We want people to be proud they work for state government. Obviously, collaboration, communication, and partnerships are critical to this. You all touched upon the uniqueness of the public-private partnerships that we're starting to see now. I think the autism waiver is another example of that where we saw where the public was able to come up, along with the private, and create a new service. One of the other things that you heard about also is that we're looking at systems of care now, building networks so that we're not piecemealing things here and there. Todd's examples of in-home and out-of-home where the contractor is responsible for the whole line of services instead of a caseworker calling here and there, trying to get at different things. Coordination is critical because you don't want our clients to have to jump through a lot of hoops to keep the same provider. And then you've also seen a difference in how we're looking at providing those services: in-home opposed to out-of-home, community-based as opposed to institutional, low in-services opposed to higher in-services. Those are huge

shifts in how we've done our work over the last several years. We also looked, and I think Senator Stuthman brought this up several times, at prevention. This is building that net at the top of the waterfall instead of the ambulance at the bottom. Dr. Schaefer, especially, in Public Health has a lot. That's where their...their focus is on prevention so that we don't have these downstream incidences. Obviously, we have to do much more in contract oversight. That's been pointed out over and over again that we do not do well at that, and I think it's a concern that we've heard from both providers, clients, residents, ourselves. And when we move to the community-based services, what's out there to monitor, and then who's going to monitor the monitors? We need always those checks and balances to make sure that we don't find ourselves again at BSDC or Thomas Fitzgerald or any of the other times we've had bad experiences. The ninth one I would say is the funding. When you talk about Medicaid working with Behavioral Health, working with Children and Family Services, that funding is very specific in what it will pay for. And when you talk about braiding, that's exactly what we have to do. We have to make sure that the services that we provide are ones that will be funded either through the DD dollars or Medicaid dollars or just the General Fund dollars, and that is...that's a dance and we're not as good at it as we can be but we'll get better at it. And then finally what I would say the last thing is, we want to be able to sustain our programs for our most vulnerable citizens. We need to have a responsibility, a fiscal responsibility, to make sure that we are using efficiencies, not just expansion, what should the state's role be and how deep does the state get involved in the daily lives of citizens. And so that is a constant policy discussion more into your laps than mine, but I want to assure you that our role is that we will...the dollars that we are entrusted with and the relationships that we have with the people we serve, we will continue to hold ourselves accountable for those and hopefully do a much better job in the future. But thank you for your support. [LR363]

SENATOR JOHNSON: Yeah, Tom. [LR363]

SENATOR HANSEN: Thank you. Thank you for your patience the last couple of days,

too, so... [LR363]

CHRIS PETERSON: Oh, we've...this has been a pleasure. [LR363]

SENATOR HANSEN: This has been very good. There were some pages that you didn't go over in your part of the book... [LR363]

CHRIS PETERSON: Yes. [LR363]

SENATOR HANSEN: ...and we really appreciate, this committee, really appreciates going over the programs, but there was some questions brought up earlier about cost savings and where those cost savings are to be redistributed. Would you care to address that? [LR363]

CHRIS PETERSON: The one specifically that C.J. brought up which has to do with where the dollars, as we move state wards out into the community, where those dollars are going. Right now, I think somebody else brought up the issue of the caseloads. What we're looking at is we're not moving the money out right now. What we're doing is reducing the caseloads. So it's kind of a balancing act. In terms of when we get down the additional 500 state wards or another 1,000, let me get back to you on that, Senator, because that one I wasn't prepared for. [LR363]

SENATOR HANSEN: It was...I think it was percentage anyway from 129 percent to 103. I don't know, maybe there wasn't a percentage there. I think that was Scot that was talking about that this morning,... [LR363]

CHRIS PETERSON: A 129 percent down to 103. [LR363]

SENATOR HANSEN: ...caseload reductions, and he was talking about being front-loaded rather than...rather than the way it was now. So... [LR363]

CHRIS PETERSON: Let me find out on that one. Yeah. I do know that we have two...we rank caseload size on two different things and the goal is to get closer to the national than the CWLA one. [LR363]

SENATOR HANSEN: And that may have been what the percentages were. My question for that was what about the guardian ad litems? Is that trend...it has to be the same for them, too, that their caseloads are less and we expect more better work. [LR363]

CHRIS PETERSON: Foster Care Review Board, yeah, same thing with the guardian ad litems, the CASA workers, the county attorneys' roles, everybody, including the time on the dockets for the judges, when you have a reduction in even just one case. I don't know if any of you have ever seen a case file because it's all paperwork. It's huge. So there's a tremendous amount of savings, not only in time and people, but just in paper. So I'm sure there is something out there. CASAs would be...have more time with their clients, guardian ad litems definitely would, all of those. Whenever the system decreases somewhere, it opens up time somewhere else. So what I don't have is the dollars that that is going to free up or if we have a plan for where those dollars go. That one I just wasn't ready for. [LR363]

SENATOR HANSEN: Yeah. Thank you. [LR363]

CHRIS PETERSON: Uh-huh. [LR363]

SENATOR JOHNSON: Arnie. [LR363]

SENATOR STUTHMAN: Thank you, Senator Johnson. Chris, first of all, I want to thank you for everything that you've done for this program so far. [LR363]

CHRIS PETERSON: Thank you. [LR363]

SENATOR STUTHMAN: The question that I had is when you contract out for services and go to community-based. Do these individuals or clients, do they still have a caseworker... [LR363]

CHRIS PETERSON: Uh-huh. [LR363]

SENATOR STUTHMAN: ...that works with them, or does that reduce the load of caseworker when you contract out for service? [LR363]

CHRIS PETERSON: You know, there's a couple of different programs and it works different ways. Back, I believe, in the early nineties, there used to be developmentally disabled regions across the system similar to the mental health regions now, and at that time there was the Developmentally Disabled Act which made the regions into providers and then the state, in essence, picked up the community-based services. So we do not provide and never have provided services. We've always contracted with providers for the community-based services. In the regions, the mental health regions, for some time the regions themselves not only did the network but they also provided some of the services. I think there's only one now, one or two regions that still do that. For the most part, the state has not provided the services for the developmentally disabled. Those have been community services that have...we've had longstanding relationships with community providers for the developmentally disabled. We provide the service for the state-run ICF/MR, which is the institution. In the behavioral health, it's similar to that. We've always had the regional centers and then we worked with the regions themselves to funnel the money out into the community and then they create those systems of care. In behavioral health there could be a community support worker or the region will have someone that follows them through. In the developmentally disabled, one of the things...and I know you're all aware of this, but services for the developmentally disabled are not an entitlement as Medicaid is. One thing that is, is everyone who qualifies to be a DD...to be DD eligible also has access to a service coordinator to help

them find services, kind of case management. And so they will have a service coordinator if they request it, DD does. Behavioral health again works with the regions. If you are a state ward, you have a caseworker. So out of the three: state wards have caseworkers; developmentally disabled have a service coordinator; behavioral health works with the region, they might have a community support worker; and those...and then Medicaid, they do not have. They are people who go to their provider themselves. They don't have a caseworker helping them with case management. [LR363]

SENATOR STUTHMAN: Okay. Thank you. [LR363]

CHRIS PETERSON: Uh-huh. [LR363]

SENATOR JOHNSON: Any other questions or comments around the table? [LR363]

SENATOR GAY: Joel, I've got just one. [LR363]

SENATOR JOHNSON: Yes, go right ahead. [LR363]

SENATOR GAY: Chris, to follow up on Tom's, that struck my interest, too, on the savings, what we're going to do with it. Are you going to get back to us then on that? [LR363]

CHRIS PETERSON: Oh, and I'm just blanking right now on it to tell you the truth. [LR363]

SENATOR GAY: No. Yeah, that's fine. But I'm kind of interested in that. I look at that on ACCESSNebraska and some of these other programs that are I think good programs and need to be implemented, and they will be correctly and we'll correct some of these issues we hear. But I guess on some of those savings, I mean it's not...it's redirecting what we're doing. I mean it's...and I know you've got to watch your budget, executive

branch does, and so does the Legislature want to do that, but it is important, I think, we kind of look at where we can maybe redirect those funds. But the question that the gentleman asked, Mr. Johnson, is, is that a legislative...do we have any say in that, or do you have a say in that, or is that through the budget, or how is that done? [LR363]

CHRIS PETERSON: Senator, you have a say in just anything you want to have a say in. (Laugh) [LR363]

SENATOR GAY: Well, I know you had to say that. But I'm just saying, well, then do we? [LR363]

CHRIS PETERSON: You know, I am sure that... [LR363]

SENATOR GAY: Because in the budget, how do we know that those dollars would be redirected, and maybe they wouldn't, instead of just going into the General Fund? [LR363]

CHRIS PETERSON: Uh-huh. And what I would say right now is in ACCESSNebraska we're showing a reduction in those dollars, and when I walked you through the budget, and you have it under...behind my chief executive officer, there's the budget request there, the savings that we will have in ACCESSNebraska are what we are using in the upcoming biennium to keep our costs at a 2 percent increase overall. What I don't...I can't tell you right now is if Todd figured that into his budget already and the reductions are showing up in less of an increase request. That's what I'm not... [LR363]

SENATOR GAY: Okay, but we could... [LR363]

CHRIS PETERSON: ...that's what I'm not sure about. [LR363]

SENATOR GAY: Well, and we can visit with Bob on that as well then. [LR363]

CHRIS PETERSON: Absolutely. [LR363]

SENATOR GAY: Okay. [LR363]

CHRIS PETERSON: If the reduction in state wards has been taken into account in Todd's budget, I just don't have that detail in front of me right now. But for the most part, the cuts that we made were to allow us to fund the increases without having to ask for a larger increase above the CPI. [LR363]

SENATOR GAY: Same case with Vivianne, the savings... [LR363]

CHRIS PETERSON: Right. [LR363]

SENATOR GAY: ...that she's proposing. [LR363]

CHRIS PETERSON: Right. That's what the savings do, is they allow that...I think it was a .001 in the first year and then a 2.2 total increase in the second year. And again, when you look at us that are 35 percent of the General Fund total budget in appropriations, as well as what I know you read on the front page of the paper about Medicaid being in crisis, this department needs to make sure that the quality of the services that we are provide are there, as well as to maintain their sustainability for the people that need them most. I will get back to you, if not today, by tomorrow, on where the dollars are through the reduction of state wards. [LR363]

SENATOR GAY: You could wait till Monday, I suppose. (Laughter) [LR363]

CHRIS PETERSON: I'll wait till Monday. [LR363]

SENATOR JOHNSON: Call him tomorrow. (Laughter) [LR363]

CHRIS PETERSON: I'll call him tomorrow. I have your cell phone, I think. (Laugh) [LR363]

SENATOR JOHNSON: Dave. [LR363]

SENATOR PANKONIN: Thanks, Senator Johnson. Chris, I just want to thank you and your staff for the time you spent getting ready for this and I think it was, for those of us that hopefully will be back on the committee, a good...you know, this two years I've really picked up a lot of knowledge from not being involved in this endeavor before, but it was a good tune-up for us, I think a good perspective. And I guess the comment one of you made was we want to provide people with services that truly deserve them, need them, don't have any other avenues. But we all know there's a lot of Nebraskans out there who, from a DD standpoint, John, take care of that child as long as they can and maybe when they're not healthy or they're gone they can't. And there's a lot of people with children or an aunt or whatever with behavioral health issues that they're doing the best they can. And so I think we always want to keep those folks in mind, be thankful for them, what they're doing, and also provide as much information and help we can. Maybe it's not direct assistance but just where do they go. And I know there's, you know, Web sites and whatever, but I think that's another thing that we just got to be thinking about because it keeps them from coming in the system. There's a lot of people that will take care of these things themselves if they can and they need help sometimes, just where do they go. [LR363]

CHRIS PETERSON: I think that's an excellent point. One of the things that I have found in the year or so that we've done this, we have better ways of doing things than we're doing them now, and we have found some specific efficiencies and there are more out there. Every time we dig down, we find a little bit better way to do something. And I commented to Senator Gay, I'm appreciative of his desire to take that money and reinvest it then within the system. I did want to say one thing about DD. When you're a

child, the school is responsible for the special education piece. One of the things that I said, the only entitlement piece is the service coordination. Actually, each year the Legislature builds into the budget for those 21-year-olds that now enter into the system for day services so that base goes up each year. So those are the kinds of things, that's the prevention piece, making sure that people can keep them at home with their families as long as possible. [LR363]

SENATOR JOHNSON: Well, before we break up, I want to relate something to the committee that I don't know if they know about. But I judge people by how they respond to crisis and the person in the chair in front of us, and we just got done one day talking about that the federal officials had come down extremely hard on the state of Nebraska for their handling of the Beatrice situation, and so we discussed that and basically the person in front of us said, well, we've got a lot of work to do, better get going at it right now. I then left and drove to Omaha, walked into the University Hospital and the first of the shooting victims from Von Maur showed up the same day. And we responded very well to that and so I'm actually extremely optimistic that we're headed in the right direction and, yeah, it hasn't...we're not that far down the road yet, but we've...I'm impressed with the quality of work that the people are doing at the top and we need to build the whole system now, there's no question about that, but I'm optimistic. So thank you very much. [LR363]

CHRIS PETERSON: That means a lot to me. Thank you. [LR363]

SENATOR JOHNSON: And that is all for our hearing today. [LR363]

MARY ANGUS: If I may,... [LR363]

SENATOR JOHNSON: Thank you all. [LR363]

MARY ANGUS: ...I found the information. [LR363]

SENATOR JOHNSON: Okay. [LR363]

MARY ANGUS: With Director Wyvill's indulgence, Mary Gordon, who is the director at the Developmental Disabilities Planning Council, spoke before the investigatory committee on the 16th. There are, she said, 1,628 people on the waiting list who are waiting for residential services. The problem is that approximately 200 people graduate from school and they are automatically going into services, with about 145 people going off the waiting list because of death of no longer needing services, and so the waiting list never goes down. And as we've heard before, this becomes a crisis-driven system because the only way on the waiting list that you go to priority one is if there's a crisis--you have no home, you have no whatever. As a parent spoke at the committee hearing last...that same week and said the only way my kid is going to get services is if I die. And another caseworker had said, you know, if you abandon that child, then they won't have any place to live, and so that's going back to that crisis-driven stuff. But that was the information that we were given approximately a week ago. So thank you. [LR363]

SENATOR JOHNSON: Yeah. Well, hopefully we can get more out of the crisis mode. [LR363]

MARY ANGUS: It's so nice to have a computer. (Laugh) [LR363]