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JIM JENSEN: Yes, could we come to order, please. Thank you very much. We have a short time. This is the Behavioral Health Oversight Commission, not the State Fair Committee, so (laughter) in case there's anyone here in the wrong room. Thank you. We do have an agenda before us. Are there any additions, corrections to that agenda? Seeing none, we will then proceed on that agenda. Also the minutes of September 14 were circulated. Any additions, corrections to those? []

MARY ANGUS: I would move that we include the reports of last meeting that were given, like from Ken Timmerman and those reports in the minutes, please. []

JIM JENSEN: Okay. []

JEFF SANTEMA: Could I clarify, please? []

JIM JENSEN: Yeah. []

JEFF SANTEMA: Mary, at the last meeting, a report was...some information was handed out Carole (inaudible). The specific request was made that that be included as part of the minutes and it is an attachment to the minutes. []

MARY ANGUS: Right. []

JEFF SANTEMA: The other thing that's attached to the minutes is the working session on-line. What else, Mary, would you like? []

MARY ANGUS: Well, there were reports. Maybe J. Rock will refresh me when they were...okay. []

J. ROCK JOHNSON: That discussion was about another meeting. []

MARY ANGUS: Oh, okay. I rescind that, please, and apologies to the Chair. []

JIM JENSEN: If there are no other additions or corrections, the minutes will stand approved as presented. We do have a real time restraint this morning that we must be out of here by 12:00. There's another meeting coming in here after that. Also we have members of the commission that do have to go onto other issues. So as we proceed through the rest of the agenda, certainly we want to allow time for consideration, for comments. But if we could hold our comments to a minimum, it would certainly help. And then if we get through everything, then certainly we can allow some time for further comments. It's been a very filled few months that we've gone through. And by the way, I had originally...we were not going to meet until March, but there were things that came up that I really thought that we should meet yet this year, yet in December. And so I do appreciate everyone's attendance on maybe a little, short notice. But we do have some very important things, I think, that need to be taken care of and so we'll proceed on that. The next item on the agenda is item 4, consideration of "Notice of an intended discontinuance of the ACT, Assertive Community Treatment Services at the Hastings Regional Center, August 26". Any comments on that or, Jeff, do you want to... []

JEFF SANTEMA: Yes, Senator Jensen, members have a draft motion with respect to that notice (inaudible) as well. So if you'd like to refer to that. Typically, the way the commission has handled these notices and this response is consideration of a motion to have a report prepared pursuant to the statute. And Senator Jensen, as Chair of the commission, prepares and submits that report. So...and notices, Senator Jensen, are in front of the... []

JIM JENSEN: Okay. Any comments on that? I'm ready for a motion, if... []

DANIEL WILSON: Motion to approve. []

_____: Second. []

JIM JENSEN: Any additions? Any comments? Any discussion? Yea. []

SUSAN BOUST: On 2(b) it says, such services possess sufficient capacity and capability to effectively replace the service needs which otherwise would have been provided at the regional center. The department is saying that this is accurate for the "ACTing" that they have the capacity and capability to replace the ACT services that have been provided at the regional center? Is that an accurate statement? []

RON SORENSEN: Yeah, actually, the service moved to the community. So it's still in...it's just in the community now. And a community provider is responsible for delivering services (inaudible), all of the people moved, the consumers moved, so all (inaudible) funding is now directly to the regional (inaudible). []

SUSAN BOUST: My question has to do with an awareness that there is some difficulty with getting psychiatrists to work in that environment. And so just, you know, making sure as a commissioner that that need and part of capacity is being addressed in some effective way. []

RON SORENSEN: We...I don't know how much time was spent on it. But right now there is not psychiatrists available. We are paying...Medicaid is not paying for that service, we are paying for it. And we are in the process of reviewing Medicaid rules and regulations to alternatives that could be considered that might get that covered under Medicaid. So (inaudible) discuss that (inaudible)... []

SUSAN BOUST: But the services are continuing and the patients needs are being met? []

RON SORENSEN: The services are continuing. []

SUSAN BOUST: Okay, that's what I needed to know. []

JIM JENSEN: Any other comments? []

MARIO SCALORA: Just a point of clarification. We are considering a motion for the assertive community treatment team only, not the other motion, just the one motion? []

JIM JENSEN: That is correct. []

MARIO SCALORA: Thank you. []

JIM JENSEN: All those in favor say aye. Opposed. Motion carried. Now item number 5: consideration of "Notice of intended reduction of capacity from the children's mental health services at the Hastings Regional Center." Ron, would you want to comment on this or, Scott, perhaps? I think everyone knows what the notice is however, but the numbers that we're looking at here. []

SCOT ADAMS: You know, I was with you right up to the end there, Senator, in terms of numbers. This notice was a decision that was submitted, I believe, October 23 it was dated. And that was in recognition of the continuing sort of downward census at the Hastings Regional Center for the mental health side of substance abuse services to adolescents and it was an attempt to sort of balance a couple of factors. One, the presence of the LB542 Children's Behavioral Health Task Force and the work that was in process and going on at that time, realizing that the Unicameral would be considering those reports and recommendations from a policy perspective, on the other hand wanting to, of course, balance as best we could fiscal responsibility for the resources entrusted to us with regard to those services. And so the decision to move from 16 to 8 bed staffing capacity was made in that time frame. We have...are authorized by the

Unicameral for 151 full-time equivalents at the Hastings Regional Center in all services. And through attrition, as of two weeks ago today are about at 130. And so in the October time frame we were...I don't recall the exact number, but above 130 and fewer than 150, I'm sorry for my beeping right now (laugh), and so decided to just reduce capacity from 16 to 8 at that point in time, trying to balance the fiscal responsibility, not wanting to get ahead of the Unicameral, those kinds of things. Now subsequent to that October decision then and delivered, I believe, yesterday was another notice of discontinuation of service. And we intend to close that program. There is one young woman in there currently. And when she is placed in another location and service that will meet her needs and be appropriate, we intend to fully discontinue the mental health side of that service. And so you don't have that formally today in front of you. That was delivered to the Unicameral yesterday as a decision effective, we think, January 1. Is that helpful, sir? []

JIM JENSEN: Yeah and thank you for that comment. Now are there any comments from the commission? []

MARY ANGUS: Well, I have one. I'm sorry, I should be raising my hand. []

JIM JENSEN: Go ahead. []

MARY ANGUS: What type of treatment is this woman getting or this girl getting as the only person there? []

SCOT ADAMS: The Hastings Regional Center mental health program is licensed as a residential treatment center. She has had a variety of different particular service activities, modalities that have gone along with that treatment experience. And so I think that's probably my answer to that. []

MARY ANGUS: Thank you. []

TOPHER HANSEN: I'm confused. Forgive me. Is what I'm looking at here different than what you just talked about? []

SCOT ADAMS: It's a continuation of the same sort of theme, Topher. []

TOPHER HANSEN: So is this down to... []

SCOT ADAMS: What you're looking at here was a decision in early October to move from 16 to 8 beds. []

TOPHER HANSEN: 16 to 8. []

SCOT ADAMS: And then there is another notice that you may not have in your hands yet. It was delivered to the Unicameral yesterday. []

TOPHER HANSEN: 8 to none. []

SCOT ADAMS: Yeah, 8 to close. []

TOPHER HANSEN: Okay. []

SCOT ADAMS: And anticipated date of January 1. Again, trying to make the best placement and treatment activities for this final patient. []

TOPHER HANSEN: And at the current time, you said the total FTEs are down. Is this program, that the one person is in, at a minimal staff or is there still a full structure to support 16 or 8 people? []

SCOT ADAMS: We had moved to the staffing for 8 persons along with that. And that

accommodated that sort of gentle glide down. With this decision, we have transferred folks to openings into the chemical dependency side and have also issued some layoff notices for staff in that...in the mental health program. []

TOPHER HANSEN: Okay. []

SCOT ADAMS: There may well be additional layoffs moving forward in terms of other pieces of the staff and support functions and things like that. []

TOPHER HANSEN: Um-hum. And those FTEs that then move over to openings in the substance side, are they under the same authorization for FTE and under the same funding streams? []

SCOT ADAMS: Yes, sir. []

TOPHER HANSEN: Okay. And then is their plan to then similarly reduce the substance programs and make them community-based? []

SCOT ADAMS: We are in process with the LB542 Task Force and their recommendations, the two particular recommendations that I think are relevant there that were just moments ago voted on and approved to move forward, include a cessation of the mental health program and the recommendation from the LB542 Task Force that other appropriate placements be pursued as best as possible. And so we will be involved, over the course of the next several weeks, in the depart's response as directed by LB542 to those recommendations. And we'll...(phone rings), good, that one's not mine (laugh), and working with those recommendations and building upon those recommendations and building upon those and moving forward. []

TOPHER HANSEN: So no plans exist on the substance side as they are now on the mental health side, and you're looking at the LB542 recommendations to whether that

will impact those? []

SCOT ADAMS: Yes, yes. Today, the... []

TOPHER HANSEN: Would that make sense to you to follow the theme of behavioral health reform that we try and move those services into the community? I mean the task force may have other ideas, but would that be consistent in your mind? []

SCOT ADAMS: You know, there are a number of factors. The difference between the two populations are significant. One is under the court jurisdiction, and their view of resources differ somewhat from the mental health side, which is a statewide resource, not necessarily through court jurisdiction or especially OJS, in particular, jurisdiction. And so the populations are slightly different. And I think you'll...as we are developing our thoughts and thinking around this, you'll see that more fully in our report. []

TOPHER HANSEN: Okay, thanks. []

JIM JENSEN: Any other comments? []

TOPHER HANSEN: Senator. []

JIM JENSEN: Yes. []

SHANNON ENGLER: If I can just a little historical perspective on this. The services used to be available for youth at LRC. And we...from a historical perspective, I understood that when they were moved to HRC that was because a system of excellence was going to be constructed out there for youth services for the state. And now it seems like these are all being dismantled. And in the background, we all know that there has been significant staffing issues that are in part driving this. And I would say that I have concerns about are there appropriate services available, when I happen

to know that we have youth that in acute settings waiting for residential placements? So I guess, I'm sharing that with all my fellow commissioners to let you know that I don't believe that appropriate community-based services are fully in place, and I have a concern about that. But I have a concern about just the loss of those youth services that used to be provided at one facility and then kind of moved to the center of the state, and now they're just disappearing. So... []

JEFF SANTEMA: For clarification, Shannon and Scot, is there a distinction that should be drawn here between the LRC services that were transferred to the Hastings Regional Center? Those are not the youth that are now there at the Hastings Regional Center. It's a different program that's being replaced. Is there some more clarification? []

SCOT ADAMS: You know, it's something of a twisted path in terms of the process. The original generating factor, from my recollection, and I'm going to beg off a bit in terms of my newness to understanding all of the history, but was that while there were plans and ideas around a center of excellence involving Hastings and that kind of thing, that the real precipitating factor was a facility issue at the Lincoln Regional Center where, with relatively comparatively little notice, months not years kind of thing, in fact probably weeks not...rather than many months, we were told that a whole building was going to be taken out of service over the course of time and that the capacity at Lincoln would be impacted as a result of that, renovation for a considerable time, measured in years. And so the move of the kids, of the young people to Hastings was really precipitated by that factor. At that time Hastings had two psychiatrists on staff. And Dr. Boust has rightfully acknowledged or brought to light the more recent concerns about that. When we lost psychiatrists at the Hastings Regional Center, we had to suspend and end acute inpatient care because that requires daily monitoring by a physician and psychiatrist, which we were unable to do. And so the licensure moved then to the residential treatment center, RTC level of care. And so that's something of the path. I would also note that in reaching our decision to close these, we did do a survey of existing capacity in the state and that there are openings in a number of different providers. And thus we

felt that since we had not received referrals to the Hastings RTC over the course of a few months, and the fact that there are openings and other providers, that this made sense. []

JIM JENSEN: Yes, Brad. []

BRAD BIGELOW: How many children do we have in out-of-state placements currently? Do we have any figures on that? []

SCOT ADAMS: Yes, sir. The most recent report on that, through October of '07, indicates that there are 29 young people out-of-state. That's down from a high in the last two years of 78. []

BRAD BIGELOW: Now ostensibly, wasn't our thought, our projections at one time to eliminate out-of-state placements and expand our residential care within the state? []

SCOT ADAMS: You know, that was an issue that was raised at the LB542 Task Force as an effort to try to help define a parameter. The task force did not end up with a recommendation on that score, recognizing the tensions of...to build the needed capacity for some of the more extreme situations, if you will, versus out-of-state care. And so there is no recommendation from the LB542 Task Force, though there was conversation about that. The department probably in its report will try to address that more fully and directly in terms of our intentions, in terms of developing a children's behavioral health system. There are arguments, as you can see, on both sides of that. []

TOPHER HANSEN: I think, and correct me if I mischaracterize your statements, but I think this raises the issue that's come up before, which is when what we're trying to do is decertify these programs from 16 to 8 or to 0, or the adult or the children, the question that we are supposed to ask ourselves is, are there sufficient services in the community to handle those services that were at the regional center? And so because there is

nobody in those programs, there is one person or no one, doesn't necessarily means that there are sufficient community-based services to handle that level of activity. And the concern that I've raised before and I think Shannon is raising right now, and I know I've heard out of Alegent and elsewhere in the state is that kids are now making up a higher percentage of the crisis situations, the emergency departments and other acute settings than they have in the past five years or so. And so then one has to ask, because...and while I think it's a good idea that we move from the regional center institutional-based system into a community-based system, if we're not raising the other funding pot to develop the services that the kids need, then, you know, we're not doing the job. Just because this pot empties doesn't mean this pot is filling up and we have to make sure of that. The other thing I know is that I hear from Shannon all the time, from Steve, from others that they're in the jails and other places, that there are kids who need help. And yet I know at least a couple of providers in Lincoln that are not at capacity and other providers in Omaha and west of Lincoln have said the same thing. Somewhere there is the Bermuda Triangle of children's services, that we have kids in crisis and they're not getting into treatment. And we have to resolve that problem. So do I think we ought to close down the services, the mental health program and get it to community-based? Yes. I don't know that I see the evidence of what's happen to say, absolutely, the services are in place to receive those kids. And so I'd be interested in...because what this...bringing this forward to us says, we think sufficient services are in the community to handle the load. So I'm interested, I guess, in what do you or others on your staff think are the indicators to say that there are sufficient services in the community to handle this reduction, which is in effect already handled? It's just a matter of being official about it. But how do we take facts to support our action? []

SCOT ADAMS: Well, again as I said, when we are looking at the decision on this one in trying to balance the various factors of expense and capacity and capability and not wanting to get ahead of the legislative process and others, we looked at a variety of factors, one of which was I did a quick survey through the Magellan network of providers, your e-mail, Topher, indicating that you were at a low census, was another

source of that information. And so we had a variety of different pieces that sort of said that the levels of care do not seem to have backup at this point or I suppose backup is the best way to say that, waiting lists or things like that. We're aware of some of the concerns about young children in detention centers and in other places. Not sure that that's a question of capacity on the RTC level of care, which is what this conversation is about, as much as assessment, judge perspective and other issues like that. And so we continue to work with judges and with others on those kinds of questions. Those are access questions and really not...we didn't, in our judgment, feel it was a capacity question. We also agree that the development of the implementation of LB542 recommendations and the department's response to that begins to address some of, hopefully, what you're saying about the change of system resources and reallocation and reutilization of resources. And so we're at work with that as well. So that's really where we are with that. []

JIM JENSEN: Dr. Boust, but before you comment, I...at 9:00 the behavior or excuse me, Children's Task Force concluded their report and you will all get a copy of that, by the way, after meeting since last June. In that report, some of the things that Scot is talking about will be brought forth, and also that task force does not conclude, it goes on into the next two years. And we'll be getting additional information from the department in January, as a matter of fact, and we'll be meeting quarterly to follow up on those issues. And I will comment that I've also met with some providers who have also said, yes, we have beds available. And when I met with the five juvenile judges in Omaha, I think some time in October, at the Douglas County Detention Center, they have a capacity of 130, and they told me there were 200 there, and 60 of those were awaiting placement. So I think we need to do a better job, and we'll be following up on that, of getting them from those detention centers where they're not receiving treatment to where they can receive treatment. And there are providers that do have space available, too, I know. So along with that, Dr. Boust. []

SUSAN BOUST: Well, I think this is really kind of a point of order question about the

role of this commission. I appreciate that we have a couple of people here who work more with adolescents than I do. But to date our finances and discussion have focused on adult mental health services. I am concerned that there is another commission focusing on children's services that has not taken a position on this, and it leaves us then without maybe the right people around the table to take a position on it with what sounds like conflicting information. I don't know that...I understand that LB1083 is to look at the entire mental health system. But this commission again has been looking at adults. And I don't even understand what happens to the money when this...if we should support the closing of this service, which I am in support of closing a service that only has one patient and all these staff. I'm in support of that, don't get me wrong. But I just...that's why I'm saying it's, I think, a point of order question. Is this really an appropriate thing to put before this body? []

JEFF SANTEMA: Just to clarify a couple of points, Dr. Boust, the notice before you is to downsize the adolescent mental health unit at Hastings from 16 beds to 8 beds. That's the current notice in front of you. The Children's Behavioral Task Force took the position of recommending the closure of the mental health...adolescent mental health residential services at the Hastings Regional Center. That was their recommendation. []

SUSAN BOUST: Okay. So, I guess, it makes it easier for me to support at least cutting it in half. []

JIM JENSEN: Okay. Any other comments? Yes, Dr. Wilson. []

DANIEL WILSON: Just briefly, I appreciate that immediate discussion. But this entity certainly does have the responsibility to discuss and review and recommend closure of state-based institutional-based services in order to transform to a community-based system. And Jeff's clarification is very helpful. Just very briefly, though, I'm interested to know...I'm not surprised to hear that there are areas of incomplete engagement of available community services which is something we haven't actually focused on

perhaps as much as we could. In almost any state transition from centralized services to community-based services there are those sorts of problems and gaps. And I don't know that we have a mechanism at the state level or within regions to manage that as effectively as we could. The triage and placement of particular people across the entire system is not actually in place. And I just offer that as a comment. We need to focus more on fully engaging the community system and getting away from reliance on the state hospitals and in fact the private hospitals and the private emergency rooms, which are the de facto crisis system in many parts of the state. []

TOPHER HANSEN: And you're referring on the kids' side, the... []

DANIEL WILSON: Both, adults and kids. []

TOPHER HANSEN: Because the systems are very different and it is more of a gauntlet approach on the kids, whereas the adults have many doors where they are able to access the system, and the kids is a very different system that way. []

DANIEL WILSON: I think the underlying principles are the same though, Topher. []

TOPHER HANSEN: Oh, absolutely, I agree with what you're saying. And the kids, I think, needs help that way. []

DANIEL WILSON: And I agree with...I mean, I share Susan's point that we're not really well equipped to engage a broader discussion of the childrens' issues at this particular point. []

TOPHER HANSEN: No, we're not. []

MARIO SCALORA: Point of order. []

JIM JENSEN: Thank you. Yes, Doctor. []

MARIO SCALORA: We have a motion to go from 16 to 8. Given the time of when it was first offered, I understand from Director Adams that they have formally filed with the Unicameral, with the Executive Committee to move that from 8 to nothing. Is...are we going to have to reconsider this issue again or can we change our motion? How we address this issue to deal with it at once, since we're addressing the same issue de facto rather than wait until March to deal with this again? []

_____: A friendly amendment. []

MARIO SCALORA: Is this something we can amend verbally? []

JIM JENSEN: Well, your...our counsel has just left. (Laughter) But I would tell you that it would seem to me, however, that in light of what Director Adams said, that I would think that we could, and I don't know about notice requirements or whatever, that we could accept a recommendation to go from 16 to 0,... []

MARIO SCALORA: I'd be happy... []

JIM JENSEN: ...unless I'm informed otherwise. []

MARIO SCALORA: I don't think there's any way we can argue that the capacity is being well met, in general, for the system for youth. But I think I'm in agreement that the state doesn't need to be in that part of the business and be happy to offer that motion. []

JIM JENSEN: Or maybe the motion could be in consideration of Scot Adams' announcement that we terminate Childrens Behavioral Health Services at Hastings. []

SUSAN BOUST: Does that imply that the money will go to community-based services?

[]

JIM JENSEN: I didn't say that. (Laughter) []

SUSAN BOUST: I mean, I guess, I would change my mind if I'm just saying, well, let's eliminate this money. And it looks to me like it's not being well...there is no good stewardship here on this money. But I don't want to do a vote that takes the money out of Behavioral Health never to be seen again. []

TOPHER HANSEN: Or shifts into another state program. []

SUSAN BOUST: Like Roads? []

TOPHER HANSEN: Like substance. []

GORDON ADAMS: I have difficulty supporting this when I hear the testimony I'm hearing that there are patients that aren't getting through the system or that there are patients in Douglas County way over capacity. Are the needs really being served? And that's one of our issues that we have to justify this, are the needs being served? And I'm hearing that maybe they aren't. I think it's quite easy for someone in HHS to close the door on Hastings and say, well, you know, they'll go some where or they'll be in jail or whatever. But that isn't serving the public. So I'm having problems reconciling this testimony I'm hearing. []

JIM JENSEN: Excuse me. Jeff, Dr. Scalora mentioned the fact that if...since Scot Adams' announcement that they're going to close, should we change this consideration to...from 16 to 0? Should we act on what we have before us and address the other at another time? []

JEFF SANTEMA: I think that the commission could choose not to act on the notice

that's before you. It certainly is appropriate to act on it. I just...I do have a copy now of the notice that Dr. Adams referred to, dated December 12, to discontinue the adolescent residential psychiatric services at Hastings Regional Center. []

JIM JENSEN: Could we not accept that recommendation rather than the one before us? []

JEFF SANTEMA: The commission could choose to do that. []

TOPHER HANSEN: Are there notice provisions or other things like that that we can just waive or... []

JEFF SANTEMA: Not that I'm aware of that the statute says it has to be given to the commission so many days in advance of a meeting. I don't believe that the statute...the statute is silent on that. []

DANIEL WILSON: Senator, may I withdraw the motion and allow Dr. Scalora to come up with a better motion? []

JIM JENSEN: Yes. []

DANIEL WILSON: I so move or anyone else. []

TOPHER HANSEN: I second it and I'll support it. []

JEFF SANTEMA: So there is no motion currently to approve the notice to downsize. There is no motion on the floor. Is that right? Is that correct? []

DANIEL WILSON: That's my intent, yes. []

JIM JENSEN: Well, yes, as Dr. Wilson is withdrawing his motion. So we don't have a motion before us now. []

MARIO SCALORA: So basically, we propose and obviously would need time for discussion to consider what Dr. Adams wants to raise here. Motion, in light of the notice filed on December 12, is that the correct date, to discontinue residential-level adolescent mental health services at the Hastings Regional Center. []

JIM JENSEN: All right. []

JEFF SANTEMA: That...that's... []

JIM JENSEN: Now is there a second to that motion? []

_____: Second. []

SUSAN BOUST: I don't understand the motion? It sounded more like a... []

_____: Is there a motion now? []

MARIO SCALORA: Yes, I moved to support or to endorse the state's closure of those services. []

SUSAN BOUST: Can I ask a question? If you'd be willing to put into the motion the caveat that the money must stay in mental health? []

JEFF SANTEMA: The statute does require that. []

DANIEL WILSON: The statute does require that? []

JEFF SANTEMA: That any funding associated with regional center services that are discontinued or reduced, that money has to be, and that will be your discussion and the next point in your agenda, that has to be reallocated for the provision of community-based services. []

SUSAN BOUST: Okay, that was...thank you. Okay. []

MARIO SCALORA: So we will now need a friendly amendment to that. And I'm happy to entertain that, but I don't know if we need that. []

JEFF SANTEMA: So the motion will be similar to the motion before you. The motion: that a report be prepared pursuant...and that the report be addressed to this December 12... []

MARIO SCALORA: Yes, sir. []

JEFF SANTEMA: ...notice to discontinue adolescent residential psychiatric services at the Hastings Regional Center. []

TOPHER HANSEN: Second. []

JIM JENSEN: Yeah. Does everyone understand the motion? And we have a second. Now discussion, is there discussion on that motion? []

MARIO SCALORA: You were raising concerns earlier before the motion. So please... []

GORDON ADAMS: Yeah, basically, on the testimony I heard from the table that we need to be sure that alternative services are being provided. And I'm hearing conflicting testimony that maybe it isn't being provided. And that's the question. I don't necessarily want to resurrect a dead program out at Hastings, but are we really providing alternative

services? And who's suffering in the mean time? That's my question. []

MARIO SCALORA: It strikes me what I hear is that there is a need, but the ability of some...there are groups of youth with different types of needs out there. The types of services that...if I'm hearing HHS correctly, the services that were at Hastings were not necessarily going to meet the needs of some of those youth anyway, whether they be out-of-state youth or other youth. Now one could raise the question, was the lack of use of those services due to an arbitrary desire to keep the door closed and we're not letting one in...anyone in or was it that the services being offered not being appropriate? My feeling would be, Mr. Chairman, that even if we were to say to HHS, you know, maybe if you could try better and maybe open the door a little wider, I'm not sure if we're going to get anymore youth served at that institutional level if we were to push for the alternative. And if we can get the money moving to other areas of the system, we could get other youth served. So even though I'm not convinced capacity is being adequately met, I'm not sure it's going to be met by forcing it open either. So that's my rationale for doing that. I, frankly, as a commission member, we haven't addressed youth issues well enough to know what the alternatives would be. []

JIM JENSEN: Yes, Topher. []

TOPHER HANSEN: I would agree. It feels like a rock and a hard place. And, I guess, I want to go to the hard place which is we've got to transfer the money here and not goof around with it. It has to go into developing services and moving kids out of the emergency departments, out of detention where they're not getting treatment and into these community-based services. To have our alternative, to say the EDs are jammed up, the jails are jammed up, oh, therefore let's create of the 16-bed mental health program at the Hastings Regional Center makes no sense. We have to continue going the way...and especially there's one person there. So we have to go in that direction, I think. But the key has been the key that we've wrestled with since the beginning, which is the transfer of funds to effectuate the community-based system. And so I think that's

our challenge at this point. I'm also concerned, I'm really concerned about that that money transfer and transfer quickly to ramp up. I don't know the logistics piece. If we go to 0 and there's one person there, is that person on the verge of being discharged or placed someplace else or...I don't want to harm the one person that's in the program. And so if there is a logistic issue there, I want to be sensitive to that. Otherwise, I obviously support this, having seconded it. []

JIM JENSEN: Yes. []

SUSAN BOUST: My question is again about money and knowing the situation with adult services much better than children, will the state being saying this is money that is already in the community, and so when we close this program, you've already got that money? Or will this be an additional amount of money to childrens' services to better meet the needs of some of the things we've talked about? Do we have an answer to that? I mean, I think I'd know the answer if it was in the adult system, but I don't know it in the childrens system. Nobody knows? It's a concern. []

TOPHER HANSEN: Well, in theory if this program is still operating and has operated and it hasn't...and there's an approval of 130 FTEs, it sounds like there is still money there that would have been appropriated to this program, operating all the pieces of it. And that when it closes down there should be a shift of the dollars, like in the adult system. []

SUSAN BOUST: Isn't that what our debate has been about in the adult system though? []

TOPHER HANSEN: Yeah. []

SUSAN BOUST: Yeah. []

JIM JENSEN: Yes, Chief. []

J. ROCK JOHNSON: I have a question for... []

JIM JENSEN: Oh, excuse me. []

J. ROCK JOHNSON: ...Director Adams, if he'd come up to the mike, please. What's the current licensed capacity at the Hastings Regional Center? []

SCOT ADAMS: You know we have an unused acute hospital license for six beds. It's an empty unit. It is a 16-bed unit on the...14-bed unit on the mental health side at the RTC level, and an RTC level also for CD side at 40. I believe those are all of the licensed beds, so that's 60. []

J. ROCK JOHNSON: So it's a total of 60? Well, you know, nature abhors a vacuum, and it also seems that an empty building owned by the state is rapidly filled by that vacuum. So my concern is, has there been any discussion whatsoever by anyone that you know at any level to place people at the Hastings Regional Center for any purpose? []

SCOT ADAMS: You know, J. Rock, help me in my response because I'm not entirely sure I understand your question. But there have been conversations about alternative uses for the space, representatives from the city of Hastings have certainly been concerned about that. There have been discussions with the DAS, Department of Administrative Service, with regard to potential utilization of the facility in some fashion. Clearly no decision or firm plans have been identified or certainly nothing put into place. Is that responsive, ma'am? []

J. ROCK JOHNSON: Yeah. I'm not talking about adaptive reuse. I'm talking about any intent to use the Hastings Regional Center for the purposes for which it has been used? []

SCOT ADAMS: Okay. []

J. ROCK JOHNSON: The acute beds, the RTC or any other use? []

SCOT ADAMS: You know, back in late summer, early fall there was certainly effort to make efficient use of the programming at Hastings. And so there were conversations about were the beds in fact needed? We had conversations with Magellan in order to make sure that we were part of the weekly call list, that kind of thing, to see that there would be appropriate adolescents available for treatment at the mental health side. But really beyond that, I can't say that there have been any serious efforts in terms of trying to fill the space or use that up. We were focused on its licensed purpose and that kind of ting. []

J. ROCK JOHNSON: So there's no intent to house anyone for any behavioral health purpose in the future? []

SCOT ADAMS: There are no intentions or plans at this point with regard to that. I can say that clearly and with a clean conscience. There have been all kinds of ideas sort of tossed about I'd characterize as hallway conversation about immigration, that had been there at one point, as an example. There have been some questions by some fronts about using it for an EPC center, for example, in that area. So there have been many ideas that have been tossed out, but none of those I would consider as having reached the state of planning or that kind of thing. []

J. ROCK JOHNSON: Could you tell me what you mean briefly by an EPC center? []

SCOT ADAMS: Well, there have been some difficulties in different parts of the state with regard to emergency protective custody situations. And so as we have conducted what we call the EPC road show and went to each of the regions to talk with law

enforcement and hospital personnel in those areas, different ideas are generated to assist in that process and to make it a smoother one for different parts of the players involved in an EPC situation. And the possibility of reopening Hastings and Norfolk, actually, had been identified as a possible solution to that situation. We felt that was not in the interest of LB1083 and so have not developed planning around that. []

J. ROCK JOHNSON: Are you familiar with the regulation that's in the Governor's Legislative Policy Research Office, the next step is to the Governor's desk, that would create a subacute category for hospitals that don't have a psych capacity? That people who have been EPCed could go there and that they would be admitted, that they would be segregated and that assessment and diagnosis would constitute active treatment? Are you familiar with that proposed regulation? []

SCOT ADAMS: You know, I'm aware that there is that regulation there. And I'm hoping that when I turn around that Ron will be there. (Laughter) Yeah, this is a good thing, so we can give him a fuller response. But it's my understanding and, Ron, I'd ask you to come up, it's my understanding previous subacute did not exist as a particular category for reimbursement. And so with the development of services, especially in Region 6, we wanted to bring those services on and to be able to reimburse them within the framework of Medicaid and other services. []

J. ROCK JOHNSON: I'm not sure I need more information. My only point there was that the subacute EPC specialty could be met by the acute hospital 6 beds at the Hastings Regional Center, should that decision be made. I hope I didn't plant an idea in your head. []

RON SORENSEN: I think the subacute that we're talking about with the Medicare regulations is actually in adult service at this time. Is that what you're suggesting? []

J. ROCK JOHNSON: Yes, and there's licensed acute beds which are adult beds at

Hastings. []

RON SORENSEN: Right. I think...I don't know how far you want to go with this. But I think one of the issues at Hastings remains the availability of the workforce, psychiatrists in particular. I mean that's an issue we have anywhere outside of largely Omaha. And if you recall, subacute was originally developed for Region 6 for the purpose of creating community services that would be outside the hospital and people could move out of the hospital directly to those services. There was an issue with how Medicaid regulations would allow that, so they retitled it to a different service. And now what we've done...Medicaid has done, I guess, is create the subacute category so hospitals can be paid for that service. []

J. ROCK JOHNSON: Obviously, my questions go to we have had experience with a regional center being adaptively reused within the field. And that's my concern here. My one last question if you know is, what are the fixed costs at the Hastings Regional Center? So long as it is open, what are those costs and whose budget is that coming out of? []

SCOT ADAMS: Largely, the fixed costs represent probably the facility infrastructure kinds of costs and those kinds of things. []

J. ROCK JOHNSON: And maintenance and so forth? []

SCOT ADAMS: Yeah, keeping it them up and that. I think it would be...I don't know the exact number and can get that for you, though. But it's a significant number, under $2 million, but probably more than $1 million, in fact it is more than $1 million. And then how far you want to go with that is, like how much heat would go into that, you know, is another question about fixed costs and things like that. []

J. ROCK JOHNSON: All right. I was looking for your total (inaudible), but that's fine. And

whose budget does this come out of? []

SCOT ADAMS: Yeah. It comes out of the department's, that is paid to the Department of Administrative Services for those kinds of costs. []

J. ROCK JOHNSON: So it comes out of the Behavioral Health Division to the Department of Administrative Services? []

SCOT ADAMS: Yes. []

J. ROCK JOHNSON: Thank you. That's all. []

MARIO SCALORA: We have a motion on the table still, sir. []

JIM JENSEN: Yes, thank you, we do. I'll take, Doctor... []

BILL MIZNER: I have just one question here. []

JIM JENSEN: Oh, yes. []

BILL MIZNER: As I look at the notice that was provided, it says that sufficient capacity and capability exists within community services to replace adolescent residential psychiatric services now being provided. If that is the case, then my question is, why do we still have one at the Hastings Regional Center? I mean, if there is adequate and sufficient services capability, why is there still one there? It doesn't seem to mesh. I just was curious. []

JIM JENSEN: I can't comment on that. I think they are saying that they are going to find placement for that individual, that one. []

BILL MIZNER: But again, the reason that I raise that question is because the assertion is being made that it currently exists. And that's the basis for closing it. Which if that's the case, I don't have a problem with that. I just am wondering if it's there, why have we not moved that person to that? And if it's not there right now, then the actual statement here is maybe not quite accurate. Just curious. []

SCOT ADAMS: Again, in the case of this person (inaudible) she's court-ordered to be there. And so we're following the direction of that authority. []

BILL MIZNER: So there is some place she could go, except the court has required her to be there? []

SCOT ADAMS: At this point that's...and we're working cooperatively with the court. And as Mr. Hansen was talking earlier, why (inaudible) make for a smooth (inaudible) transition for (inaudible) as possible. There is another court date in December coming up and we hope to (inaudible) transition plan, a discharge plan to the next stage in her life. []

BILL MIZNER: Okay. []

BRAD BIGELOW: Scot, another question about those 28 or 29 outstate placements. Is it not feasible...are we not equipped in Nebraska to meet the needs of those 28 or 29? Or is it not economically feasible to develop the range of services that they require? []

SCOT ADAMS: In the case of all of the young people who are placed out-of-state, they have all been reviewed by instate treatment providers, all of whom have declined for one reason or another. And so the move is made. So no child leaves the state prior to existing treatment providers, and including the Hastings Regional Center, prior to that child leaving the state. []

BRAD BIGELOW: So an expansion of services, residential, would not meet the needs of those 28 or 29? It's not feasible for us to develop that range of services economically or facility-wise? []

SCOT ADAMS: Well, you know, I think you would get a different opinion, depending on who you spoke with about that particular question. I think certainly some persons would believe that you could build to that. Others would argue the cost factor involved in that, in doing something like that. Still others would argue, you know, different reasons. So I can't fully agree with the concept, just to say that there is a variety of point of view about that. []

BRAD BIGELOW: But it is a pretty significant financial outlay to subsidize 28 out-of-state placements. []

SCOT ADAMS: You know, we pay the Medicaid rate, so the additional costs are those of transportation. []

MARIO SCALORA: We're not paying additional funds to fund their out-of-state placements? []

SCOT ADAMS: No, we're not. []

SHANNON ENGLER: Those open beds that you were talking about, just to clarify it for everyone, because I believe that we have open beds because those providers won't accept several children that could otherwise be served, but may be seen as having they'll say more aggressive behavioral tendencies or something. That's why we have some open beds, but we still have a subpopulation of youth that are not being served at that level. I just want everybody to understand that piece of it. It's not that we have this big capacity out here to service all of the youth in the state at an appropriate level. []

JIM JENSEN: We'll take Dr. Wilson's question, and then we'll move on. []

DANIEL WILSON: Well, I appreciate the interesting discussion about whether to continue spending millions of dollars to keep one person in a state facility. But I'm just curious about the time, Senator, and looking forward to maybe calling the question. []

JIM JENSEN: Thank you. I might mention also that the staff at Hastings is a real problem. The Youth Task Force looked at that. They were serviced by a psychiatrist from Lincoln, 100 miles away. And so with that, we'll ask for a vote. All those in favor of the motion say aye. Opposed. Let's ask for a show of hands, please. All those in favor raise their right hand. Opposed. One, two, three... []

JEFF SANTEMA: Seven yes and four no. []

JIM JENSEN: Motion carried. We'll now go on to discussion of transfers funding, item 6. Scot, you want to lead us down this road? And again, it's five minutes after eleven, we have three other items on the agenda. []

SCOT ADAMS: If I could begin with a point of clarification. I'm not sure what materials the commission has received. And so... []

JEFF SANTEMA: The commission has three pieces of paper. The first one is a narrative from you, Scot. The second sheet is a more detailed spreadsheet from you. The third sheet is from Sandy Sasse (inaudible). []

SCOT ADAMS: Okay. Well, thank you. I think I'm familiar with those three then. Thank you. At the last commission hearing there was conversation back and forth about the amount of money to go to the community. At that time, I believe, the department was identifying $3.5 million, others on the commission had identified a higher number. And as a result of that different point of view, there was conversation involving...at a

subsequent meeting of a subset of this group...thank you, sir, involving the Legislative Fiscal Office, the department. And really have come to an agreement on a number of $9.3 million, in rounded terms, available to go to the community. That number includes the cost of operations at the closed serves of the regional centers to date and the inpatient side. It includes also outpatient services of adult services and Norfolk and Hastings. It includes the ACT program, previously talked about today and it includes annual increases that have been granted by the Unicameral and signed off by the Governor during subsequent years. And so that number then, minus what has already gone to the community, is $9.3 million. In the current fiscal we, because of cost overlays with regard to ACT is a good example, which moved in August of this year as opposed to cleanly on the first, subsequent hangover costs with regard to personnel and the bumping system involved of layoffs that just take time and cost fiscal years, we're suggesting that those costs are around $400,000 for this transitional year, but $9.3 million really is the number to keep as an ongoing, permanent, sustainable number for services into the community. Now then we're looking at a distribution recommendation that looks to put $3.3 million of those into the community through regions. We hope to have conversation with regions and others, hopefully in early to mid-January, with regard to best and highest use of those sources of funds. As we have talked about previously here, there are some special populations that seem to be sort of difficult to either move out of the regional centers or to manage in the community. And we would like to pay attention to those in special ways. That may be the development of a service within a particular region, but may well have multiple region or even perhaps statewide capacity and draw, if you will. Examples of some of those things include persons who are older adults and who suffer a behavioral health disorder, have had difficulty being cared for in a nursing home as an example. Another example would be persons with developmental disabilities or near definitional inclusions of developmental disabilities services and programs of the state that are causing difficulties for perhaps the DD system or in other ways being managed and living in the community. And so we'd like to have particular conversation about some special populations here, what regions are experiencing themselves, and to develop further plans for utilization of those services

that can help sort of pinpoint that. Secondly, we would like to provide to Region 6 up to $2 million to help develop a long-term secure unit in the Region 6 area, the Omaha area, for persons living currently at the Norfolk Regional Center who, with all good efforts by all persons have had a difficult time leaving the regional center. And so hopefully to transfer up to 16 people from Norfolk closer to the Omaha area. Thirdly, as I mentioned earlier, we've been on a series of EPC road shows to listen about that particular issue. That has caused a number of levels of different kinds of concerns and issues across the state. It looks a little bit different in Norfolk than it does in Scottsbluff, than it does in Omaha. And so we're reserving some funds to give to regions, to the community, to help manage the EPC situation in particular. Finally, then the department is proposing that it retain, that the state retain $3.5 million in case we can't get the remaining 30 people out. We've been trying hard, quite a while, at this. And so if there is necessity, to be able to retain operating costs for that unit at Norfolk. With that then, I might just be quiet, because I suspect there is reaction to all of this, and respond to particular questions you may have. []

JIM JENSEN: Thank you. Any questions? Yes, Topher. []

TOPHER HANSEN: I guess, I have foundational questions, which is, what data did you use to come up with this? I hear about the EPC road shows, but in terms of information from the regions that would provide a data base to suggest that, number one, how did the dollar amounts come about? []

SCOT ADAMS: Why a half million dollars for that? []

TOPHER HANSEN: $3.5 million for 30 people, as an example, why a half million? Why two million, why... []

SCOT ADAMS: Sure. The $3.5 million represents approximate costs at a regional center on a per person basis []

TOPHER HANSEN: Which is a different rate than community-based providers get, correct? []

SCOT ADAMS: I suppose that would be true. []

TOPHER HANSEN: Okay. []

SCOT ADAMS: So it was the cost of operating a...rough cost of operating a unit, a 30-bed unit at Norfolk. []

TOPHER HANSEN: Then is that money not already there from LB1199 to handle those same beds? []

SCOT ADAMS: Well, this is where it gets interesting, Topher, and thank you for that question. As I understand it,... []

TOPHER HANSEN: Anything to help, Scot, you know that. (Laughter) []

SCOT ADAMS: Yeah, I understand, yeah (laugh), that's why I sent you that note. My understanding is that the Unicameral, this year, basically funded Norfolk for 120 beds, inclusive of the mixed population, and really without regard to the nature of the population. That is it was 120 beds at the appropriation level. And so, currently, we have roughly 40 persons on the mental health side and 46 or so on the sex offender side. Eventually, because it was funded essentially through the LB1199 mechanism, the Unicameral and Governor expect that those beds, 120 beds, will be sex offenders. And the data clearly indicate a continuing uptick in terms of the number of sex offenders coming into the Health and Human Services system for care. And so that is a real kind of thing. The...and so the concern then becomes, gosh, that's a ticking time clock, let's say, and we need to be able to accommodate 120 sex offenders. And thus, the $3.5

million being retained is for the potential development of a fifth unit, a fifth 30-bed unit at Norfolk, should that be necessary and should we not be able to move folks to the community. And so that's how that one sort of unfolds and, I think, addresses your question. The $2 million then, with regard to the Region 6 care, was again intended to provide some transitional funds, but to help move sufficient numbers of people from Norfolk to at least get below that 30-unit number at Norfolk, to be able to have a full unit. You may all well know already that the nature of the building at the Norfolk Regional Center comes in blocks of 30. And so it's necessary, for a unit to be put into use for sex offenders, that all the mental health people come out. And 10 doesn't work, it's got to be to 0 and below to have the unit available. And so...and thus that was again approximate cost of those services, with some transitional monies and that gets us below the 30 threshold. []

TOPHER HANSEN: And that's...that $2 million comes out of...is there a cost model that's developed around whatever level of service has been identified? And is the $2 million commensurate with that cost model? []

SCOT ADAMS: You know, it's probably at the upper end of that, Topher, which is why the "up to" is really very important. The other question still in play with regard to that one is the involvement of Medicaid and want to make sure that we get this to a Medicaid reimbursement model. We know it can happen. Got to make sure that we're clean with Medicaid with instate, but we also need to make sure we can do this. And so at some point I suspect that $2 million in state funds could be less, but right now we wanted to make sure that we could get the unit up and going, reduce the size and the number of people at...with mental health issues at the Norfolk Regional Center in a timely fashion. []

TOPHER HANSEN: Was the Region 6 management group or governing board or network providers, were they involved in this decision? []

SCOT ADAMS: I would...I believe that they were involved in this decision, yes. []

TOPHER HANSEN: I mean, did you sit down and talk about what the need were and here's a plan kind of deal or did you guys...was it made in concert with that group or did you hear information and then decide here's what we're going to do? []

SCOT ADAMS: Well, I think, yeah there certainly was conversation, has been conversation as late as yesterday. Their request for proposal is in the paper this weekend, I'm told. And so the development of those plans and their activities certainly preceded that issuance of that RFP. So, yes, we've been in conversation with Region 6. []

TOPHER HANSEN: Okay. []

JIM JENSEN: Any other questions? Yes, excuse me, I'm sorry, Topher. []

TOPHER HANSEN: Well, I guess, I'm...when this came out, I had talked to a couple of people who were waiting for information that they heard about was coming out, but hadn't received it...and I...at the region level. And I had then received it and they didn't know about it. That raises, I guess, concern in me on the fundamentals of this whole proposal which is it seems contrary to the kind of system we're trying to generate which is a community-based system. And so if it is a community-based system, then the state's role in this is to sort of say what the boundary is, what is it that we don't want you to do? Don't go across that boundary. And within that then the regions and Region 5, I know, I don't know about other regions, Region 5 submitted a phase IV plan document to say, here are the things that we think are priorities within our system that pertain to Region 5 and the unique characteristics that it brings to be in phase IV, as I assume other regions were talking about or actually did to meet their needs. And my concern then is when I see a document like this that the, number one, that it didn't involve...it did not start at the community planning level and didn't allow the communities to identify

what their priorities are. So if the allocation went out in a formula way and Region 6 said, gosh, we'd really like to have that secure program or all the regions said, we want a piece of our money to go to EPC situation transportation or things like that, that's where I think it ought to generate from. Not to mention I have real problems with the double standard of seeing 30 beds at $3.5 million. I operate 16 beds at $1 million and I have psychiatrists, APRNs, RNs, therapists, rec therapists, technicians, cooks, you know, the full gamut. And it feels like there's a different standard there and that these monies, that's why I asked the foundational questions, where do these dollars come from? How is that calculated? Where is the planning process? It does not sound like it's in line with what consumers have been saying about trying to think outside the box on how we're promoting recovery. It doesn't sound like it's come from the community-based planning process that we're trying to implement so each community identifies the particular interests that they have and how it would best serve their locality. And I...it sounds like a top-down directive. And the $3.5 million or $3.3 million that kind of was an original number is what we're going to get, but the rest of it is going to disappear and $3.5 million of it is for future anticipated issues that, in mind, is just going to disappear. I mean, it always has in the past. Your intent may be different, but you have to know that the history is the best predictor of the future and that's what we have to go on. So I just have problems with the process. And I would prefer to see $9.3 million dispersed to the division for planning at the local level and disbursement of a formula basis to let the localities decide what their priority is and how best to spend it. And then, should there be special projects that we don't have money for, we have $600 million in the coffers and have to recognize that, while our initial investment brought us up to a better place in the world on behavioral health services, we are still way behind the curve. We did not fund this system so we're at the top flight level. We have funded the system so we're in a better position than we were, but we're still in the lower fifth of the country in terms of our per capita spending. We have to continue to invest in this system. And to divert funds and not invest in programs at the community level, I think, is a real mistake. []

JIM JENSEN: Let me just...the 30 that are remaining there, still if they can...if the

system finds placement for those, they would leave and the money will follow the patient. Is that correct? []

SCOT ADAMS: As it's noted, Senator, on 3(c) point IV, for a unit of 30 persons currently residing at the Norfolk Regional Center until such plans and services are developed to care for these persons in the community. So hopefully, we've been clear in writing on that,... []

JIM JENSEN: Certainly. []

SCOT ADAMS: ...not withstanding, you know, what people may (inaudible). []

JIM JENSEN: But the only thing is they'll have to go out... []

SCOT ADAMS: That's the tricky part. []

JIM JENSEN: ...in a group of 30... []

SCOT ADAMS: Yeah. []

JIM JENSEN: ...or very close. []

SCOT ADAMS: Yeah, right, exactly, yeah. []

JIM JENSEN: Approximately, yeah. []

SCOT ADAMS: And, well, yeah. We can argue a lot about that. []

TOPHER HANSEN: But you also said the money is allocated for those 30 beds right now, it's just on...identified as a sex offender. But if we're going to get to the 120 sex

offenders in that program, those 30 are going to have to disappear into community programs anyway and not be at Norfolk Regional Center. So the money is in place to fund those beds and those services right now. The question is, is there $3.5 million in the community to develop wherever those locals are that those people would then go live? Is there a service there to assist them in living there? And... []

SCOT ADAMS: Yeah. And that's really...you know, Topher, I think we're like just different sides of the same sheet of paper on this one, because I view that with the excitement of the next steps. I really view this as the coming to completion of the initial thrust of behavioral health reform and understand that that's an ever evolving process. But we're sort of in that last leg with regard to that potentiality. Our view really is that we are aware of, from community-based planning, by the way, of a variety of special populations that exist in different parts of the state and for whom providers, like you have not taken for whatever reason. []

TOPHER HANSEN: Absolutely. []

SCOT ADAMS: And so, gosh, today that's not there. We have $3.3 million that can begin that next phase. We want to make sure that we are absolutely careful. We also got to guard against the fact that you may continue not to take those at some point later in time because, as you say, the past is the best predictor of the future and that's what has been the case so far. And so I think working together, as LB1083 outlines shared responsibility for planning with regard to behavioral health between the state, which it gives statewide authority for, and the regions, we're looking forward to the next step to this. I find it an exciting time. I think we can move forward. []

TOPHER HANSEN: When you add elderly and the developmentally disabled, you're talking about then individuals who present circumstances that cross over our funding boundaries, if you will,... []

SCOT ADAMS: Yeah. []

TOPHER HANSEN: ...which, of course, are artificial. People don't come with funding boundaries,... []

SCOT ADAMS: Yeah, yeah. []

TOPHER HANSEN: ...they come with their own individual and unique package, but in our system what we have to do. So I would much prefer to see our state say, you know what, we need to grow this system a little bit in some particular ways and get DD and behavioral health or aging and behavioral health or whatever the groups are to collaborate, much like providers are always encouraged to collaborate to form unique programs to help people with circumstances that to date we have not developed or have in place. []

SCOT ADAMS: Yes, exactly. []

TOPHER HANSEN: But I don't see us...I see us taking the money that was supposed to go into community-based services. And now we're identifying different uses, and we're starting to stack it up a little, and it's all of a sudden diminishing to where we're back to $3.3 million transfer as opposed to $9.3 million transferred. That concerns me. []

SCOT ADAMS: Well, and again if you look at it, it's $3.3 million, plus $2 million, plus $500,000. So...I mean, all of that is going to the community. []

TOPHER HANSEN: Right, but what I'm saying is, why not let the communities decide how they distribute their pro rata share? []

DANIEL WILSON: I think, Topher, I've got to interject, it's because, to make the point clearly, the communities haven't actually gotten the attention focused sufficiently to get

these people out already for a variety of reasons. []

TOPHER HANSEN: I'm sorry? They have not? []

DANIEL WILSON: They're still in the state hospital system. []

TOPHER HANSEN: I understand. []

DANIEL WILSON: And the question ultimately is, do we want to monetize and incentivize to get them out or do we want to sort of dither for another year or two? []

TOPHER HANSEN: No, we can't, Daniel. We have to distribute money to the regions and beef our system up to meet the needs of the people of the state. And what I think we ought to do is let Region 1 plan what its services are with the money that we've allocated and so they can meet their unique needs as Region 6, 5, and so on. But to have a planning process what's dictated about what will happen in certain areas, I think, is a mistake, I think is a planning mistake. []

DANIEL WILSON: I've preempted Susan, so I apologize. []

SUSAN BOUST: I am very mindful of the time and I think we have important other topics on our agenda. And I think the philosophy about how we do this work is important. But as I understand our agenda item today it's to get clear about the money, not then how it's doled out. But if we miss that point of what money should we be following, we've not done our job. So that has to take precedence, I think. And I have, you know, no one is ever going to accuse me of being the spreadsheet Goddess. So let me ask my dumb question that, hopefully, get us back to $9 million, plus. I don't understand how the cost of $3.5 million was allocated for the 30 beds at the Norfolk Regional Center? My poor little math says that's at $116,000 annually per bed. If I go back to Carole's spreadsheet, she was at $133,000 annually per bed. So there is still

always that difficulty when you have all of that overhead, saying, what is really allocated to these 30 beds? Because if we're going at the rate of $116,000 instead of $133,000, and I don't know who's right, but that's a lot of money. And if that's ours sitting in those 30 beds, then I want it allocated to us now so that when those close we get it. Plus, I believe the other issue was the increase, that as we've gone from '04 to '08 that there have been increases and that we don't want to hold our behavioral health money static to the 2004 numbers. []

SCOT ADAMS: Right. And the $9.3 million includes those increases. []

SUSAN BOUST: Okay. []

SCOT ADAMS: As pointed out in point number 1, up above. And I would also just like to make the point that these conversations, and I'm looking to Sandy now (laugh), were held with the Legislative Fiscal Office. And I think it's fair to say we're in agreement with the numbers and as those principles are outlined there with regard to the services, the increases, the residential side, those kinds of things. []

SUSAN BOUST: Then, okay, I'm sorry. So the $3.5 million was generated how? []

SCOT ADAMS: You know, it's sort of a target number to do that. I don't...you know, to be honest with you, I can't quote the per bed cost at Norfolk Regional Center today. But that Carole's number is higher means that more money is going to the community sooner and so it's sort of on your side. I mean, it's a number that's on your side. []

SUSAN BOUST: I might suggest a per bed cost at least starts to get us all talking the same language. Whether the payment is for Medicaid or not, at least we can then start to talk some efficiencies and I don't think all of those things are exactly transferable. And then the $2 million for the 16 beds in Region 6, my again poor calculation comes out at that would cost $2.7 million, if it was the same rate as what you're currently charging at

the Regional Center. And since I believe that it's supposed to be a transfer of essentially the same level of care, are you saying that the difference in that would then be made up by Medicaid on top of that? []

SCOT ADAMS: We're hoping Medicaid will pick up some costs. We're also looking at the likelihood is, you know, as Topher points out I think rightfully, when I was at Catholic Charities, we ran less per bed costs, that moving to the community has some inherent savings to it and is, you know, a rough number kind of thing. So I can't offer you the particular precision with regard to that, but it seemed to be a reasonable approach, given costs of care and ensuring moving forward. We wanted to make sure we put as much money into the community services, especially in item 1 there, as we could to facilitate exactly Topher's point about local, regional kinds of planning and development in conjunction with the state. []

SUSAN BOUST: And, I guess, I just use that to reiterate the whole philosophy behind LB1083, that if we really can do the same job for $2 million in the community that it's costing $2.7 million for in the regional center, then let's get going, you know. (Laugh) []

SCOT ADAMS: Yeah. But that's sort of the point that we're at. []

SUSAN BOUST: Okay. []

SCOT ADAMS: After three years that hasn't happened. And so we just need to be, I think, "planful" and careful about these next steps in terms of these services. []

SUSAN BOUST: Okay. And then my last question about money, your adjusted amount to be transferred in '08, the $2.971035 million, that is money not yet allocated and available for something like what Topher was talking about, for planning for meeting other needs? That's not yet committed money? Am I understanding that right? []

SCOT ADAMS: Yes, ma'am. []

SUSAN BOUST: Okay. []

JIM JENSEN: Any other discussions on this? This does not require a vote, it's for discussion purposes. []

TOPHER HANSEN: Yeah. What's the...is there a question that is being asked? I mean, is this a train that we just watch go down the track or is this still under consideration (laugh) or where are we with this? []

JIM JENSEN: I think if you'll recall, this came up at our last meeting when Carole Boye started questioning the $25 million that was there. And, I think, Carole is not here. She went out to see Nebraska play at the National Volleyball Tournament, but they didn't quite make it. (Laugh) But that's where she is. []

TOPHER HANSEN: She doesn't watch the news then. (Laughter) []

JIM JENSEN: So that's why she's not here today. But anyway, it was that $25 million figure that she questioned was not in the statute and that we need to take a look at the dollars, how they come out. And with that, there was a small committee that was formed that then did meet with the department, met with Fiscal Office to look at this. And then this is the result of where fiscal, with the department and where Carole and others came up with. And, I believe, I don't want to put any words in her mouth or discussion, the $3.5 million is the figure that's kind of in question. But, like I said, if we can get those last 30 people out, the money will follow the people. How we do that, I don't know? As far as LB1083 and looking back at the progress that we've made has been, I think, very, very good. There is one area that I think was...that we really didn't look at and that was the long-term secure care situation. That is what the $2 million addresses is that long-term secure care issue--individuals that may never be on the street and individuals that do

require a secure environment. I, frankly, think there needs to be a second one of those somewhere and probably not in Region 6. But that's just me, personally, and we'll see what happens on that. But anyway, this is then for discussion purposes and...at this point in time. And then, I think, the next time we meet we will even review this further, as well as other finances and they'll issue their full report to us at that time, like they have in the past. []

TOPHER HANSEN: Well, if I might. Again, the issue I have is the foundational one that brings all this forward as well as the process. And if it is that there is a $2 million allocation to Omaha because there needs to be a secure facility in Omaha, what is the data in the state that says that there is such an overwhelming problem in Omaha and a need for a secure system as opposed to, and what providers and regional folks and so on will tell you in Lincoln is that the Regional Center here in Lincoln, the prison facilities that are here in Lincoln, and the service development that is historical in Lincoln, draws an enormous number of people to Lincoln from other places in the state. I don't know how that is relative to the whole rest of the state? All I know is that's what goes on in Lincoln. So, I guess, my question is when I see an allocation like that is, what's the process? What's the data? Why does... []

DANIEL WILSON: It is really pretty simple. About 28 out of the 40 are from Region 6. RECORDER MALFUNCTION, SOME RECORDING MAY HAVE BEEN LOST []

JIM JENSEN: Dr. Wilson. []

DANIEL WILSON: I don't mean to prolong this discussion so we can move forward too much, but these...I thank Scot for this. These numbers make considerable practical sense to me. Perhaps having had experience both in community services as well as state institutional services, including reducing the size of institutions and closing institutions, we're very near the final lap in completing what was intended in LB1083 at Norfolk. From a hospital administration point of view, these people need to be

somewhere else. That, I think, is a top-down sort of directive based on the present inability of the community system to have brought them out of the institution at this point. It sounds to me like the process was not merely top-down, but from a hospital administrative point of view, something else needs to be done and it needs to be done in a concerted manner with input as much as possible from those involved. I assume Region 6 is not resisting or objecting to this proposal. []

TOPHER HANSEN: Why would they? (Laughter) What I'm saying is, you know, it was curious, Dan, that Region 5 is calling me and saying, I don't know what's going on, I'm hearing about a letter. And I said I have it in the e-mail right now. And so, to me, that said there have been no consultation with the regional provider and division group about what the whole conversation is about. And again, I think that's just... []

DANIEL WILSON: Well, but there have been several years of conversations, Topher. This didn't come out of the woodwork in the last six months. There's been an effort from the whole system to move people out of institutional care and we're not quite there. And understandably, the last bunch of persons there are probably more complicated than the earlier ones. So it probably does require different solutions. Again, I don't mean to belabor the conversation. It has a great deal of face validity, to me. []

JIM JENSEN: Okay. Well...yes, J. Rock. []

J. ROCK JOHNSON: I'm looking for a fast answer. I see the EPC resources statewide at $500,000. Could you please tell me how you define that situation or that problem or what it is you intend to solve with the $500,000? []

SCOT ADAMS: You know, J. Rock, that's a great question and I'll do the best that I can. Let me just summarize and say that in our conversations with regions and with law enforcement and with others involved in that total system, including hospitals and others, that a number of different components have come up as sort of sticking points.

Some of it is a training issue. Some of it is a capacity issue in terms of readily available bed nearby, reasonably nearby for placement. Some of it is a transportation issue that some people have indicated in some cases. For instance, a critical access hospital may be a reasonable place for an immediate period of time. But given the nature of EPC and commitment, they need to get to see a more qualified professional within a reasonable time. Some law enforcement personnel have indicated reluctance to move more than one time, if you will. So there are a host of different issues involved with this. And our hope is that, as a result of that, that this is a reasonable effort to again distribute this money through regions to help with their unique situations and potentials in their areas of the state. []

J. ROCK JOHNSON: That's the answer I expected. The answer I'd like to hear would be prevention. How do we keep people...and that's not being funded anywhere, it's something Topher mentioned. We have no transfer of funds here to peer-run services or peer-operated services. And with this conceptualization of EPC, it's back to, we really don't have enough beds. So that...I just want to really strongly make that point, that unless and until this system starts to think about prevention, there will never be enough beds, there will never be enough law enforcement transportation. And I really want to leave it at that. []

SCOT ADAMS: Well, let me just say that I don't disagree with you, and I thank you for continuing to raise that point. I wish I had listed that as one of the particular elements that could be helpful to the EPC. I didn't...as I didn't list other elements as well. We think that within the EPC money, per se, and also within the other money to the community, that there is opportunity to help do those kinds of consumer-based activities. We chose not to sort of highlight that, if you will, within the framework simply because we didn't want to get to prescriptive, top-down and heavy emphasis in one direction or another. It's a balancing act between trying to sort of set a framework of working within and trying to also be helpful with particular issues. So your point is not lost on us, ma'am. []

J. ROCK JOHNSON: Well, if we're not measured, we don't count. And I would like to see you all come back to the next meeting with your figures and with a narrative and with specific inclusion of consumer-run services and places that consumers can be involved here. Because it is conspicuous by its absence. We don't have a focus on prevention, we don't have a focus on recovery, it's not part of the division's mission or approach that's being taken. And it's time to get it down in black and white on paper and with a plan. That's another problem that we have, is failure to plan. I think Topher raised that. But we definitely have failure to plan as to how we include consumers. It is not happening at the grass roots and the regional level and it needs to have some leadership from the state. Thank you. []

JIM JENSEN: Thank you. []

SHANNON ENGLER: Hopefully these are going to be quick. Scot, on number one, that methodology for distributing the fund, is that the, I'm going to say, normal or general methodology that's been used before to distribute funds to regions? []

SCOT ADAMS: The 75 percent, 25 percent? []

SHANNON ENGLER: Yeah. []

SCOT ADAMS: This is a longstanding formula that has been--for good reasons, I believe, in the past--sort of varied from and our hope is to bring into greater balance across the state that formula. But it has been agreed to by regions, providers, different folks. []

SHANNON ENGLER: Okay, thank you. My second question, a real quick one, this 16-bed facility in Omaha, would that be accessible to clients throughout the state or is this going to be envisioned as this really is going to be a long-term and these may be clients that are just going to be there? []

SCOT ADAMS: Well, you know, again, the original basis was that a significant majority of the folks remaining in Norfolk Regional Center were Region 6. And so that's...again, to sort of facilitate regional care, the movement of the facility, that kind of thing, we're sort of focusing in on that. Whether that will evolve over a time to a more statewide resource, certainly could happy. You know, a region, you may have to arm-wrestle with Region 6 a little bit about that kind of thing. Senator Jensen's perspective about there's a need for two such units, you know, is another alternative, another way to look at that. For the time being, I think it's fair and safe and more secure to say this is a Region 6 resource. []

SHANNON ENGLER: Okay. And then my last question, I think, for the second time, just to ponder is on the item number four. Now that you've described that, I can appreciate it. You have to move all 30 clients out in order to not need that money. []

SCOT ADAMS: Yeah. []

SHANNON ENGLER: And I think that we're interested in the money moving from the regional center program into the community-based program. And I would propose, although it would be sticky, to consider, is there a way you can move it into--is it program 38--the community-based program out of the regional center program and have the community-based...the regions or somebody there buy those beds until such time as they're not needed? Then we can be sure that that money is in that community-based program. Just something to chew on. []

SCOT ADAMS: Yeah, something to chew on. Yeah, something to chew on. Appreciate the idea. []

JIM JENSEN: I like that approach. []

_____: I'd second that. Good idea. (Laughter) []

JIM JENSEN: Scot, why don't you just go comment on the one-time funds if you can, and... []

SCOT ADAMS: Well, sir, I, again, just really a fair...just a simple statement. That is that, as we talked about last time, is somewhere in the neighborhood of... []

JIM JENSEN: Excuse me, I got out of line. We have the Medicaid MRO legislation that's on item seven. []

J. ROCK JOHNSON: Might we move that to the end so that it doesn't expand and fill up all the time? []

JIM JENSEN: Yeah, okay. Let's do that. We'll put item seven down where item nine is. So, all right, go ahead with the one-time funds. Is that okay? []

SCOT ADAMS: And I'm being urged to be quick. Simply put, we wanted to have sort of a stepwise approach to this situation. The conversations with regard to new services, potentiality, that kind of thing will be going on, as I mentioned earlier, hopefully in early January. Decisions about one-time funds and their ability to augment support, enhance system elements, we thought could be made on the other side of that kind of thing. []

JIM JENSEN: Any comments? J. Rock. []

J. ROCK JOHNSON: Okay. It's the general procedure for contracting that the state gives regions guidelines. Do you anticipate issuing guidelines of any shape or form relative to these regional expenditures? []

SCOT ADAMS: Well, you know, we're looking to have a conversation to bring the

regions in, to be able to have conversation about what they hear, what they see, fuse in our perspective in terms of we see several individuals from different places but probably not a critical mass in any one. Thus the need for something like you were suggesting, Topher, about a resource that--or, and Shannon--that might be a resource that could serve more than one regional area, that kind of thing. So we're looking at a conversation, hopefully consensus and agreement. Failure on agreement and consensus will result in a decision by us. []

TOPHER HANSEN: Why January? Why the time frame? []

SCOT ADAMS: Wanted to talk with you all today, get out of the holiday season, get it done early before the session drives me nuts and go from there. []

SUSAN BOUST: And what will be the process for the discussions around this? It will just come out as RFPs or discussions in the regions or discussion with the state or... []

SCOT ADAMS: We're hoping to have a meeting the week of the 14th, a conversation, bring people together to talk about what...the next steps. []

SUSAN BOUST: And how will those invitations be... []

SCOT ADAMS: You know, we'd like to have...in my thought, and you can tear this apart if you like or add to it, relatively small conversation that would involve the regional persons, some people from advocacy and consumer groups involved. But a relatively small number of people in the room. []

SUSAN BOUST: Everything about that sounds fine. The reason I ask the question (inaudible) continued perception that hospitals and doctors finding difficulty getting voice in such situations because the region doesn't represent them, can't see them, at least in Region 6. So making sure that you... []

SCOT ADAMS: We had talked about the possibility of a coalition that hospitals are part of. But it can be a really big room real quick and we'd like to have the development of, you know, a working paper that could go out for further comment. []

JIM JENSEN: Okay. J. Rock? []

J. ROCK JOHNSON: Yeah, will the advocates and consumers include people who aren't employed by the state government or aspect of state government? []

SCOT ADAMS: Yes, ma'am. Yes. []

J. ROCK JOHNSON: Thank you. []

JIM JENSEN: Okay. Anything... []

SHANNON ENGLER: Just one...I need put my two cents in on the long-term care issue, because the groups that you just identified are not traditionally--I don't know--aware, supportive, whatever of the long-term care issue. And you and I have talked about this. What I'm talking about is we...our whole population is aging. We all know that, this is not new news. And those individuals that are going to require a long-term care that have behavioral health disorders, they're going to increase in number. And now seems like an opportune time to begin to address that rather than to wait when we have minus $500 million in the state coffer, or whenever that is. But now seems the time and...so there's my two-cents plug on that. Thank you. []

SCOT ADAMS: You know, that's a great point. And that topic is a delicate conversation. Is Alzheimer's part of us? I don't know. We have an interesting opportunity for mission creep here, if you will, in terms of the Division of Behavioral Health Services. And I think we'd want to keep focus as best we can. So that's going to be a tough conversation. I

appreciate the comment. []

JIM JENSEN: Thank you. Let's go on to item nine. When LR203 by the Health and Human Services Committee was studied, I had several individuals that came up to me and, as you all are aware, that this commission terminates on June 30, 2008. But I received several comments that they really felt that this commission should continue. To what date, I don't know. But we're not done yet, of course, as to LB1083. And then there were other individuals that felt that despite the fact that we have some meetings that we discuss and cuss and so on and so forth, that this has been at least a worthwhile commission. And all my tenure in the Legislature I wanted to eliminate commissions, not add to them. And I certainly am not looking for another job or continuing the one that I have, whatever this is. But with that, I really thought that we should at least have a small discussion as to should this commission continue in the future. And if it is, again, we're coming to the point that the first ten days in January is bill introduction time. And if we could find someone to introduce that, at least to continue this commission. Maybe it not be as many members that we have, we meet on a quarterly basis or a biannual basis or whatever that might be, and that would sure be all discussed. Maybe there be a term and a rolling of members so that we're not all the same people all the time, so we put a term on the numbers that are serving. But all those things would be discussed and brought forward in the form of a bill. Any discussion by any of the commission members? []

TOPHER HANSEN: Mr. Chair, I know among the commission members I've talked to that there has been consensus. I can't say I've talked to each one of you, but there's been consensus about the value of the voice that this group provides and from outside, the people that know I'm a part of this have also voiced that they value the interaction and conversations that this group is able to have in this process and that were it not here, there would be no conversation and that it's valuable for that reason. And I would support the notion that we advise this commission or a body like this commission to continue beyond June of '08. Which may rise to a motion. (Laughter) []

JEFF SANTEMA: So the motion would be to recommend to the Legislature that the commission continue. Is that (inaudible) motion? []

TOPHER HANSEN: Yes. []

JEFF SANTEMA: And I think was seconded by Dr. Boust. []

JIM JENSEN: Any discussion? And we will take this up...or when we get to public comment, there are individuals that may want to speak to that in the audience, too. I saw J. Rock and Bill's hand. []

J. ROCK JOHNSON: I think that the concept of the accountability and the mutual accountability has been extremely helpful. And for this group to be a venue that gives a voice has been extraordinarily important. My experience is it's difficult to get information. Most of the information that I get comes out of the block grant applications. And so to be...one thing, I think, that we need to perhaps develop more is a capacity to ask questions and have them answered. In addition, I'd note that the advisory committee and the planning council, being the block grant planning council, I don't think has really worked out very well. It's kind of confounded. And that advisory capacity--and I'm not saying it has to be specific--but I think that there's been part of that function for this group. But I myself personally feel hampered by not having had information, some of which I've specifically asked for or we've been told would be delivered and we did not get. For example, if I read it correctly, the November slides that...PowerPoints that came from the state did not include anything about the Office of Consumer Affairs and its activity, which I have a great deal of interest. So I think to be able to continue that kind of back-and-forth exchange of information, partnership, reflection, looking at the numbers is really critical as we go forward. Because reform doesn't happen in a day or a month. It happens over the long term and it happens when you're dealing with the right principles and values. And we need to continue to discuss recovery. []

JIM JENSEN: Thank you. Bill? []

BILL MIZNER: I would also like to voice my support in the continuation. I will tell you that prior to my being involved in this, my opinion and that of generally most law enforcement in the state was that the behavioral health system was something that we did not include us, that we should make every effort to divorce ourselves from it. And having been involved in this commission and the discussions I've had and the associations, I think that there's coming to be a realization that actually law enforcement is a part of the system. I think more and more officers are now taking a more holistic approach as they view this and they see that they play a key role, not only in responding to emergency issues and trying to get individuals in crisis to help or to take them into custody. But I think there's becoming a greater realization that law enforcement can play a major role in trying to divert them from actually going into emergency protective custody, but actually to try to divert them and work with other elements of the system to try to prevent that, which I think is in everyone's best interest. And I credit this commission with helping to bring all various aspects together to share views, points of views. Maybe everyone has learned a little bit about the entire system as opposed to their little piece of it. And I think that to stop it now, I think, would actually be a detriment to the further development and evolution of our behavioral health system within in the state. []

JIM JENSEN: Thank you. Any other comments? []

GORDON ADAMS: Call the question. []

JIM JENSEN: The question has been called for. All those in favor say aye. Opposed. []

MARIO SCALORA: One abstention. I don't feel the need to vote on my continued involvement. Seems personally bothersome to me. (Laughter) []

JIM JENSEN: Let's go back to item seven and then we will take public comment right after that. The pending Medicaid MRO legislation, Jeff, who was... []

JEFF SANTEMA: Scot, does Roxie plan to talk about that? []

SCOT ADAMS: We had some conversation with the Division of Medicaid and Long Term Care and Roxie Cillessen, who works in that division, has some thoughts on...with regard to that. It's a little bit of a fluid situation, but I'll try to fill in (inaudible). []

JIM JENSEN: Okay. []

ROXIE CILLESSEN: I'll try to be pretty brief. This is the MRO proposed rule change for CMS, which is the Center for Medicare and Medicaid. And it's really pretty much just been out there. They did public comment that was finished in October. It really hasn't moved. After Scot asked me to do this, I did quite a bit of research trying to find out, even calling CMS. And it's just out there and hasn't moved and that's not especially uncommon, I've learned, that a lot of these rule changes do take time before they're finally published. I can tell you the purpose for the rule change is that CMS, over time, has felt that a lot of services have been charged to the rehab option that perhaps intrinsically were services that belonged to other programs. So they intend to put this rule, this rule change out there to better define what rehab services are. I can just say it bluntly: they believe that states charge things like their child welfare services, their juvenile justice services to the rehab option when it's not specifically for the purpose of mental health rehabilitation. And so they state that their purpose is to continue to pay for mental health rehabilitation but they do not intend to fund other programs with Medicaid money. This also is not uncommon that they're doing this with a lot of their services. So there are a number of Medicaid rule changes out there on various rules because they are kind of doing this in all of their programs. They want to be certain that their money is going for Medicaid and medical treatment and not for other services. I think that we

looked at...we've looked at our services here in light of the fact that they've indicated they're going to come and audit. And they have been out and audited other states. There were three states, I can't remember. West Virginia was one of them. But there were three states that they went to and there were substantial findings in those states, that the money had not been appropriately used for mental health rehabilitation, particularly treatment, foster care programs notoriously have been used to fund by mental health rehabilitation. And they've been very clear, they're not going to fund those programs for treatment of foster care anymore through the medical rehabilitation rule. So the things that we've looked at, we've looked at our regulations. We think our regulations look pretty good. We've read the rule. We think that we're in pretty good compliance. We're continuing to look at this. There are a couple of things in the rule that, depending on how they interpret them when we get the final rule, may have some concern for the state of Nebraska. And they are the kind of services that we bundle up, we call them bundled rates, that this proposed rule change is going to take specific...call specific attention that whole Medicaid payment model which is fee for service. Medicaid loves that fee for service model. And in many of the rehabilitation services, because of how the services are delivered, it's difficult to fund them as a fee for service. But they're going to look at case rates, they're going to look at per diem payments, and they're going to look at bundled rates. And if they do that and if they come into our state, we are going to have to pay particular attention to the services that we have that are paid for that way, particularly community support and the ACT services that are paid in bundled rates. So we'll need to look at those services. We still believe that with...we have really good documentation from our providers and we've been trying to encourage our providers to do really good documentation, that if we really do have really good documentation, even the bundled rate would probably stand up. But that is some of the things that we're looking at in terms of this proposed change. But it's just sitting there right now. It's not going anywhere. The comment period is over and it's just sort of there. []

JIM JENSEN: It's not really a matter of if, it's a matter of when they're going to do an

audit. Isn't that correct? []

ROXIE CILLESSEN: That's pretty much true, yes. They've put everybody on notice. We're coming. We're coming and we're looking. []

TOPHER HANSEN: Is it all rule change or is there legislation? []

ROXIE CILLESSEN: It's rule change. []

JIM JENSEN: Well, thank you for giving us that information. []

J. ROCK JOHNSON: I have a...one question. []

JIM JENSEN: Yes. []

J. ROCK JOHNSON: Has any consideration been given to a biopsychosocial definition of medical necessity? And were consideration to be given to that, it might make a difference (inaudible). []

ROXIE CILLESSEN: CMS has used pretty much the same medical necessity definition for as long as I've been involved with this process. So that would be a legislative change. And so I don't really know if there is a movement afoot to do that or not. []

J. ROCK JOHNSON: Well, that's something that came out of SAMHSA a few years ago and I can't name you states, but I would suggest that it would behoove us to look into that to see what kind of flexibility that might offer. []

ROXIE CILLESSEN: You probably all know that SAMHSA and CMS are two different medical organizations and they function very differently. I mean, SAMHSA does function more around that social rehabilitation model and CMS functions around that medical

rehabilitation model. So they're really different. They are. And I think what you're talking about probably would more likely come from the SAMHSA organization and be funded that way. []

J. ROCK JOHNSON: Well, it was in connection with how to change CMS and I'm delighted to say that the two are actually talking with each other. []

JIM JENSEN: Thank you. While...first of all, is there any other business? Yes. []

DANIEL WILSON: Senator, just very briefly. Maybe it could have come up in the one time only or in earlier discussion, but I would just wish--assuming the commission does continue--that we don't lose focus of something I've talked about previously, which is getting beyond the current situation in which Region 5 has a different relationship with institutional care in the state as opposed to the rest of the state. []

JIM JENSEN: Thank you. Yes? []

SUSAN BOUST: One quick announcement just for your information. Senator Jensen continues to work on potential legislation that would fund that behavioral health education statewide interdisciplinary piece that we know is so essential to kind of finishing up this program. So just so that you're aware of that and not surprised as we come around and continue to talk about that. []

JIM JENSEN: Thank you. And while we're...as we now will open it up for public comment, I'm going to just pass around. This is a program, and since we won't meet before then, on January 15 and this was done before the events that happened in Omaha at the mall. This is being put on by the Nebraska Medical Center, Lasting Hope, and Alegent Health. And it's targeting violence in the workplace and on campus. If you have any interest, you can certainly notify them. But it's, I think, a worthwhile program. With that, we're ready for public comment. Yes, come forward, Alan. []

ALAN GREEN: Commission members, I'm Alan Green. I'm executive director of the Mental Health Association. I just want to voice our support in the motion that was passed regarding the reauthorization of the commission. For us, if it even comes to the core of LB1083 that talks about inclusion at all levels. The discussion today is a good example of communication that never would occur if this commission didn't exist. There would be bits and pieces coming out from the division, all different things, and you'd have to know exactly what to ask for to get hopefully whatever information you wanted. There...we need more accountability, more transparency to make sure that the behavioral health system provides efficiently and effective service. And so this commission is very, very necessary. I agree also with what was brought up about having the commission have the ability to even ask more pointed questions. Being the mere fact that the division and the Department of Health and Human Services is an executive level department, for the Legislature this is really the only mechanism that I know of that you have direct conduit of this level of information. There might be...you know, there are financial conduits but to be actually talking about levels of service and having the ability to have a dialog, this is a very, very unique instrument. And it's very, very important. So again, I want to thank all the commissioners for all that's been done over the last couple of years, watching the evolution of not only the whole behavioral health system, but the commission itself has been very interesting and enjoyable. It's been frustrating at times but all in all it has been very, very effective and it's very, very important that it continues. Thank you. []

JIM JENSEN: Thank you. Anyone else? []

JOHN PINKERTON: I'm John Pinkerton. I've spoke here before and I've been to about every one of these meetings there ever was. I'd like to second Alan's idea here of using MHA and NAMI to do any education possible. NAMI and MHA rely on very, very, very few dollars and do a great deal of educating a lot of people. And matter of fact, there's four NAMI board members in this room right now and I don't know how many MHA. But

they're great organizations and I hope you all can help support them in any way you can. I would like to see, myself, I'd like to see this commission continue. I do think it's a good forum. And even though there's hardly any time for public comment at the end usually and everybody is gone when they talk. But in that regard, I would like to see more--some--representation from private enterprise on this commission. People that...for-profit businesses that pay taxes and pay some of your salaries out of those taxes. I'd just like to see some representation by private enterprise here. And along those same lines, we really need to look at conflict of interest in regions providing direct care. As a taxpayer, it really, really disturbs me and I plan to make a...I own a printing company and I plan to make it obvious to a lot of taxpayers this year of the conflict of interest that's perpetuated by HHS through the regions providing direct care. I think it's wrong. I think it ends up with taxpayers paying way too much for things. What Topher speaks to about private enterprise or small business providing services at 1/3 the cost that HHS or the regions can provide it is very true and I just think it's a very bad thing for regions to be providing direct care. And as a competitor of a region in North Platte in Region 2 and having to witness the horrors of having to compete with government, having the government as a competitor, it's very, very bad. Three years ago when I first got crossways with Region 2, it was because they would not acknowledge that...I wanted them to acknowledge that we need more psychiatrists in North Platte. They would not go along with that, would not acknowledge it. Now the only psychiatrist in North Platte has had a stroke and we have zero psychiatrists in North Platte. Again, conflict of interest perpetuated that, or caused that. If we could do something about that, and I beg all of you to think about the downside of conflict of interest. It's just not good. Regions paying themselves to provide services. Not a good thing. Merry Christmas and thanks for letting me talk. []

JIM JENSEN: Anyone else, public comment? Eric. []

ERIC EVANS: Good afternoon. I'm Eric Evans. I'm with Nebraska Advocacy Services and I, too, would like to recommend that the commission continue in some form. I think

LB1083 was a very ambitious piece of legislation. It's taken a lot longer than we had anticipated to move where we are today. I think we've made some significant progress in terms of our work with reducing the regional center services and population, increasing the capacity of community services, including consumers and family members in all aspects of services planning and delivery, and beginning to move towards a recovery-oriented system of services. But clearly there's more than meets the eye. And if we listen to the discussion today, and these may be subparts of these other things, but you know, the Office of Consumer Affairs is still out there in terms of scope and definition of its activities. The issues...the placement of sex offenders within the behavioral health system and how that impacts not only institutional resources but community resources. Emergency protective custody issues that are out there. Funding, the mental health professional and provider (inaudible) that are there, peer organized and operated services as well as the new issues that you began dealing with today in terms of children services. So I still think there's a lot of work that needs to be done. And this commission, and I think the ability of this commission to become...develop real good sets of questions has increased steadily over the last four years. And today I thought was a real good example of why we continue to need this commission. I guess there are three reasons: accountability, accountability, and accountability. So I urge you to continue that. Senator Johnson, if possible, I would hope that, you know, a bill could be introduced on behalf of the Health and Human Services Committee to continue this. But if that's not possible, hopefully we'll have somebody out there who will take this on and move it forward. Thank you very much. []

JIM JENSEN: Thank you. Any other comments? Yes. []

PATTY JURJEVICH: Good afternoon, everyone. I'm Patty Jurjevich, Region 6 administrator. I did want to respond to the comments that were made about the 16-bed secure residential. I think the comment was made that it was a top-down kind of process and it was very much different than that. It was the community taking a look at what the needs are for folks that are in Norfolk, our residents in Norfolk. We did some study

around to answer the very simple question: what are we missing in the community to be able to bring our residents back? And so the secure residential was one of those needs. Other needs, some supportive kinds of services that we could wrap around individuals in nursing facilities and DD kinds of residential facilities. So it isn't just the only service that we feel we're missing. Obviously we're going to be hopeful for some additional dollars to meet some of those other services. But it was very much specific to Norfolk Regional Center residents and came out of our community and we obviously pitched it to the state and they felt like they could support it. So my other comments, I hope that you continue to ask questions around the dollars. I am still concerned that the dollars that are due to the behavioral health system need to come out to the communities, whether it's the sustainable dollars or the one-time dollars. So I ask you to continue to ask those questions. And then I think it also enforces the need for this kind of group to continue so that we can continue to see those questions asked. So thank you. Happy holidays. []

JIM JENSEN: Thank you. Any other comments? []

JOEL McCLEARY: I have one. []

JIM JENSEN: Yes. []

JOEL McCLEARY: Joel McCleary, consumer affairs at behavioral health. I wanted to just tell you that I appreciate what you're doing. Was talking to a group yesterday who are finishing up their wellness plans and one of the...I told them I was going to be here. I said, is there anything you'd like to have me say? And they...two people did say, one is, thanks for the money that I do get, not enough but it's helping. Another asked that you remember where they're at and they're looking forward to going home. And another called last night and she was upset. She said, you know, I am going to be going home and I know there's hundreds of people like me out there. And she didn't want it to be wasted, that her days over the holidays are going to be at the regional center. But she

said a couple hundred of my friends, I know, are out there. They will be home for the holidays. And I thought that was a....that's a goal. I mean, you're helping that to become possible. So thank you for giving the time you have all this time and it does make a difference. Huge what you're doing. And I appreciate everything you're doing in terms of listening and applying what you hear. The consumers know that you're working on their behalf and I try to make that clear. And so just thank you. []

JIM JENSEN: Thank you. Any other public comment? J. Rock. []

J. ROCK JOHNSON: I wanted to ask Joel McCleary who's just spoken here at public comment if he has developed a program of work for the Office of Consumer Affairs. This was brought up previously within our commission. And if not, could we please have that for our next meeting? Or if you wanted to distribute it to the commission prior to that time, I'd appreciate it. Do you have a program of work (inaudible)? []

JOEL McCLEARY: Well, I have work and I think it's a program. I'll define it better for you. We're working on it. []

J. ROCK JOHNSON: Okay. Well, as soon as you have it, I'm sure all of us would be interested. Also, I don't know where the failure to communicate came in, but I ask the division to please bring copies of the directory which comes out in January of '08. And it's 139 pages, so for those of us who monitor our ink, we would prefer to get the copy. So I got four copies, two of which have been commandeered with my permission by the individuals to my left. I'm going to give one to Mary Angus and keep one. But I want you to know that this directory does exist. You can call the division and get a copy, or you can put your printer to work. Thank you. []

MARIO SCALORA: Move to adjourn, and happy holidays. []

JIM JENSEN: Thank you. Motion to adjourn. We are adjourned. Merry Christmas to all.

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