BEHAVIORAL HEALTH OVERSIGHT COMMISSION
March 14, 2008

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The Behavioral Health Oversight Commission met on Friday, March 14, 2008, in Room 1113 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing. Members present: Jim Jensen, Chair; Mario Scalora, Vice Chair; Gordon Adams; Mary Angus; Andrea Belgau; Susan Boust; Carole Boye; Shannon Engler; Topher Hansen; Linda Jensen; J. Rock Johnson; Doris Karloff; Bill Mizner; Howard Olsen; Barbra Westman; and Daniel Wilson. Members absent: Senator Joel Johnson, Brad Bigelow; Ron Klutman, C.J. Marr, Joe Patterson, Cindy Scott, Ellie Tompkins, Karen Weston, and James White.

MARIO SCALORA: Thanks, everyone, for coming. Mr. Santema, do we have a quorum present?

JEFF SANTEMA: Mr. Vice Chairman, I don't believe we do at this point.

MARIO SCALORA: We do not? Okay.

JEFF SANTEMA: We have 11 out of 25 present.

MARIO SCALORA: So we do not. So we can't approve...do any business. But we could take testimony. Okay, thank you all for coming. Senator Jensen expresses his apologies for not being able to be here for the beginning of the meeting, but he should be here shortly. So he asked me to start...kick the meeting off. We have a rather full agenda for our scheduled two hours, so I thought we would try to get moving as quickly as we could. Since we do not have a quorum present at the moment, we can't approve minutes or do any business that requires a vote, but I can ask, is there any new business we need to add to the agenda from any of the members of the commission present? Well, I take the silence to mean nothing, but knowing this group, if something comes up it will be brought to my attention later. []

JEFF SANTEMA: Mr. Vice Chairman, we do now have a quorum. []

MARIO SCALORA: We do now have a quorum. Mr. Santema, being the man on the spot as he always is, has just informed me we have a quorum, so we can address the minutes of the last meeting.

JEFF SANTEMA: You want to approve the agenda first, Mr. Vice Chairman.

MARIO SCALORA: Oh, I'm sorry. We also need to approve the agenda. Love to entertain a motion to approve the agenda.

TOPHER HANSEN: Move to approve the agenda. []

DANIEL WILSON: Seconded.

MARIO SCALORA: So moved and seconded. Thank you. all those in favor...any discussion? All those in favor please say aye. Opposed, same sign. Thank you. The minutes from the December 14 meeting are present. Are there any changes? Any comments on those? I see Ms. Johnson has made an offer to approve. []

DANIEL WILSON: Move to approve.

TOPHER HANSEN: Seconded. []

MARIO SCALORA: Second. All those in favor please say aye. Opposed, same sign. Thank you all. I apologize for the rather rushed and frenetic nature of that, but I thought we would need more time to hear from the Division of Behavioral Health. So barring anything else, I'd like to invite Mr. Adams and any other representatives. Sir, welcome. []

SCOT ADAMS: Good day. I thought that given the current nature of the Legislature and the situation there, I would summarize a couple of points but then be reactive to any questions and comments people might have with regard to things. So I'll be relatively brief here. You have previously, I believe, been given the typical, usual statistics and data with regard to system performance and the reporting that you have seen before, and I'm not going to spend any time on that at all today. I think that previously those have been highlighted and the meaningfulness of those presented, and so you're able to draw your own conclusions, I think, with regard to the data themselves. Three or four points I would like to make. One, of course, deals with money with regard to the system, and there is currently a...the Appropriations Committee has recently released its recommendations with regard to both this year's funding and changes in the current fiscal year funding, and also, then, funds to the community. And so there is an issue at play with regard to the legislative branch, going forward. The division's plan for about $8.9 million to infuse into the system was along these lines--it's a quick summary. About $2 million to Region VI for a long-term secure unit, about $2.9 million to regions in two sets of dollars, if you will--$250,000 to each region, totalling $1.5 million. The intent and purpose for those funds were to be able to sort of smooth out the particular idiosyncrasies in their own regions, and in particular, with two foci in mind: one with regard to helping to smooth out emergency system problems that may exist--those are dramatically different from region to region--and then the second, area focus then would be with regard to involving consumer-involved services as much as possible. And so again, by region there are a variety of difference of perspective and utilization. But most all of those have been approved at this point, and so moving forward with implementation. The remaining $1.4 million in that section, then, is additional monies, that has been announced (inaudible) in moving forward, contract revisions being developed and being considered at this point. We had intended to retain a half million dollars for systemwide, statewide perspective with regard to the emergency systems. Things that had arisen in terms of potential were training issues of a statewide nature, system development and enhancements for particular services where there may continue to be some emergency system problems in excess of the regional resources,

and then perhaps the largest single chunk of money in that, then, was a decision to withhold $3.5 million at this point for the potential development of a fifth unit at the Norfolk Regional Center. Happy to respond to further questions there, but in essence, LB1199 funded 120-bed of sex offenders in the current fiscal year, and we still have today, 37 persons in the mental health unit at Norfolk Regional Center. So that at some point it becomes a problem with regard to the funding intention of the Legislature and the Executive branch with regard to the sex offender population at Norfolk, and so this was intended to be a resource, should that be necessary. These are funds also that could go to the community, should that be a potential resource and potential answer for that, as well. Secondly, with regard to one-time money...and I might take a moment here to acknowledge the apt job of Dr. Scalora in your absence, Senator. He did a fine job. With regard to the one-time money, there is, again,...had been a number of discussions and intentions with regard to regions and with others, including the oversight commission, about the utilization of this. Our intention had been to use what is known as one-time monies for the, sort of the strategic improvement of this next round of operational monies; in other words, was there a twinning effect that could have a maximum beneficial impact? It is our understanding that the Appropriations Committee is intending to send the one-time funds to the regions by virtue of the formula, and so those plans are on hold at this point, pending the outcome of that discussion and the decision by the Unicameral and how that plays out. I should note briefly the nature of the one-time funds. These are funds that have been part of behavioral health reform over the course of the past several years, and for a variety of reasons have not been utilized. Some services began mid year but were not fully used in a current year, and so there was some left over, if you will. There are other situations where services came up and then went away, for a variety of different reasons, but did not continue on with regard to service provision, and therefore there was, again, sort of a chunk of money that was there. There was a timing question with regard to some of the funds, and in terms of when a service actually closed at a regional center and how much, then, really was available for transfer. And wading through all that, bumping situation with personnel and DAS and different situations, caused a delay in terms of arriving at a number. And

then the annual increase that has been generated the past couple of biennium budgets for services added to that amount, as well. And so all total, it has generated I think in the neighborhood of around $11.5 million at this point. So there is that fund available, and again, it's my understanding the Appropriations Committee is recommending that those be distributed to regions by virtue of the formula, the allocation formula. A third item that I'd like to report on is a recent accreditation and status of the regional centers themselves. There have been a couple of things of note that I think have happened that are, I think, significant. The Hastings Regional Center, within the last couple of weeks, has received its triennial site visit review, an unannounced visit by the Joint Commission, and there were only two standards with which the hospital was out of compliance out of nearly 400 standards. By anybody's book that would be an A+ in terms of the effort. The Joint Commission requires 100 percent compliance, but as those of you who have operated or been involved in accredited institutions, two out of 397 standards is a pretty good number, a pretty good hit. In addition to that, there were quotes in the letter and the documents that were laudatory about the level and the quality of services going on at the Hastings Regional Center. In the case of the Norfolk Regional Center, the Norfolk Regional Center is not Joint Commission accredited. That lapsed a number of years ago, but it is CMS certified. And the Centers for Medicaid and Medicare Services comes in on about an every three-year schedule as well, to ensure that the core Medicaid standards are being met. And that review occurred also in the February time frame--passed with a resounding positive review. The quote there was "Outstanding treatment is going on here." With regard to the Lincoln Regional Center, that unannounced Joint Commission site visit occurred in January as part of the regular basis. They passed 386 out of 397 of the standards and again, a very positive review would have been a resounding success there, except for a moment in which they visited the highest security unit, known as S-5. S-5 is the area of the hospital, the unit with the folks who are the most psychotic, if you will, and in dangerous situations. The reviewer, a psychiatrist, was concerned that there was an element of danger present when a nurse went down the hallway and was out of sight from the rest of staff for a period of time and had no other linkage or connection to other staff, and so placed the hospital in

what is known has an immediate threat, which is sort of a sidebar process through the ongoing review process of the mainline standards, if you will. It's important to note that the hospital never lost its accreditation but was placed in what is known as a PDA, preliminary determination of...what's the A? []

_____: Accreditation. []

SCOT ADAMS: Yeah. Excuse me--preliminary denial of accreditation, the preliminary denial of accreditation. It was a... []

TOPHER HANSEN: I had mine right. []

SCOT ADAMS: You had yours right. I didn't have mine right, and thanks for the help. It takes a team to deliver a report (laugh). And so there were a number of particular things that were identified by the Joint Commission to abate the PDA, and those included the provision and development of cameras on the unit and throughout the unit, the provision of emergency buttons for staff throughout the unit, the development of an additional security resource, a human security resource that would be present and available for simply those purposes, and a number of other items of lesser extent and impact, if you will. For a period of about two weeks, then, cameras were installed and involved drilling. There was a physical transfer of the people from S-5 to the gym area, for a period of two weeks during days, but they would sleep back on the unit at night, and so all the measures have been installed and complied with. The Joint Commission came out about a week and a half ago, completed its unannounced site visit to ensure that what we said we were going to do we in fact did, and in fact we completed more measures of security to enhance security than we had indicated we were. The event went well, and we have been restored to full accreditation status at the Lincoln Regional Center, because of the abatement of the PDA and because of the mainline review that was a highly successful review otherwise. So maybe with that, we could take a breath and see if there are any particular questions on that side. There are a couple of other items I

would like to talk about with my report, but if there are some... []

MARIO SCALORA: And you'll have the floor, sir, when questions are over. Thank you, Dr. Adams. Dr. Boust. []

SUSAN BOUST: Is there any plans to try and get Norfolk reaccredited? []

SCOT ADAMS: You know, not today. We're not entirely sure of the potential value for the changing model there at this point, in terms of the accreditation. On the one hand I value external accreditation, as a measure of objectivity and quality and those kinds of things. On the other hand, CMS is also doing that service and providing that service at no cost. And while it's not a huge cost by state numbers, it's about $36,000 a year for the privilege of them coming in and knocking us around (laugh). So today, because of the changing nature and mission, that's not anticipated. []

HOWARD OLSEN: You talked about $8.9 million that's going to be distributed in some fashion or other. How many funds are...what is the amount of funds that is undistributed? []

SCOT ADAMS: $8.9 million would be the number that, yeah, in this fiscal year are available. That would rise to $9.3 million in the following fiscal year and subsequent fiscal years, then. []

HOWARD OLSEN: Is the $3.5 million for the Norfolk Regional included in that $8.9 million? []

SCOT ADAMS: It is, and so that would be withheld, depending upon the nature of the use and need for a fifth unit. []

HOWARD OLSEN: What is the amount of the one-time funds that you referred to? []

SCOT ADAMS: I think I said $11 to $11.5 million. []

HOWARD OLSEN: And so if you take the $11.5 million and add to that the $8.9 million, is that the extent of the funds that remain undistributed? []

SCOT ADAMS: Yes. []

HOWARD OLSEN: What's the time frame with regard to the one-time funds and their distribution? []

SCOT ADAMS: The Appropriations Committee has intent language to be yet agreed to and voted on and determined that, I believe, has a 5-30-08 date. []

MARIO SCALORA: Mr. Hansen, you had some questions, sir. []

TOPHER HANSEN: The $8.9 million and the $9.3 million--those funds have...I think we identified this last year. I don't remember the month. But...so they've been sitting in the meantime and not being used. So there's been greater accumulation in the meantime, I assume, from that, and then the $3.5 million in particular which, as I understand it, the 120 beds at Norfolk are fully funded and the $3.5 million really sits on top of the money that's there for those beds now. And so what happens to that $3.5 million, because it does not look like this year it will be needed. As I understand a reasonable forecast, it doesn't even appear as next year that it would be needed and beyond that, I guess, who knows? So what happens to this extra $3.5 million that will be $7 million next year and $10.5 million the following year, if it's not expended? What happens to those dollars, and why can't we figure out a way to inject those things in the system, maybe in one-time funds, until such time as that money is needed? []

SCOT ADAMS: We provided testimony to the Appropriations Committee on that

question and indicated that of the $3.5 million, roughly $2.9 million could be used reasonably effectively on especially some of the things involving the Lincoln Regional Center in recent times. And so in the current year, with regard to the S-5 incident and security concerns there, there was some potential for that kind of thing. It's my understanding that the Appropriations Committee has some thoughts about that, as well, and so that may all play out in a different way. []

TOPHER HANSEN: So the $3.5 million for this year was used at the Lincoln Regional Center to help the accreditation process, the things you just described, occur? Is that what I... []

SCOT ADAMS: We did not have all the funds necessary in the straight operating budget within Lincoln by itself... []

TOPHER HANSEN: Right. []

SCOT ADAMS: ...to accommodate that. And so we'll have to figure out some other source in some other fashion to be able to do that. That seems like a reasonable source at this point. []

CAROLE BOYE: So the answer to Topher's question is, have you used it or you would like to use it? []

SCOT ADAMS: We have made the improvements, and over the course of the year, you know, the state simply pays its bills. And how it ends up accounting for that is going to be the question at the end of the fiscal year. []

CAROLE BOYE: So you can't answer that question right now. []

SCOT ADAMS: Because it's hard telling what's...how we're going to come to it. Yeah, I

think that's probably an accurate answer, Carole. []

TOPHER HANSEN: But you spent about $2.9 million in that process of improvement? []

SCOT ADAMS: Of improvements and...yes. []

TOPHER HANSEN: Okay. But I guess the overall point is, in terms of efficient use of dollars in a system that really needs to use all of its dollars effectively, we have a pot of money that's funding 120 beds, but sitting over 30 of those beds is a whole nother layer of funding that the 30 that are there, we're not even using the whole 120 beds. So we have money that's funding beds that aren't full, and on at least 30 of those, we have two layers of funding on those beds that is not being used. So what I'm saying is, can't we effectively use those dollars? And even if the position is that we have to have money in reserve down the road because this is the picture that we see to be inevitable, if those are used as one-time insertions in the regions in our state system for a number of purposes, wouldn't that get us further along than just holding the money? []

SCOT ADAMS: First of all, a couple of things. I think...because you scattered around in a lot of different directions, and I may not catch all of the points, but I'll do my best. It's important to keep in mind that Norfolk runs on 30-bed units, and it's sort of like a light switch--it's either open or it's not. And so while the census may reflect that we're in a less than 120-bed mode, we're in four units. We have 37 mental health patients and the rest are sex offenders, around 50-some, mid-50s, and so we are in all four units. And so for purposes of budget, really are at full capacity in terms of the dollars. []

TOPHER HANSEN: Even though beds aren't full, units have to be open. []

SCOT ADAMS: Yeah, yeah. Staffing is there, and you run residential stuff. You know that it's sort of awkward to do some of that. It's even more awkward, and when the beds have been configured from a prior year run and that kind of thing. So anyway, that's that

part of it. With regard to the lapsing of it, you know, there's another perspective that's going on, I think, that is closer to yours going on, and I think that that will be probably played out in the Unicameral. As for the efficiency and effectiveness, you know, I think reasonable people can disagree in terms of use of those funds for improvement of safety at a particular place versus deployment to the community, and so that's where we are, really, today. []

TOPHER HANSEN: I'm not sure I understood that part, that that is to say... []

SCOT ADAMS: Well, in saying that some of the funds are...have been used at Lincoln for improvement of the security. []

TOPHER HANSEN: In the regional center. []

SCOT ADAMS: Yeah, yeah, so. []

TOPHER HANSEN: Okay. []

CAROLE BOYE: Scot, on that same subject, did I understand you to say that as you were going through all the dollars, the $8.9 million, the $5.4 million, the $3.5 million, and the $11.5 million, which has actually been identified at about $11.6 million the last I saw of carryover money, all of those are identified funds that were generated as a result of moving...of services being moved from the regional centers into the community under LB1083? They're all LB1083 funds; is that right? []

SCOT ADAMS: Well, I probably disagree with you a little bit, but it might be an accountant's quibble more than anything, Carole, with regard to that. []

CAROLE BOYE: Okay. []

SCOT ADAMS: And while the base of the funds are all service reductions or closures,... []

CAROLE BOYE: Okay. []

SCOT ADAMS: ...some of the funds also accrue as a result of annual increases,... []

CAROLE BOYE: Right. []

SCOT ADAMS: ...which are not really the services source, if you will, but an increase granted by the Legislature. And so... []

CAROLE BOYE: Okay. []

SCOT ADAMS: ...but would be on those dollars, if...it's splitting a hair, I think. []

CAROLE BOYE: Well, and with that, I mean, that actually was the discussion that we had last fall, and I think we all came to some agreement that that portion of the increases over the years since LB1083 passed would be proportionately kind of attributed to...to move out of the regional centers and some would obviously stay with the regional centers. []

SCOT ADAMS: Yes. Yeah, I agree. I just wanted...in your question here, if they were all services, just wanted to make sure everybody understood that they all derive from the services. []

CAROLE BOYE: Okay. I think that...I guess my question is, is that under the provisions of LB1083, which is state statute, as we talked about two meetings ago at the oversight commission, it says that all funds attributable to the reduction of services from regional centers shall be moved into the community for the development and provision of

behavioral health services. So the desire to spend $3.5 million of the $8.9 million that has been identified as to be transferred as the result of reductions in services, to use that for regional center expenses, be it for, you know, meeting accreditation standards or what have you, I'm not sure is consistent with the language of LB1083, which says all funding shall be transferred to the development of community-based services. Could you comment on that? []

SCOT ADAMS: Yes, and thanks. I think it's a good question, and I think it probably is a question that comes at the end of the...near the end of the time and the closeness of how close we are to success here, overall. And so I think it's a great question. What I would say is that I think it's really important to keep in mind that over...that LB1083 looked at the system and said, we're moving from this kind of a system to this kind of a system. It also spoke about the reduction of particular services at a regional center, though not at any one regional center, over time. I think that your perspective is a valid way to approach the question. I don't mean to demean it or to deny it. What I would offer, though, is another reasonable perspective, is the total system perspective overall, that as LB1083 was impacted, the number of people and beds in service has gone down, and that that has largely been pretty much a flat, straight line at Hastings, for example. It has been a line that--it's a closure, by the way, for adult services. And at Hastings it has been sort of leveled off here for a couple of years now, and at Lincoln has been sort of that. My point is that as a system, we're still on system moving down, and that as a system, if the system is able to absorb more folks into the community, that's great. That will continue that downward trend overall. But if we're at a bump in the road, where for some reason the community-based system is unable, unavailable to sort of finish off completion, we've got...the state has to make sure it has the ability to care for whatever number of people are left in its care. And so what I guess in summary I'm suggesting, to try to say this as succinctly and clearly as possible, I think there is validity in your view of a service-by-service decline, but there also is validity in saying that there is a regional center system of care that has to be looked at overall. Let me give you another example of this that is parallel, but I think very much on point. In the

discussion of how much money goes to the community, that has only been a revenue-above-the-line consideration, how much money has been allocated for those services at that place. It has not been a net consideration. In other words, we still pay rent at Hastings Regional Center, despite the fact that all the revenue has gone into community-based services. A systemwide perspective has to take into account sort of the net availability. I mean, like it or not, we still have a regional center, and even if it's closed, the state is paying for some element of it. And so that's another parallel example, just to sort of articulate the point. []

CAROLE BOYE: Yeah. And you know, as a businesswoman, I totally appreciate all of that, but I would suggest with the oversight commission hat on that a reading of the statute makes it very clear that money shall be transferred. I mean, that's the language--dollars shall be transferred, and that everything that you have just said, I think, is absolutely appropriate conversation to have with our state legislature, saying there are still needs within our regional centers. But our state legislature and our Governor did speak in LB1083 and mandated the transfer of dollars. There is very clear language, and I guess I would just suggest that the language doesn't allow us to have a debate about where that money is to go to, and for what purpose. That's all. And we can continue to have this discussion. I would like to see this discussion....I would have liked to have seen this discussion of the needs of the regional centers for security cameras and that we're still paying rent at Hastings and all of those things, to have been brought forward to the Appropriations Committee at the time of the HHS hearing, as opposed to, let's borrow money from here, or let's do this or that. Let's have a clear accounting of all the needs, as opposed to after the fact saying, well, yeah, but we have some of this money here and we need to do this for this fiscal year and that. That's all. As a businesswoman, I like straight cost centers, that says this or that. If I could ask just one more question, which is, the sheet that was put in front of us... []

MARIO SCALORA: Mr. Santema, would you explain what that was, please? []

CAROLE BOYE: Yes, would you do that? Because lots of numbers have been talked about, and I think this is the Appropriations Committee language, is that correct? []

JEFF SANTEMA: It is. It's a summary prepared by the Legislative Fiscal Office of what the Appropriations Committee did. []

CAROLE BOYE: Okay, and so would it not be correct to say that under this language, that the Appropriation Committee's budget, at this point in time, actually recommends that the $3.5 million that are being set aside--back to your question, Topher--that the $3.5 million that was set aside for that extra unit at Norfolk for this year, is being in fact reappropriated to one-time funds to the regions, under this language, for this year? And then next year, if it's needed, it's there for the regional centers. If it's not needed, then it will be sitting in, I assume, Program 365 for potential distribution. But I think for this year, Topher, what you were suggesting, the Appropriations language does, in fact, appropriate those dollars. Am I reading that correctly? []

SCOT ADAMS: That's how I read it for the current fiscal year. []

CAROLE BOYE: Okay. []

SCOT ADAMS: And by the way, Carole, we did at the Appropriations Committee hearing make those arguments with regard to the funding. []

CAROLE BOYE: I was at the Appropriations Committee, and I heard use of what I would...what I term LB1083 dollars for some of those needs. I didn't see it separated. I...but I appreciate... []

SCOT ADAMS: We did provide the committee with the information. []

CAROLE BOYE: ...what you're saying, because this is all very confusing. []

SCOT ADAMS: Yeah. And the place for the debate does go on in the Unicameral, and so that conversation, as you can see, is engaged currently. []

DANIEL WILSON: Thank you, Scot, for your overview of all this, and just very briefly, congratulations on the reaccreditation. In addition to the $6,000 of direct cost for Joint Commission, though, more significantly is a huge amount of staff time that's taken away from direct patient care and recovery services for all sorts of bureaucratic reviews. I'm not a great fan of Joint Commission. I'll say that on the record. But congratulations for that, and I think it lays the framework for ongoing good clinical care, improving that foundation perhaps for more collaborations with the community and educational services. And I gather Norfolk is trending toward a forensic kind of population, sex offender population longer term? []

SCOT ADAMS: Sex offenders continue to come into the system at a one- to two-, sometimes three-month basis. We have ongoing conversations with the Department of Corrections for those folks who may or may not be coming to us from that source. And there are, of course, sex offenders also in treatment at the Lincoln Regional Center, and so they are increasingly a regional center system of hospital care. []

DANIEL WILSON: But is it the intent to have Norfolk continue as an HHS regional center or not? []

SCOT ADAMS: Norfolk has today a mixed population, 37 and mid-50s. And we hope to, with the resource to Region VI, the new services there, to be able to get under the magic number of 30, and with the infusion of the rest of the dollars in the system, there may well be opportunity to be able to bring that down further. But I don't know that today, and I have to admit that these have been folks that have been reviewed by a lot of different people, in terms of variations, not only their region of origin, but efforts with nearby regions and resources, and folks have declined to accept them. []

DANIEL WILSON: Thanks. Now to turn to the, what I might call the cookie jar money that you've got here, $11.5 million. []

CAROLE BOYE: That's quite a cookie jar. []

SCOT ADAMS: It's a hell of a cookie...Girl Scouts would go crazy, wouldn't they? []

DANIEL WILSON: We had...and this is perhaps relevant Carole's question as well, we still have this anomalous situation in which Lincoln Regional Center is a community component for Region V. Was there any consideration given, as has been discussed here previously, to using money to change that situation? []

SCOT ADAMS: Well, we had had conversations with a couple of other hospitals and can't get a buyer, can't get a taker at this point. Now whether or not the region wants to reconsider that and try it again, but that has been historic anyway, in terms of willingness to participate. So it has not been necessarily one-sided in that regard. The regions, with the distribution of these funds, come back into far greater balance with regard to the formula overall, and Region V will be receiving one of the larger distributions of the funds, though they'll still be under the target for their area. []

DANIEL WILSON: Well, I guess my question could be put differently. The rationale for continuing to use Lincoln Regional Center as a...in a way distinct from the rest of state, for Region V, as a receiving hospital basically for them, the rationale was that they weren't given the start-up dollars a few years ago. And that's a very reasonable point. But it has been stated here over a number of meetings, even over a number of years, I think, that that should be addressed and corrected, if and then there was money available. There appears to be money available. The idea that there isn't a buyer presumes that every other hospital in the country buys into indigent care, and they don't. They accept that responsibility. Long term, this needs to be...I think this needs to be

fixed, because it creates a two-system hospital, state hospital arrangement in perpetuity. []

SCOT ADAMS: I think your point is well taken, and I think with the infusion of these monies, it's an element and an opportunity revisit the topic. []

DANIEL WILSON: Thank you. []

JIM JENSEN: And also on top of that, Dr. Wilson, we are losing Medicaid dollars. That was one of the reasons for LB1083, to get those into the community, and so as long as we're...keep the institutional approach, we will not have those Medicaid dollars. Anyone...oh, yes. Mary. []

MARY ANGUS: Scot, one of the things, like you said just now, the maximizing or increasing or even getting Medicaid matching funds was important. Are we going to be using that in the residential secure in Region VI? Will we be able to use Medicaid there? []

SCOT ADAMS: In the new program? []

MARY ANGUS: Residential secure. []

SCOT ADAMS: Yeah. We are taking a final look at the regs that have been proposed, to see if that's possible. We're not fully sure of that question at this point, but efforts are being made to ensure that. The other dynamic at play, that we want to make sure that we're careful about, is in writing regulations that fit a state and not a particular service--we always have to write them across the whole length and breadth of the state--that we don't have unintended consequences. The potential for unintended consequence in here represents something of a potential for conflict of philosophy, if you will. Let me put the hypothetical situation out there that we're considering. If

Medicaid regs are written such that subacute can be matched in a variety of settings and places, then that's a high-end service, and the short-term effect is good news, that you get Medicaid to participate in it. Longer term, though, the match has to come out of behavioral health funds, and so if lots of places start using subacute services, then that match has to come from someplace. That's one of the questions on wanting to be careful about the infusion of the dollars to regions. But we could be faced with a situation, to put it bluntly, that if subacute all of a sudden springs up all over as a good idea, then intensive outpatient community support and less intensive services could well be cut to help pay for the match for the subacute. And we don't want to do that, I don't think. []

CAROLE BOYE: That's a policy decision, though, that the match has to come out of behavioral health dollars, is that correct? []

SCOT ADAMS: It's a decision that we will be living within the dollars that we have. []

CAROLE BOYE: Yeah, but it is a policy decision. It's not a federal regulation decision. []

SCOT ADAMS: The monies have to be matched. []

TOPHER HANSEN: And if I might, on that point, we don't want a whole bunch of subacute services, because there probably isn't the data to demand it. That a system has a balance to it, and there should be a short piece on the emergent end and then a larger piece in the middle, with out-patient services and services to fit the need, which aren't all acute or subacute, and so you put that balance. In Lancaster County we have 15 crisis beds for a population of 250,000 people. We don't think that we probably need a lot more than 15 beds if the system is in balance, but we have to get the whole system in balance to do this. But the issue I have, then, is...on especially the 30 beds at Norfolk, are one, what Carole was pointing out, which I think is exactly right on this issue, which is, this is statutory language and does not give management, if you will, discretion on

where to go utilize the funds. It is directed as to where it shall go. And if then indeed we have a problem at Norfolk, where there are individuals with severe, persistent mental illness who need continued assistance at that level, we would be smarter to put that into a community-based system, strategically located community-based system that could capitalize on the Medicaid dollars for those same 30 beds. So instead of $3.5 million behavioral health dollars, we leverage the Medicaid and we have money left over to enhance or grow other services. It just isn't using the money effectively, and you know, boy, Howie, when I look at my short-term residential program that is a substance treatment program and 100 percent of the people there are co-occurring, and we have a psychiatrist that we're paying out of our own pocket and all those things, I want enhanced services there. We need to think smartly about how we're delivering these things and use our money wisely, and I don't think just scraping that off the top is a good idea. Number one, it's contrary to statute, and I think that point has to be just really, really banged loudly to the Legislature. And number two, it doesn't leverage the money in any effective way for our whole system. So I would really like to see these monies get into our system so we can utilize them in a way that attends to the services that are needed and more effectively leverages them for the greater good. []

MARIO SCALORA: Do you want to respond to that? []

SCOT ADAMS: Nah. []

MARIO SCALORA: Okay. Ms. Jensen, did you have a... []

LINDA JENSEN: Oh, well, my question was about the subacute services. Haven't those, or have they been shown to decrease to recidivism--I guess I pronounced that word right--as far as, you know, if people have adequate...if we have adequate time to help these people find what they will be going into in the community and have a little bit, that adequate, you know, transitional time, and so that that might help in the long run? I know it's probably not been in place long enough to really see those results maybe, as

far as numbers, but... []

SCOT ADAMS: You know, I...Linda, I appreciate it, and intuitively it makes some sense, but I'm not aware of any data that supports that or disconfirms that. There is data that lower-level services, and surrounding a person with a variety of in-home care and lesser intensity services makes a difference, in terms of recidivism and relapse. But I'm not aware about the...I just...I can't comment on the subject because I haven't seen anything. []

LINDA JENSEN: Because that was the reason for even starting those subacute services; isn't that correct? I mean, is to have kind of transition, where they (inaudible). []

SCOT ADAMS: Oh, I think it probably...I think the conversations I heard, which began before I got here, were related to cost limits on high, expensive acute care costs and wanting to keep people a little longer at a lesser rate and a little less intensity. So I think, again, the point that you're making is intuitively correct, but I have not seen data one way or another. []

LINDA JENSEN: So they have time for learning more about (inaudible) and other skills, you know, that they can use. []

SCOT ADAMS: Yeah, it makes sense. []

MARIO SCALORA: Mr. Olsen, you had a question, comment? []

HOWARD OLSEN: You referred, in the one-time funds, that one of the reasons those funds are available is because some of the community services haven't worked or the programs have gone away for one reason or another. You also referred to bumps in the road along the way, and so I assume that across all the regions that there have been

some difficulties with one or more programs that may have not worked or may not have been structured correctly. And I guess what I'm wondering about is, what resources does your office provide to the regions to help them with alternative programs or to help them restructure existing programs, to move forward with a particular community service that doesn't work very well? []

SCOT ADAMS: Yeah, good question. The rubber meets the road in the regions and through the regions, and so the role of the division is to provide sort of cross connectivity among regions, so that if one region is having a problem with, say, bringing up a pscyh res rehab service in a particular region, that the division, because it has connections throughout all the state, may know of a resource to help that person or that provider with or the region with. We have those kinds of conversations on a weekly basis and also on a spot basis, if you will, as troubles occur. Because we have a role in the system that's defined for us as an approval role, we want to make sure that we can help people think through and troubleshoot, if you will, ahead of time a lot of times, so that as plans are developed by regions for the beginning of services, if they're missing a component around licensure, or they've forgotten about particular zoning issues that may be in one city versus another, we can sort of bring those to their attention. Yet another way that I think we can be of assistance is Dr. Schaefer can help provide some clinical review and input to the program plans that are developed for the clinical side. Most often regions and providers have pretty good sets of those, but you know, sometimes an extra set of eyes doesn't hurt and can be helpful in that regard. We have close relationship with a separate piece of the Department of Health and Human Services, that is to say, Regulation and Licensure side, and we can be helpful in clarifying an application process in terms of our nomenclature versus others, and that kind of thing, and so those are four or five different ways, I think, that the division can be helpful in there. []

HOWARD OLSEN: Do you have staff that are regularly in the field, offering those kinds of resources? []

SCOT ADAMS: Yes, sir. Each region has a field representative assigned to it, and we try to maintain consistency with that person over time, so that they know and physically are present in the regions. []

JIM JENSEN: Okay. I just want to remind you...and first of all, I apologize for being late. I was at a Great Plains public health conference that I had committed to before I ever even set up this meeting, and so I thank Dr. Scalora for filling in while I was a few minutes late. But we're...we have many times to discuss yet today, and this type of discussion, I think, however, tells us perhaps the importance of this committee, and I think we...if there's any pressing questions of Dr. Adams, certainly I want to hear those. But if not, we've really got to watch our time. We do have a...we can stay in this room until 12, maybe a few minutes after. At 1:30 there is a Children's Behavioral Health Task Force that will meet here, and so we're a little pressed for time, and I certainly...it's a very important meeting. I want to do as much as we can and accomplish as much as we can. []

MARIO SCALORA: Mr. Adams had a few more points before...Topher, did you have another question, real quick? []

TOPHER HANSEN: Yeah, on some of the data that was handed out to us, and Scot, you may have seen in the Lincoln Journal where they talked about a gentleman in the York County Jail who couldn't get into the Lincoln Regional Center, and even later heard the Speaker of the Legislature say...recount that story and say that the guy was eighth or tenth or somewhere down in line and he couldn't get in. But when I read these numbers and then hear what I hear at the local level, at the regional level, in terms of where the regional center census is, I don't understand those two conflicting bits of information. Do our regional centers...are they jammed up and there's no room and people can't get services, or...this says that there are openings and people can get services. []

SCOT ADAMS: Yeah. You know, I think there are two or three pieces of information that may help to clarify that. One, the particular situation was complicated by virtue of the S-5 stuff, and we quit taking folks into that unit during the time when we were remodeling the unit. So for two and a half weeks or so while we got equipment and getting used to the new procedures and stuff, we just sort of had to say, heek, yikes, you know. And so there was...that was a complicating factor, and a number of folks waiting to get in for forensic evaluation did back up. That is now back down. I think also there was an unusual sort of blip in the number of those that happened, and that's one that you just can't predict, when somebody is going to go off, commit a crime, and also have enough behavioral health involvement that the judge calls for a competency restoration or things like that. So, sort of had a couple of bad moons align in that one. Secondly, it's important to note that that side of the business, if you will, is separate from the general psych side, and so when you see the fullness of beds, if you will, there are 100 general psych beds, and I think we were at 91 one or so. A number of people are taking up two beds or taking up a single bedroom by virtue of issues of safety, and those are issues that are challenged from week to week and tried to resolved so that we can get two people into the room, but we have a number of cases where we may look like we're below census in that regard, but because of those factors, we may not be able to get somebody else in at the particular time. So those are a couple of things that I would say in response to that. []

MARIO SCALORA: I might be able to add some insight into that. There's a bigger-picture issue that affects some of the general psych issues. I would agree with what Dr. Adams has said, but because of the shifts of resources that have taken place in our communities,...for those of you who don't know, for the past 15 years I've had the privilege of coordinating forensic evaluations at our secure unit. We do three types of services in that unit. One is evaluations for the courts, second is providing competency restoration and treatment for those declared not responsible by reason of insanity, and the third is providing secure services for people who are deemed unsafe at whatever

level of community service. What has happened is we have aggressively done everything we could to deflect any admissions to that part of the hospital for evaluation, consistent with what many states are doing around the country. I can count on one hand how many times we have actually had to do a formal evaluation, just strictly it's a service on an in-patient basis. All the evaluations we do for the courts on a (inaudible) patient level. For the 40 beds, and there are now 43 forensic beds now because of the changes we've had to make due to JCAHO. Half of those beds are designated for (inaudible) treatment for those not responsible by reason of insanity or (inaudible) for competency, and those are not general psych beds. Unfortunately, what has happened is that half of those beds are now taken up by folks who would have come in through the civil commitment system, who may have been at one point in a general psych bed, but because of...and I think legitimate issues of violence or concern in the community, they were deemed unsafe to be treated in a community setting or other regional center bed. What happens is that those people take up a secure bed, and while they come in rather easily because there's a crisis that precipitates it, we cannot move those people out very easily. And the six regions have very different views as to what priority those people have, in terms of reintegration back into the community. What that has meant is that we have a waiting list now of 12 people under forensic rubric, who would traditionally fit a forensic psychiatric admission process. Most of them are not competent to stand trial, very similar to the case you read about in your county. What happens is we...which we have not had in close to seven years, we now have a waiting list for forensic admissions, in part because we cannot move the civil cases that have been sent to us, because of security issues and being able to move them to other services. So that is the issue that is taking place. Related to that I think, Dr. Adams and many of the staff, both inside and outside the regional center, need to be lauded for their very quick and very aggressive reaction to the JCAHO issue. I was there when the reviewer witnessed the incident. I had done a briefing with the reviewer at the time, talking about the increased acuity in our units, that as a result...because when we do get people into the security unit now, they tend to be much more disabled. They are folks who are much more aggressive. You do not have the mix of patients that you would have maybe ten

years ago, where half the unit would have been there just for evaluation. And we talked about all the security precautions we were taking and things we needed to do. As I'm literally...and as we're being praised for all efforts, and the reviewer agreed with the quality of care we were offering, as we were walking out the door a patient had approached a nurse wanting some more medication. The nurse mentioned, I will be happy to discuss that with you. Give me a moment. The patient yelled at the RN who was walking into the med room at the time, and we were very well aware of who the individual was. It was not an immediate safety issue, but the reviewer was rather surprised by the loud outburst and the fact that the RN walked away and was not in sight of anyone, because she was in the med room and no one else could see where she was. And his concern was, what would happen if we weren't there to see her. I'm not quibbling with what the reviewer said, but having been present at the time, I thought I would add some insights. I think some very important questions were raised. These things are going to happen when we shift the nature of clientele who come into those services. People were not ignorant of that fact, but I think it's important for us to know what the big picture issue is and appreciate the opportunity to share that. Sir? []

GORDON ADAMS: Did I get the wrong impression from what you said? I gathered from what you said there are 12 people, forensic psychiatric patients, who need to be in acute psychiatric care and are backlogged. Is that what you said? []

MARIO SCALORA: That's of earlier this week when I last heard the number. That was the number I had, yes. []

GORDON ADAMS: Follow-up question: Are those people now in jail? Are they incarcerated? []

MARIO SCALORA: I would think. Dr. Adams? I'd have to look, but I think the vast majority of them are. []

GORDON ADAMS: Well, isn't that a failure of the system? []

MARIO SCALORA: Gordon, I'm not thrilled either, and I'm bothered by that as much as you are. []

GORDON ADAMS: Yeah, I'd be very bothered by that. That's what we worried about in the beginning. []

MARIO SCALORA: I am very bothered by that, and we're trying very hard to move those people in, and I share that concern. []

GORDON ADAMS: Well, in the meantime, you've got empty beds in Norfolk Regional Center, which would handle those people. []

MARIO SCALORA: I would question whether they would be geared up to manage that population. I would have some grave concerns about moving them into a ward at Norfolk without their taking some significant staffing changes to address that population. []

GORDON ADAMS: And the ones you're talking about on the (inaudible) end, what I gather, the acute patients come in and then they become less acute, let's say, and yet they're holding beds. And couldn't they be handled in another setting? []

MARIO SCALORA: You mean the civilly committed patients who come in? []

HOWARD OLSEN: Yeah. []

MARIO SCALORA: I think it's an open question where those people could go. I would think, frankly, a number of them could be moved to less restrictive levels of service, but there are some significant...I think in many of those cases some of those folks, as the

term may be used, burned bridges with some community providers who may be a little reluctant to treat them because of what brought them into the regional center to begin with. I think it is an open question what should be done with those cases, and a legitimate one. []

SCOT ADAMS: The other comment that I would make about this is, I think that the words "mentally ill" and "in jail" are words that scare all of us, and would be...raise lots of concerns. However, I think it's also important to keep in mind that typically when that fear arises in conversations, it is as a result of folks who have been left and have gone out into the system and have ended up, as a result of their illness, committing a crime and ending up in jail. These are folks at the front end of that determination. Nobody is quite sure whether or not they are mentally ill. That hasn't been determined. But they have committed a crime, and so it is not inappropriate at that moment to be held in that setting, coming into the process. We want to make that as rapid as possible, and...but it is a different situation than I think the longer term kind of consideration. And one of the things I wanted to say is that the division is actively involved with a process involving a variety of folks from the criminal justice side, with a behavioral health/justice, justice/behavioral health planning grant, to help us look more closely at this. There was a conference in December that the regions were involved with and invited to and participated in with great excitement and enthusiasm for other kinds of activities that at a variety of points along the continuum, if you will, that diversion can occur and further treatment interventions can be made, so that persons with mental illness can be addressed more appropriately, both at arrest or at the point of a criminal involvement, at the point of booking, at the point of involvement with incarceration--a variety of kinds of different things. And so there's conversations and planning going on with a number of Nebraska departments on that topic. []

DANIEL WILSON: I don't want to forget your suggestion, Senator, that we should move on. I would just very quickly mention if...Mario, if I understood you there, some civilly committed people who...at Lincoln Regional, where the hospital doesn't feel that they

need to be in the hospital, I believe that the medical director can discharge those people. []

MARIO SCALORA: To where? []

DANIEL WILSON: To the receiving regional authority. In fact, it's incumbent on... []

MARIO SCALORA: I'm (inaudible) medical... []

DANIEL WILSON: ...on hospitals to not retain people who they don't believe should be in the system. []

MARIO SCALORA: We also share legal liability to prematurely discharge people to a lack of or inappropriate service. I mean, it's very easy to say that in the abstract. We cannot just discharge people to the (inaudible). And we have an obligation to those patients and those communities, and I am not armed to force people to take individuals at gunpoint, nor would I be inclined to do that. []

DANIEL WILSON: I wasn't recommending it. (Laughter) It was just a comment in passing for you to consider. []

SCOT ADAMS: Well you know, and actually...and I appreciate that. And Dr. Wilson, you sort of have put your finger on the reason for the retention of the $3.5 million. []

JIM JENSEN: Are there any other questions of Scot? []

MARY ANGUS: Senator. []

JIM JENSEN: Excuse me. []

MARY ANGUS: I just had a real quick. []

JIM JENSEN: Mary and then J. Rock. []

MARY ANGUS: And it doesn't require a response. I just was appreciating what you had said earlier about maximizing the consumer involvement in the process, and I wanted to let you know that I am a little disappointed that Joel is not here, or that there is no report on the consumer involvement in your report. []

SCOT ADAMS: I got to here,... []

MARY ANGUS: Okay. (Laugh) []

SCOT ADAMS: ...then we started questions, and the very next item was with regard to consumers. []

MARY ANGUS: Okay. []

SCOT ADAMS: And I'm happy to continue with that, but I also understand the Chair's interest in timing this. []

MARY ANGUS: Yes. Well, I didn't require a response. []

SCOT ADAMS: But there were five or six things that I had to say about consumers, if... []

JIM JENSEN: Let's go on to J. Rock's question. []

J. ROCK JOHNSON: Yeah, we are in the fifth month of having zero reference to anything having to do with consumers, so I appreciate that it's on your list. Would you

agree that we are not a data-driven system? []

SCOT ADAMS: You know, I would agree in part with that. I would disagree in part with that. I think that... []

J.ROCK JOHNSON: We do the best we can with what we got. Would that be more accurate? []

SCOT ADAMS: Yeah, I'd come closer to that one. []

JIM JENSEN: Excuse me. J. Rock, would you talk into the mike just a little bit? We're having a little trouble hearing. Thank you. []

SCOT ADAMS: And let me also add to that, that I think that we have great hopes for the new contract with the ASO, that we will be able to improve that come July 1. []

J.ROCK JOHNSON: I wonder, would it be possible for you to send more information to the whole commission about that, so that we don't have to spend a lot of time about what you intend in the ASO? []

SCOT ADAMS: You know, the application is on the DAS Web site, the RFP, with all of its specs, so that's there, as well as questions that have been raised and the responses by the Department of Administrative Services to the questions in the process, so all that is out there. []

J.ROCK JOHNSON : I'll jump to that, and I don't have the reference, but as I recall... []

SCOT ADAMS: I'll make sure you get the... []

J.ROCK JOHNSON: No, as I recall, there is, if you will, a codification of the waiting list

that the ASO, in its contract, has a responsibility and an intention to maintain, to process, a waiting list. Does that sound familiar? []

SCOT ADAMS: In the current contract or in the proposed one? []

J.ROCK JOHNSON: In the proposal. []

SCOT ADAMS: The proposal? I...you know, that doesn't ring with me with clarity, but if you tell me your question I'd be happy to get back to you and to the commission or the task force. []

J.ROCK JOHNSON: Well, my question, I guess, is actually an observation. Are we in fact codifying a wait list? And maybe it goes back to the philosophy. I thought we were operating, and believe still myself, and most of us, I would assume, operating under a philosophy of getting people out of institutions and into the community. Now when we talk about the $3.5 million for Norfolk and the various ways of looking at it, one of which appears to be it's not actually being spent at this time, I wonder as I look at that, and hear people talk again about the increased acuity and we perhaps need to open up Hastings, and we need more beds, the only thing that we have to do to make it absolutely mandatory that this state put more money into bringing up more beds and the responsibility of the state being fulfilled, is to do little or nothing. I do not yet see us having as a state, as an administration, as mission, values, visions, even (inaudible) just having any rules and regulations, (inaudible) that say, this is our goal. And when I read in the ASO RFP that a waiting list, as part of what they're going to manage, it seems to me to fly in the face of what it is we say that we're supposed to be doing. Also, as to Norfolk, the last I knew was Chris Peterson being here saying that there would be...she expected there to be 120 beds being paid for out of LB1199, and in fact, we'd be paying for behavioral health beds. So that's one question. The other was her comment that they were spending at that time $1.4 million on creating Norfolk as a facility that would meet the Joint Commission standards. So I'm wondering, has it happened that it met the

standards? Is there more money than that being spent? What's the purpose and rationale for doing that? And it doesn't have to be a long answer, because I like long questions. []

SCOT ADAMS: Okay, okay. The last one, the $1.4 million, I believe was a life safety issue, related to CMS and not necessarily Joint Commission, and had to do with sprinklers and that system. That work is completing, finishing up throughout the building. And it was a life safety issue in terms of that expense. The comment about the ASO managing the wait list. I'll look into that, but it is the fact in all the regions, from time to time, that there is a waiting list for services at all levels, not strictly to get into the Lincoln Regional Center, but for outpatient services, and sometimes those are...to a particular provider of outpatient care or intensive outpatient or assisted living facilities. I mean, throughout the system at any point in time, there is that, and we wanted to, I believe, to make sure that somebody is aware of who all the people are, because in addition to, for instance, seeking service at say, Heartland Family Service in Omaha, they may also go to Lutheran Family Service in Omaha and be on two waiting lists at the same time. This became an issue for us with regard to the federal substance abuse block grant earlier this year, in terms of what is known as a particular requirement of the federal substance abuse block grant known as interim services. And this is a piece of interesting little whatever--trivia or whatever. But a requirement is that if you're on a waiting list, you must have services, which sounds to me like you're not on a waiting list anymore, but it's still a waiting list. (Laugh) In any event, some level of interim services must be provided to persons who are on a waiting list, and so we need to sort of know who they are, where they are, and how to be in touch with them, so that information update, access to emergency care, touch in base, making sure things are going okay while they wait to get into the full treatment experience occurs. []

MARIO SCALORA: Dr. Adams, I want to thank you for your report and fielding questions for an extended period. I apologize to my colleagues. We're going to have to cut it off right here. Could I invite you, if you would be willing, to send the remaining

points in writing to the commission, if you would be willing to do that? []

SCOT ADAMS: Sure, yeah. That would be great. You bet. []

MARIO SCALORA: I appreciate that. J.Rock, you have a... []

J.ROCK JOHNSON: May we, then, submit questions? I've got a couple more. []

MARIO SCALORA: That would...I...would you be open to that, Dr. Adams? []

SCOT ADAMS: Always. []

MARIO SCALORA: Thank you. []

J.ROCK JOHNSON: That would then come back to the commission within reasonable time. Thank you. []

MARIO SCALORA: Please. Thank you. Thank you both. We have... []

SCOT ADAMS: I might just ask that they be sent through Jeff, so that they sort of all get coordinated, and I'll work with Jeff to distribute. []

MARIO SCALORA: Well, if you're going to have to go rigid about it, I guess we could. (Laughter) No problem. Thank you for your willingness to do that, and Senator, do you want to take us through? []

JIM JENSEN: Yes. Thank you very much. Well, the next item on the agenda, Item 5, is legislative review and discussion regarding the continuation of the Behavioral Health Oversight Commission. As you all know, in LB1083, that the Behavioral Health Oversight Commission goes out of existence on June 30 of this year. And at our last

meeting that we had, there was a vote that said that we would like to, or at least the commission felt the necessity to continue on, and there was a bill that was introduced to do that, to extend it, and it was heard before the Health Committee. There were members in this room that testified in support of that. At that same time the Speaker of the Legislature did issue a letter to the Health Committee saying that in his opinion, that the committee was formed under a conflict of interests, and you have, I believe--or if you don't have, you will receive--a copy of the Speaker's letter to the committee. The committee at this point in time is sitting on that and are in a quandary as to what to do. They have heard from some of the commission members and from other individuals. And by the way, certainly in defense--and not defense at all--but in recognition of the Speaker, he has also probably sent letters to--I don't know what the number--close to a dozen other committees that have been formed. Matter of fact, like I said, at 1:30 the youth behavioral health task force, which has been in existence since the last session, the same issue is there. There are one, two, three, four, five, six, seven, eight various commissions that he feels are in violation of the balance of powers and there is a conflict of interest there. I am not an attorney; however, after reading his letter, I can understand exactly where he's coming from and feel that he is certainly valid in that statement. Now...and also the Speaker and the Chairman of the Executive Board of the Legislature are doing an interim study this year, where they will look at not only these commissions but several others, and to look at their validity and so on and so forth. I have suggested to the Chairman of the Health and Human Services Committee, Joel Johnson, Senator Johnson, that perhaps if the commission could be extended for one year and at the same time do an interim study, that might even result in a combination of several commissions into one. And I didn't bring with me, but if I would have brought boards and commissions of the state of Nebraska, it's in a book that is this thick. And I don't know how many appointments that the Governor makes every year of various people on the boards and commissions. We have four behavioral health commissions besides this one. This would be five. If you count the task force on youth, that's six--all dealing with some form of behavioral health. In some cases it's chemical dependency, it is gambling addiction and those services, and so I think...and I certainly suggested to

Senator Johnson and to the Speaker that--to Senator Flood--that I think it's time to look at those, and perhaps could we bring those together. And an interim study also before you, I think there is a statement as to what Senator Flood is suggesting, that a reconstituted committee be formed of 12 members. He's saying, you know, I'm just suggesting those people that be on there and it be under the Executive branch of the Legislature. I don't know if that's a correct way or not. I will give you my personal opinion, then I want to open it up to hear from all of you. And I do want to leave time for public comment, too. That's very, very important. If we're going to do an interim study and look at all the commissions, I think that might be the time to not only look at those other commissions, but this commission also, and those other four behavioral health commissions that I mentioned. But I kind of feel that if we, as of June 30, establish--July 1, really--establish a new oversight commission and then go through an interim study, that a year from now, there will be another different, perhaps, oversight commission that could be avoided if we waited until we did an interim study, look at all those commissions, see if there's some way of melding several together to reduce the number, and then go from there. But certainly, the Health Committee, the seven members, are very cognizant of what the Speaker has said, and it lies in their court and then with the full Legislature, because right now there is a bill that is still sitting in committee--they haven't passed it out--as to what may happen. You also know that here we are at a late date in the session, and what is ever going to happen must happen very shortly, I would say, matter of fact, in a week or so. So we need to give, I think, the Health Committee a direction of what we would like, for whatever that is worth, mind you. And then we'll see where it goes from there. I feel that this commission, and it's really evident, about what went on before Item 5 came up here, that I don't...I can't recall in my 12 years of service anyway in the Legislature, of a commission that had the input, dug as deep, as this commission has done. And I commend all of you for the work that you've done and the work that you have dug into. These dollars that we were talking about, the one-time dollars and those other expended funds, I don't know, frankly, if that would have come up if it hadn't been for this commission digging into that. And when you're talking about $11.2 million, whatever the figure is, and another $9

million, I mean, those are real dollars, and those are dollars that I believe should have gone to the community. I also feel that we're in the red zone, we're at the 10, 15 yard line. I'd like to see this ball carried over the goal line before it goes out of existence. With that, I will stop editorializing and be glad to open it up for any of your thoughts, comments, and then I want to hear from the public also on that. Dr. Boust. []

SUSAN BOUST: Thank you, Senator Jensen. I guess my first question is, is the intention for this to be the last meeting of this group? []

_____: (Inaudible) []

SUSAN BOUST: Okay. That is somewhat helpful, because I'm mindful of the... []

JIM JENSEN: And let me respond to that. Originally I thought that we were going to have maybe one last meeting before January 30. Because of the timing of all this, I called on a rather short notice this meeting. I'm so thankful that all of you were able to respond. I think that shows also your commitment. So...and I...yes, we'll have another meeting. []

SUSAN BOUST: Okay. I don't know what is the right way to go. I have concerns about having this body be under HHS rather than under the Legislature. I believe that it is the legislative mandate that we keep coming back to, and I guess my biggest concern is things that I've heard through the community, that this is really not just about concern about the constitutionality of this group, but rather a legislature is done with us. We've had our time in the limelight and this is over, and behavioral health, be quiet. I fully believe that the intention of LB1083 was to finish the job, and I for one want this commission to, sometime before we are through meeting, as a commission--this commission, not the next generation--that we put on paper where we think we really are on LB1083. []

JIM JENSEN: Thank you. Dr. Scalora. []

MARIO SCALORA: I share Dr. Boust's view. I have two things. I don't believe, contrary to the implication, and all due respect to the Speaker, I don't think we behaved unconstitutionally as we've been constructed for the last few years. I think the leverage this group has had has been through its ability to communicate directly with the Executive Board of a legislature who controls the purse strings, and I think we've been able to walk that line very carefully. And I still think the effectiveness of this group is in large part due to having that in the background. I also understand the need to look at all these other commissions and pity the fact that Dr. Adams has to report to all of them and deal with all these very important issues. But I do think there is a potential bureaucratic quagmire. I do think there is some effectiveness that is lost, having served on other boards, if you put it under the control of the same group that is theoretically overseeing. It does not make sense to me, and my impression in dealing with lawyers on a range of issues is, you get the same number of opinions on these issues, based on the number of people you've consulted with, and I think there's a mixed opinion on this issue. And I think it's worth exploring whether there's a way of maintaining something as we've had for the last three years. []

JIM JENSEN: Yes. []

HOWARD OLSEN: The Speaker earlier--I guess it was last year--suggested that he thought that single-tier courts ought to be studied, and the Nebraska State Bar Association took up that issue and studied it, and determined that it wasn't appropriate for a myriad of reasons to go to single-tier court, and then went and met with the senator, and he appreciated the study and accepted the result. And I would hope that we could see ourselves to another year here, to do the same thing, because I agree our colleague here, that there are other opinions out there with regard to what we've done. We've not implemented...we've not set policy. We've not implemented policy, we've not administrated funds. And I think that with Dr. Boust's comment, I would echo the fact

that we certainly wouldn't want to be under the auspices of Health and Human Services. Recently I tried to get an appointment with some people at HHSS, to talk about some of the struggles that our Region I has had, particularly with the future of their in-home health programs, and that request reverberated around HHSS back to the region, such that I finally withdrew the request. And that gave rise to some of the questions that I've asked today, to try to find out the issues, and I think this commission serves a purpose and will continue to serve a purpose. And I thank you for the leadership that you've given us. []

JIM JENSEN: Yes, Mary, and then Topher, and then Dr. Wilson. []

MARY ANGUS: I have to echo the idea that we would be a bit of a conflict of interest. How do we oversee our own group? And I think we've seen that with the Children's Behavioral Health Task Force, that was pretty well undermined by the decision that they couldn't vote, because they were overseeing themselves or the plan that would be implemented. I think that was a prime example. The other thing is that I do not share anybody's trust in HHS, and one of the problems with the length of our meetings has been the difficulty with which we have had, pulling teeth to get a single answer. And frequently we've gotten an answer that there will be disagreement about this. I have noticed that, especially in the last two months--there will be disagreement about this. Well, we can't get answers when we have responses like that, and we can't get answers when we're told a cheerful perspective of what has happened. I have repeatedly here heard, either by the newspapers or letters from HHS personnel, that we're fortunate to have CMS or JCAHO in to help us improve our systems. And after 18 months we have failed to comply with the CMS regulations. So I would very vehemently object to being under HHS. []

JIM JENSEN: Mr. Hansen. []

TOPHER HANSEN: Thank you, Senator. I would echo the comments here. I think that

this commission is, in fact, the embodiment of balance of power, to the extent there is a clause that might be interpreted by the courts, regardless of how many lawyers offer their opinion--there are a few that we gather together who have the ultimate opinion--and regardless of their point of view, we can craft new legislation to really carry out what the mission of this group as been over the last several years, which is to act as the eyes and the ears and the balance of power in administering LB1083, that what we have done in our decision making is simply to look at evidence offered and say, are there services in the community sufficient to close down a regional center? That has been our decision-making authority. Beyond that, what we've done is offer questions and advice to the Legislature on how we see things going. To put us under the Executive branch or to do away with us would not give the Legislature any information on how things are going, but more importantly, it would be an accountability for the people of the state of Nebraska, to understand how some of the folks in Nebraska who are the most ill are receiving services. And I see this as one of the most critical commissions, because of the fact it represents money and services for some of the people of our state who are the most ill. And to take a time out or to put us under the Executive branch would, in effect, do away with us, I think, would be contrary to balance of powers, and instead of offering...and I'm quite surprised, actually, that out of the Speaker comes a suggestion that this is unconstitutional and may be void altogether. What I'd like to see is a way that we would amend...take this opportunity to amend the statute to say, this would get away from...changing this provision would do away with that conflict of the powers and allow it to be what it is--an advisory body. Let's take a constructive approach to this, get the statute right, and continue this commission. Doing otherwise would be a disservice. []

JIM JENSEN: I'll just comment on it, before Dr. Wilson speaks. I think without a doubt we did have some power that perhaps we shouldn't have taken, and that's taking funds to do a study or some other things, also to have a sitting senator on this committee might be wrong. But I think those things could be corrected, just as you're saying, with making a few changes to that. And then I'd like to have Dr. Wilson give his comments,

and then Jeff, if you would comment on what you feel as perhaps what is unconstitutional, or what we have been doing that gets us into that balance-of-power situation, if you would. Dr. Wilson. []

DANIEL WILSON: I just would say that I was surprised by this. It seems imaginative to me, to the point of raising, at least, a concern that this is, as Dr. Boust alluded to, perhaps with the intent of not having really open-aired discussion about behavioral health in the state. I'm concerned about that but encouraged by Mr. Olsen's comments about his experience with Senator Flood. Nevertheless, you know we were duly constituted by the Legislature. No court has declared us in violation of any constitutional point that I'm aware of. It would make sense to continue at least for a year and study it, and try to come to some sensible agreement, as has been mentioned. In the meantime, LB1083 charged us with overseeing or at least advising the Legislature about whether LB1083 had been implemented, and with one meeting more--do I understand?--LB1083 has not been implemented. There are still three regional centers in operation in this state. There is no...there has been very little, if any, discussion about the educational components that helped pass LB1083. There is the unusual situation with Region V and the regional centers, that I've mentioned previously. So those are problems. LB1083 as of the meeting today has not been fully implemented. I think the proposal, AM2266, to LB994, reconfiguring Behavioral Health Oversight Commission might be something if further worked as Topher mentioned, there are solutions that could be arranged. However, I'm very concerned about the initial elaboration of who would be on that. It reflects, I think, a very narrow view or one of us blind people feeling the trunk of the elephant, but not the whole animal. This is not a representative group that could even understand the entire system of care as it interdigitates across the state, across hospitals, across teaching institutions, across all sorts of community-based systems. It's an initial document, I understand, but if that's what we end up with after all of this, LB1083 will not be implemented and there will be very little awareness of, scrutiny of, discussion about, behavioral health services at the state level. []

JIM JENSEN: Thank you. Jeff, could you make a comment on how you see, or what would bring us into compliance, perhaps, with the balance of powers, as you see it? []

JEFF SANTEMA: Thank you, Senator Jensen. I guess what I wanted to say would probably be very brief. First of all, I think that there are a number of factors that bring the commission and the legislation establishing the commission, bring us to this particular point. One of those factors is the legal separation of powers issue that has been raised in the Speaker's letter. So there are a number of factors, this being one of them. Secondly, I personally have no...I have no legal basis to disagree with the Speaker and his analysis in the letter that you have received. One of the options that are open to the Legislature, when there are issues raised about legislation that has already been adopted and is being implemented, is to request, if there are legal issues raised, to request an Opinion of the Attorney General. That hasn't been done in this respect, and at this point, we don't know what the Attorney General might say. The...and my role as legal counsel to the Health and Human Services Committee and then as staff on behalf of the committee to this commission, is to advise the committee on not only legal issues, but practical issues of legislation, passing legislation, what form the legislation should take, and those are not only legal decisions, but they are political decisions. They have other rationale behind them. As I see it, the options with respect to LB994 are these, and as Senator Jensen mentioned earlier, the Health and Human Services Committee is looking for guidance, and the Legislature will be looking to the Health and Human Services Committee for guidance: The options are: LB994 could be advanced by the committee in its current form, which we just distributed a copy to you of, which is referred to as the green copy version of the bill. And it could be done just as...in the form that it is in, coupled with an interim study that you received a copy of, to allow the time that Senator Jensen discussed to address this larger question, which arguably a reconstitution of the commission for another year doesn't actually get to that bigger question. And just continuing the commission as it is for a year doesn't necessarily get to that discussion. The committee could advance the bill, and there would be some dispute over the bill on the floor of the Legislature. So the green copy of the bill would

likely not get adopted in the process, because it's not prioritized. There's not a lot of time left in the session, and that probably would not happen. If the committee could advance the bill with amendments, whether it would be the Speaker's suggested amendments or other amendments, that...and then depending on how controversial it was, the bill could be attached onto another bill and could be adopted. The third option is, the committee does nothing and the oversight commission, as it is now, ceases to exist as of June 30 of this year. The interim study could still go on and a new bill to reconstitute the commission, dealing with the bigger issues, could be introduced next year, but in the meantime there's a gap of time where there is no commission. As I see it, Mr. Chairman, those are three probably primary options. There could be additional legal analysis requested. The Health Committee or this commission could request a written opinion from some other source. The Health Committee could request an Attorney General's Opinion. That wasn't very brief, was it? I'm sorry. (Laughter) []

MARIO SCALORA: As a clarification, AM2266, what is the status of that (inaudible)? []

JEFF SANTEMA: It's just a discussion document at this point, Dr. Scalora. The Health Committee hasn't formally addressed it. []

MARIO SCALORA: So it has not been formally attached to LB944. []

JEFF SANTEMA: No, sir. []

MARIO SCALORA: Thank you. []

JIM JENSEN : No. And I think what I'd like to do is take comments for about another five minutes from the commission, and then open it up for public comments, and then we can come back and address those. Topher, and then Mr. Olsen. []

TOPHER HANSEN: Senator, I think the issues here, if the Legislature wants to say, you

know, we want a commission to watch what is happening in implementation of this bill we just passed, LB1083, and can establish this commission to do that, and they can say, you know what? We're going to give you a little bit of money, because we understand you're going to have some other tasks that you want to do. But to the extent that they say, and the LB1083 that will implement that act, is for you to oversee and administer, that's where you've cross the line, because that's the Executive branch's duty and power to...the Legislature hands it over and says, here's how...the parameters. How are you going to do it? Go do it. But the Legislature can hold in reserve a commission and funds to watch that. It does cross the line in this, where it talks about overseeing and supporting through administration of the cash fund, or something to that extent. That's the language that I see that I think is problematic and could be easily changed. I think the approach...I don't think it's a bad idea to go back and review commissions and those kinds of things, to see how to straighten the lines out. That's important. But to do away with this and act in more of an obstructionist mode than in a constructionist mode to help make this work for the people, is important. And to let one little phrase disrupt the importance of this group, I think is outrageous frankly, and that what we ought to do is turn our attention to the positive way we can approach this, rather than calling the whole thing into question. I think the Legislature needs to watch this, I think it has been proven over the last years how this is an accountability forum, and it has thus far brought...probably brought around $20 million into the light that there's question whether we would have been aware of or not, had we not been here. So I think we need to make the changes--they're minor--and move forward with the bill. []

JIM JENSEN: Any other comments or...excuse me. Yes, sir. []

HOWARD OLSEN: I support Topher's comments. If AM2266, if that falls in the air, you know, the reconstitution of this commission I don't think is particularly appropriate. One consumer out of 12--there again, the consumers seem to always take the backseat, just like they did today with no report, although I know there was reason for it. And then the

other thing is that, you know, it doesn't recognize the geographic diversity of our state, and we in western Nebraska don't want those in central or eastern Nebraska speaking for us, and you don't want us speaking for you. We have different issues, and this reconstitution in that proposed amendment doesn't recognize that. []

JIM JENSEN: It also doesn't recognize that there are psychiatrists, psychologists, hospital administrators who all deal with this, too. []

CAROLE BOYE: Senator? []

JIM JENSEN: Yes. []

CAROLE BOYE: Just a reality check, however. Did I not hear that this bill, whether we take the light out of it or not, will not see the floor of the Legislature this session, as a separate, free-standing bill. Isn't that the political reality of the situation? I just think we need to be very realistic here. []

JIM JENSEN: And Carole, I think that's an excellent point. I guess if I was looking at reality, some form of the amendment might see the light of day. []

CAROLE BOYE: Well, other than the fact that neither is a prioritized bill, anything that's going to happen here is going to have to be attached to an existing bill, is that correct? []

JIM JENSEN: This is correct. []

CAROLE BOYE: And so it's going to have to be noncontroversial. []

JIM JENSEN: That is correct. []

CAROLE BOYE: Okay. I just wanted to check out my understanding of reality. []

JIM JENSEN: Yeah, I think...in my years...yes. []

SUSAN BOUST: Part of my question for the rest so today is, what do we need for advocacy for this? I mean, we filled this building when LB1083 passed, and I think the energy is out there right now, that if there is a sense that the Legislature doesn't recognize there's a huge constituency for behavioral health, I guess I would like some assistance in knowing where to aim that. []

JIM JENSEN: If this was January, I could agree with you. Being as it's March, middle of March, I think we're too late. I mean, I just don't...I just can't see that happening. []

SUSAN BOUST: Do we need to meet for a year at our own expense? []

JIM JENSEN: You know, we can...I think, really, our goal is to, I believe, to talk to the committee, to see if we can somehow express our feelings to them, and then perhaps address the amendment in some form or fashion. I don't know how...well, I don't know if there's...how much flexibility there is in the amendment. []

CAROLE BOYE: But my concern about that amendment is that there's very specific things in there, each of us of which will have an opinion on, which means that there's a thousand other people who care about behavioral health will have an opinion about that, as opposed to a fairly simplistic approach, which is to say, there's going to be an interim study. What is the harm in extending this until the next legislative session, even if it means taking away, you know, two lines or whatever and being a part of that study? Now if there is significant legislative objection to that, then I don't know that I could support this in its present form, and I don't know that there's a forum or time to debate anything other than extended or not extended. []

JIM JENSEN: Senator Flood is saying, hey, I just put these down. You know, he's

not...his feet aren't planted, I believe. []

CAROLE BOYE: This was drafted by Senator Flood's office? []

JIM JENSEN: Yes. []

CAROLE BOYE: Okay. I was not aware of that. Thank you. []

MARIO SCALORA: Mr. Santema had a comment. []

JIM JENSEN: Yeah, and let...all right. Go ahead, Jeff, and then I'd like to hear from Bill, and then I'm going to open it up to the general public. []

JEFF SANTEMA: I'm sorry, Senator. I was just going to, I guess, agree with what you were saying and add to what you were saying. I believe that--and Laurie is here from the Speaker's office and can correct me if I'm wrong--but I don't believe the Speaker is tied to every word of the amendment that you have in front of you necessarily. It was the Speaker's attempt to be helpful or productive and suggest some kind of alternative. []

MARIO SCALORA: After the chief, I would like to offer a proposal to move this along. []

JIM JENSEN: Okay. []

MARIO SCALORA: Chief, did you want to add a comment? []

BILL MIZNER: I do, thank you. Just as a quick review here on the proposed amendment here, I notice that most of the representation in the original LB1083 is included in there; however, I will note I am a little disappointed that a representative of the mental health board and law enforcement have been eliminated from this. I will tell you that the general view is that this is the first opportunity that law enforcement has had to have

any voice in the mental health process, and actually, it has been a very enlightening experience for me and for the discussions that my colleagues have had. I would certainly hate to see that discontinued. Secondly, I guess I would want to follow up a little bit on what Carole said. She said that if this is a noncontroversial issue, then it could be attached someplace; but if it was controversial, then would it likely not be attached. And I think the general...and I think the response was, well, if it's controversial, then no, it probably would not be attached, would not go forward. The question I guess I would have is, is this a controversial issue? And is the issue the alleged constitutionality of LB1083, or is the issue the commission? And I don't know. I'm just asking the question, because I honestly do not know. If it's a constitutionality thing, but the work of the commission is viewed to have been important and has been of service, then I guess I would have to follow with what Topher says and say, you know, it seems to be a relatively quick fix to rearrange the language and the composition, whatever, and attach it to a bill so that the commission can continue one with what it is doing, if it's viewed to be important. But if it's viewed not necessarily to be important or to be kind of a hindrance or a thorn in the side, or whatever else, then perhaps it's not as simple and easy as it would be. So I guess that's the question I would have, and I guess I don't expect an answer, I just raise it: Is it just constitutional--it can be fixed quickly--or is there more to it, and regardless of what we try to do, is it going to be a difficult thing? []

JIM JENSEN: Let me just...Senator Flood did say to me, and boy, I'll take him at his word. He says, I'm not trying to eliminate the oversight commission. And like I said, any time anybody says that, particularly him, I'll take him for his word on that. Yes. []

TOPHER HANSEN: Um-hum. But Senator, we have one spoke that needs fixing. This is trying to fix the whole wheel. We only have one little problem with it. []

MARIO SCALORA: Let me make a suggestion, because we...bottom line, it sounds like we have a need for communication and taking what the Senator said to heart. It appears there is a need for communication with either the Speaker and/or the Health

and Human Services Committee for anything legislatively to happen, controversial or otherwise. May I make the recommendation, and we can put it in terms of a motion, that we have a small group--maybe no more than five--part of whom involves a former senator, member, who can speak "senatorese" still, and approach the Speaker as well as, if they are amenable, members of the Health and Human Services Committee, to hear what their concerns are and empower that small group to make some suggestions as to what we think may be reasonable ways to approach this, given that time is of the essence and we may not have the opportunity to bring a group together to argue this all out and speak on our behalf. []

DANIEL WILSON: I'll second the motion. []

MARIO SCALORA: Is there any opposition to that as a strategy? Okay. Do you have any thoughts how you want to constitute the group? []

JIM JENSEN: No, and I appreciate that. []

DANIEL WILSON: Actually, Senator, could I also move that the commission express again its recommendation that the work be continued, at least for a year, sorting out some of these problems and noting that LB1083 is not fully implemented at this point. []

TOPHER HANSEN: Second. []

JIM JENSEN: Okay. Well, we really have two motions. Could we put those into one, or Jeff, can you do that... []

MARIO SCALORA: I'll accept that as a friendly amendment, as a guideline to the small group. []

JIM JENSEN: You know, and if you would allow me, could we take public comment

while we're cogitating that, and also while Jeff is writing this out. I'm very... []

MARIO SCALORA: Agree to suspend discussion. []

JIM JENSEN: All right. Thank you very much. With that, let's take any public comment that anyone has. Mr. Courtnage. []

LARRY COURTNAGE: Good morning, Senator Jensen, the committee members. It's been a long day. I'm Larry Courtnage from the Kim Foundation. I have three things. First, the Kim Foundation would like to thank each and every one of you for your dedication, in particular for your personal engagement in attempting to find effective and cost-efficient methods of solving this issue. Your endeavors do not go unnoticed in the community. Secondly, I would encourage HHSS, the regions, to be more forthright with data, in particular, more communicative with the information. Third, I think it's ultra important that a commission of this nature exist in some form. I think it's important that the legislative people have an independent body to advise them of what they think is happening or not happening in the real world in the state of Nebraska. Thank you very much. []

JIM JENSEN: Thank you, Mr. Courtnage. Anyone else? []

JOHN PINKERTON: I'm John Pinkerton, glad to be here. And I don't know if any of you have noticed, but my wife and I have been to just about every one of these meetings. I don't think you have to have a gun to your head to make you have a get-together and communicate. I don't know why this group couldn't get together for the next year, if necessary, on their own dimes, so to speak, and talk. I don't...and I would like to see the peanut gallery get a little more time before everybody rushes out and...my other thing is, I think this commission did have an impossible task. I think LB1083 is impossible to implement completely. Conflict of interest is huge, and I do see the conflict of interest problem, and I think...I kind of lean towards this being under the Legislature, as

opposed to HHS. But one of the biggest things, LB1083 did not encourage conflict of interest in the regions. In the regions, it's a huge conflict of interest to give regions all this money and let them perform the services themselves. (Laugh) It's elementary, but nobody has taken care of it. And the consumers suffered and taxpayers suffered. One last thing: We are putting together a group, they're meeting April 9 in Aurora, Nebraska, for assisted livings that cater to behavioral health people, consumers, and that's all that will be there, owners and operators of these groups. And we will have some...come up with some good input for HHS concerning assisted livings. Assisted livings are the people in the trenches dealing 24 hours a day with behavioral health people and getting $33 a day for doing it. We have people...the dollars are not following the consumers. We do everything for the consumers, but the region gets the community support dollars. Talked to one of our consumers. His community support worker called him up the end of the month and asked him how he's doing. That costs you and me $280. Day rehab. The region performs day rehab, $52 a day, $53 a day. Some people I know of have gone there for 12 years for that much money, five days a week, and they eat lunch and leave. Now if you think money is being well-spent here, I feel sorry for you. But again, my wife and I, we want to make this system better, and we're going to get the assisted livings at least together, the people that are in the trenches, and see what ideas we can come up with. And appreciate it. I know all you guys are...I really appreciate Carole. She is a mover and a shaker, and she's thinking all the time, and I appreciate J. Rock. I think those are the two most important people on this whole board. And J. Rock is a little long-winded (laughter), but she is thinking of consumers. Sorry, J. Rock. She has some of the best ideas I've heard anywhere, so thank you very much. []

JIM JENSEN: Thank you. []

C.J. JOHNSON: I just was wandering by and thought I'd come in for a minute. Good morning, commissioners. C.J. Johnson, with Region 5 systems. I just want to make a couple comments on some of the observations that were made earlier today. First of all, I would like to speak to LB959, AM2145. I would encourage you as commissioners...I

know you as a commission probably cannot offer an opinion, but maybe you can, in support of that. But I would say that the language that was put in there by the Appropriations Committee does speak to the money that you've all been talking about. It's very clear and it does address every dime, including the $3.5 million that is in there to be "held back." I would like to comment about that $3.5 million. I do want to make a comment that I think questions should be asked in relation to...that that money was necessary to increase safety, specifically in the S-5 unit. We should ask ourself, number one, the S-5 unit is not a behavioral health unit per se. It is a forensics unit. It is considered forensic. It is not...when you look at how the budget lays out and how they look at that internally, that is considered a separate dollar figure. The other thing I would like to point out is I appreciate the comment that there are four units open at Norfolk; however, I've ran a psychiatric hospital, and I would still...I still know that if you have 120 beds that are funded and you only have 90 individuals at any time, even if you're spread across four units, you do not have to be fully staffed at all times. There are FTE managements that you have to do. I would guess that anybody that's worked in a hospital knows that even on a daily basis, you look at your FTE counts based on your census and you make adjustments, because you simply cannot operate fully staffed all the time when you have empty beds sitting there. So I would be forced to ask the question, is that being done? Is that money for 1199, for those 120 beds, being totally spent? And if it is, why? And secondly, if it's not, why is that not being used to upgrade the safety of forensics units, which are similar types of units and programs. So I'd really question why behavioral health dollars through LB1083 are being used for those other pieces. The last piece that I would just like to mention...oh, no. One other...two other ones. I know there's been some question about LRC being Region V's acute care facility, 18 beds and stuff. I would ask that before that conclusion gets jumped to, there are some things that we might want to look at. Number one is, those 18 acute beds only constitute 6,570 bed days annually for a quarter of the population in the state of Nebraska. I would first ask that you look at what are the bed days in the other parts of the state that are available to other levels of population, because I might make the argument that we are using a very small number of acute beds compared to population.

Secondly, I'd like to point out there was discussion around Medicaid match. First of all, you would be surprised how few people actually go into the state hospital system and come out that are actually Medicaid eligible. So I think that's something that needs to be looked into from an efficiency standpoint. And then the other piece that I would say--and this is based on my information as of today--is that subacute care is not Medicaid eligible. So there are literally millions of dollars that are being used for subacute care, and subacute care is not a recognized...it's not a Medicaid eligible service at this point. Now that's my information this morning. If that has been changed, you know, I'd be more than willing to know that. But my understanding is that subacute care is not a Medicaid eligible. So when we're talking about... []

CAROLE BOYE: By our state Medicaid system. []

C.J. JOHNSON: Right, right. That's my understanding. []

CAROLE BOYE: It is recognized as a Medicaid service in other states' plans. []

C.J. JOHNSON: I wouldn't disagree with that. There's a lot of services like that, Carole. []

CAROLE BOYE: Okay. But just qualify your statement. Okay. []

C.J. JOHNSON: Right, right. But I'm just saying, right now in our state...so I'm just asking, don't jump to conclusions around, you know, some of the arguments, I guess, in relation to Region V, the 18 acute beds that we have at LRC, because I think I could probably make some good points that there's a lot of cost efficiencies, effectiveness, and some other things. I know. I know there's probably some debate on that. (Laughter) I'm just speaking... []

DANIEL WILSON: C.J., I...you're looking at me, so I feel I...(laugh). (Laughter) []

C.J. JOHNSON: No, no. Well, you were grimacing as I was speaking, so. []

DANIEL WILSON: No, no, no, not grimacing. []

CAROLE BOYE: The commission will take it up, C.J., if we get extended. How's that? []

C.J. JOHNSON: I know. Yeah, I know. So that would go to my next point, if I could just...okay. And the next thing I would say is that...I'm just going to kind of ramble through this, because it was occurring to me as you all were talking about, should the commission stay or not. I would like to point out that in LB1083 the regions themselves are required to have a governing board. It's well-established what that governing board is. It's made up of 16 elected officials from each of the counties. I would also like to point out that in LB1083 it also says that each region will have a behavioral health advisory committee, okay? That's a legislative piece that was put in there as an advisory group to the regional governing boards. And those individuals are made up of individuals very similar in this room--consumers, providers, other stakeholders, etcetera. It seems to me in saying that, that it would also make as good a sense that the Division of Behavioral Health, if you will, or Health and Human Services, has a similar advisory group that allows public comment to occur, that allows regions to go to once in a while, in open public meetings to express themselves. All of our meetings, both the regional governing and our advisory committees, have to adhere to open public meeting laws. In other words, people can make public comment, everything has to be out in the open, people are able to do that. So we have to be extremely transparent. With that said, I would say we would not want to return to the days of what I...and I'll say in my own way, of the Policy Cabinet. The Policy Cabinet would make policy. There was no opportunity for public comment. They would do it in closed rooms. And the other piece that I would say is recently there was an e-mail sent out to select members of the gambling addiction advisory group, and some of you may have seen that. But I found it startling that in the memo, looking for people to sit on that commission, it specifically asked that those who

were recommended held the same views as the Governor, which would cause me some concern, that if a commission was under the Executive side, that that would...number one, you would question that...what that body would be doing. I think...a commission like this is critical and essential to allow for public comment. I agree that maybe it cannot make decisions per se, but by golly, it's nice to know that you have a place to go, not just myself but other people in this area. I would even argue that such a commission like this should exist for every agency that is funded by the Legislature, to allow for public comment and allow people to come to on a regular basis, to make mention of what is going on. So with that, I'll answer any questions or Dr. Wilson, if you want to blast me back, that's fine, too. []

DANIEL WILSON: Oh, no. I didn't take it as a blast. Just...I mean, I applaud Region V. I just, again, think the configuration is at odds with LB1083, and all the philosophy and practicality of that. So it really doesn't make sense long term. But keep up the good work in the meantime. []

C.J. JOHNSON: Okay, thank you. Any other questions? []

MARIO SCALORA: C.J., for a point of clarification, I would agree with you where money should come from to improve the secure parts of the regional center. The point I think we shouldn't lose, though, is just because someone enters the door of the security building, that they cease becoming LB1083 eligible because they enter that building, when their legal status hasn't changed. []

C.J. JOHNSON: And I would totally agree, because I will also say that individuals who are in the forensics building do, when they become less dangerous, are moved into the allocated beds that we have on the psychiatric unit. And I also say that behavioral health funds are actually used to move those individuals into the community, so. []

MARIO SCALORA: And I think in many cases that's true. I think there's disagreement

across the regions as to how that should take place. I think there are many folks around this table who've worked very hard for that to work as you describe. []

C.J. JOHNSON: I guess my debate with that, Mario, is HHS feels compelled that there are behavioral health people at Norfolk, okay, even though it's totally funded for 120 beds, but they feel compelled to identify specific behavioral health money, okay, for those individuals, even though they don't need it. And so my argument is, why would you feel so compelled to identify that money, and then when you're upgrading a unit that is not behavioral health, forensics, why wouldn't you use forensic money to upgrade that? But instead they're saying, oh, let's use the behavioral health money, too. So it makes no sense. They're saying we need it. We need it for Norfolk, but we're also going to use it over here, and I think that's a shell game that gets played, and it needs to be accounted for. That money was for behavioral health to the communities, and I continue to say it needs to go there, and so I'm just saying, if the... []

MARIO SCALORA: I don't think you and I disagree on that. []

C.J. JOHNSON: It doesn't work for me to say one philosophy works here to keep money back, but we're going to use a separate philosophy to spend that money somewhere else around line items and stuff like that. That is concerning to me. []

MARIO SCALORA: I don't think we disagree there. Thank you. []

JIM JENSEN : Okay, thank you. Anyone else wishing to make comment? []

ERIC EVANS: Senator Jensen, members of the commission, my name is Eric Evans and I'm with Nebraska Advocacy Services. I hope many of you are familiar with Harley Burr Alexander. Hartley Burr Alexander was a native son of Nebraska. He was a professor of philosophy at Harvard University, and that was a person that Bertram Goodhue, who built this marvelous building that we're in, went to and said, would you

help us craft phrases that could go up around this building that we're sitting in? And one of the phrases that Hartley Burr Alexander crafted was, "The Salvation of the State Lies in the Watchfulness of the Citizen." And that's at the north end of the building, you know, the one with the big steps, the primary entrance to the building. Now one way in which this is achieved is through what's called a citizen legislature, so that's what we have here in Nebraska. But I don't see anything wrong with a citizen who is a member of the Legislature asking other citizens, or actually providing forums for citizens to come together to assist the Legislature in monitoring the implementation of laws that they passed, one of which is behavioral health reform. So when you go to your meeting with Senator Flood, I hope you remind him of these wise words of Hartley Burr Alexander and encourage him to work in a way that will bring more citizens into the work of the Legislature, because it is truly our salvation. Thank you. []

JIM JENSEN: Thank you, Eric. Any other public comment? And we thank you for that. Now we're back to where we were, and Jeff Santema has drawn up a motion for your consideration, that the Chair of the commission appoint a subcommittee of the commission to meet with members of the Health and Human Services Committee of the Legislature and the Speaker of the Legislature, to urge passage of some form of LB994 in this session of the Legislature, and to communicate the commission's request that termination date for the commission be extended by the Legislature for at least one year. []

MARIO SCALORA: Sounds pretty consistent with our conversation. Any... []

DANIEL WILSON: Some form...the commission discussed some specific concerns. A little more direction about the expansion of the commission, to be more representative, or is that all...just what this group will do in the next week behind doors? []

MARIO SCALORA: I think some flexibility is called for. I'm not sure...I think our intentions are clear. I hate to tie hands too much. Is there a concern you have, Dr.

Wilson? []

DANIEL WILSON: Oh, yes. I mean, I agree with other commissioners that I would not support the amendment, as written. And... []

JIM JENSEN: Do we still have a quorum? []

JEFF SANTEMA: Yes, there are 13 here. []

JIM JENSEN: Yes. Okay. []

GORDON ADAMS: Is the motion before the house? []

JIM JENSEN: Yes. []

MARIO SCALORA: We're in discussion now. []

JIM JENSEN: We are in discussion. []

GORDON ADAMS: I think it's time to call the question. We've had a lot of discussion on various issues. []

JIM JENSEN: Well, the question has been called for by Mr. Adams. There was, I think, sufficient discussion ahead of time. []

CAROLE BOYE: Would you read it one more time, please. []

JIM JENSEN: I'll read it one more time. The Chair of the commission appoint a committee of the commission to meet with members of the Health and Human Services Committee of the Legislature and the Speaker of the Legislature to discuss and urge

passage of some form of LB994 in this session of the Legislature, and to communicate the commission's request that the termination date of the commission be extended by the Legislature for at least one year. All those in favor say aye. Opposed? The record shows no opposition. Is there anything else? Yes. []

CAROLE BOYE: I would have a request that whatever happens here be promptly communicated to commission members, including what our state senators will be looking at and when, and I mean, all that information has to be very timely for this to be effective at all. []

JIM JENSEN: Okay. Thank you. We will do that. Any other comments? Yes. []

BARBRA WESTMAN: I want to take the opportunity to tell the commission that this is my last meeting, as I have taken a position with the state of Nebraska in Corrections. I start at the state penitentiary on Monday, so this will be my last day in behavioral health, and I appreciate the opportunity that I've gotten to know each and every one of you. I think the commission was a wonderful body to be working with. []

JIM JENSEN : Thank you, and we thank you for your participation. I might mention that C.J. Marr...I got a letter from him asking that he not be on the commission any more. His residency really is in Arizona. And then also, as you may or may not know, James White I don't think will be attending meetings any more, also. I'll just throw one other thing out there, and that's that we don't very often discuss Beatrice, and I'm not asking that we get into a discussion, but two of the individuals up at Norfolk are DD patients that need placement. There are two individuals at Alegent Health Care in Omaha that have been there, one of them 40 days, awaiting placement, the other something less than 30, but like 28 or so days. These are DD patients and in the same beds as people with mental illness. And I'm not saying that DD doesn't quite often go back and forth between mental illness and others, but it also points out that there are...you talked about...if you're going to have a good system, it has to be one that flows, and I think

we're running into some problems there, too, and I hope the Beatrice situation gets straightened out very quickly. Any other comments by anyone else? []

DANIEL WILSON: Senator, do we have a date for the next meeting? []

JIM JENSEN: I haven't looked at that. Let me do so and get to you as quickly as possible, Depending on what our response might be from this meeting in the next few days might play into that. But let me get back to you on that, if I can. Anything else? I want to thank you all for your attendance, really appreciate it. []