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BEHAVIORAL HEALTH OVERSIGHT COMMISSION
May 20, 2008

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The Behavioral Health Oversight Commission met at 1:30 p.m. on Tuesday, May 20, 2008, in Room 1113 of the State Capitol, Lincoln, Nebraska. Members present: Senator Jim Jensen, Chairperson; Mario Scalora, Vice Chairman; Senator Joel Johnson; Gordon Adams; Mary Angus; Brad Bigelow; Susan Boust; Carole Boye; Topher Hansen; Linda Jensen; J.Rock Johnson; Doris Karloff; Bill Mizner; Cindy Scott; and Daniel Wilson. Members absent: Andrea Belgau; Shannon Engler; Ron Klutman; Howard Olsen; Joe Patterson; Ellie Tompkins; and Karen Weston.

JIM JENSEN: Good afternoon. If everyone would take their seats, we'll begin. Welcome to the Behavioral Health Oversight Commission meeting. You have before you an agenda. Are there any additions or corrections to that agenda? Don't see any. And also the minutes of April 25 were circulated. Any additions or corrections to those? I don't see any. Thank you. Today's meeting primarily is about finances and how the Behavioral Health Division, Health and Human Services division, and how we have followed through on LB1083. As you know, April 30, this commission...oh, April...June 30, this commission will end and a new commission will take over from that point, and so I think it's very important that we leave with at least a pretty good idea of where we are and what is left, and so the new oversight commission can take over from that point with a pretty distinct and clear slate. And so with that, Scot, if you're ready, I think that we can start with your proposal, and we'll go from there. Thank you. []

SCOT ADAMS: (Exhibit 1) Thank you very much. Good afternoon, everybody. I'm really very happy to be here today and want to thank all of you for attendance. This is a good turnout today and I appreciate that very much and look forward to the conversation this afternoon. I think this is a very important meeting, and one that will be, I think, very useful and sort of fundamental to behavioral health reform moving forward, and so I am grateful for this today. This moment today that we're at, I think represents the conclusion of an important chapter in the LB1083 and in the ongoing book of behavioral health

reform. I think of it as a positive moment, an exciting moment, and a moment of transition in many ways. In a number of ways I think we have had some very highly successful elements with regard to the last four years, and I think it's useful to just take a moment to sort of consider some of those achievements. With the help of the Oversight Commission, I think the state of Nebraska, along with providers and consumers, regions, law enforcement, and a whole host of communities across the state of Nebraska have achieved a number of very important, significant elements. Among those are, we have lowered the number of mental health board commitments. We had a high of 871 back in 2002. This year the estimate is 196. I think that's a pretty significant achievement. We have lowered the number of emergency protective custody holds. Again, in '02, the high was 2,930; and this year, 2,224 is the estimate for the '07-08 fiscal year. Of course, we're not finished with the year yet, and things can change. We have closed a significant number of regional center beds in terms of services to adult consumers, as well as adolescents. There have been 9,000 new consumers in the four-year period since behavioral health reform occurred. Very frankly, I don't think anyone really envisioned that happening between '04 and this year. These appear to be unduplicated consumers who have come into the system. I think when we first talked about behavioral health reform, we talked about perhaps hundreds of people who were in regional centers, moving home, and perhaps hundreds others not going to regional centers. This is a pretty startling number, I believe. We are, I believe, provided for greater consumer participation than ever before, and with the conclusion of funds this coming week, in the next week or so, we will...I have moved $30.1 million to the community. So what does conclusion LB1083 behavioral health reform chapter mean? In our opinion, it means removing the remaining $3.5 million to community-based services on an ongoing, permanent basis. The $3.5 million that is going in one-time funds this year to the community over the course of the next week will be part of the '08-09 contracts. They will go via the regions for services to complete behavioral health reform in the LB1083 chapter on behavioral health reform. I want to say, in particular, because the phrase, completing behavioral health reform, has become a bit of a question, and you may recall at the last Behavioral Health Oversight Commission

meeting there was a great distinction, I think, made. J. Rock, I think you were the one to make it, that behavioral health reform is an ongoing effort. Any system reform, any system that maintains itself has to be going through continuous reform. And that's why we used the metaphor today of a chapter, in the LB1083 chapter on behavioral health reform being completed with the movement of the money to the community. But, no, this is not the end. Behavioral health reform will continue, and, in fact, we have yet another symbol of the newness of the next chapter of behavioral health reform with the appointment of a new Behavioral Health Oversight Commission to begin July 1. There will be fresh ideas, new points of view, similar challenges in many ways, that will lie just ahead. But I think the major focus of LB1083 was the closure of regional center hospital services and the development of community-based services, and the movement of, originally, the $25.8 million in those regional center services, inpatient services to the community. With the movement of the $3.5 million to the community in the '08-09 fiscal year, and yet in the '07-08 fiscal year it's going, that chapter closes. The new opportunity is upon us and I think the theme of the new chapter in this book of behavioral health reform is integration. As the system evolves, we want to make sure that we're able to consider the impact of $17 million that will come into the system in the course of the next two weeks, and the impact on people's lives and the development of services, we want to be able to work to develop additional community-based services for people with special needs and opportunities. We want especially to work with people to move them out of jails as rapidly as possible and within the capacity of the system. We want to work toward excellence in behavioral health care. That them of integration continues to be an important theme, even within the smaller component of the regional centers. One of the ideas of integration that we want to make sure that we focus upon is the integration of the Lincoln and Norfolk regional centers into a single regional center system of care where one complements the other. On July 1 of this year, Norfolk is still funded through 420 beds, and that is where it will remain for the foreseeable future in terms of beds. Moving the $3.5 million in the '08-09 fiscal year means that there will not be a fifth unit at the Norfolk Regional Center. We look at least 90 of those beds to be sex offender...clearly, sex offender beds, and we want to use the remaining 30-bed unit

predominantly for behavioral health clients, but probably those with sex offender tendencies and propensities in their backgrounds, as well. Ultimately what we want is maximum flexibility to put the right resource to the right clinical need at the right time. We hope of the course of the next 6-9 months to partner with consumers, colleagues, to develop an important new strategic vision for behavioral health that integrates and balances a regional center system within the major predominant community-based environment of care. That's what the vision of LB1083 was, and we need to continue to work toward that but on a larger scale. In particular, the issue of integration of special populations is a very important conversation. We have to pay particular attention to co-occurring conditions, such as developmental disabilities and mental illness. Those issues of older adults that may be in particular supported living environments, such as nursing homes or assisted living facilities or even within the community. We have to fight stigmas so that consumers who have moved back to their communities can live there with dignity, support, and respect. We have to make sure that the regional centers integrate in a way that is maximally efficient in terms of the resources that remain in those systems, and we need to pay attention to the issues of forensics that have been in the news lately. I really think that this is a time to celebrate, to take stock as the original Oversight Commission comes to conclusion and the next chapter of behavioral health reform continues onward. We should take time to congratulate one another for the work done and to reenergize ourselves to move forward. With that I would be happy to respond to any particular questions that people may have. []

JIM JENSEN: Thank you, Mr. Adams. Any questions from any commission members? []

MARIO SCALORA: I know we'll probably have a couple of my colleagues ask some very specific number-related questions, and importantly so. Beforehand, I just have a few small questions if I might. I understand that the three units currently now...sex offender units, they're full or close to being full, the three SO units? []

SCOT ADAMS: This is a bit dated. []

MARIO SCALORA: I'm sorry, Norfolk. []

SCOT ADAMS: Yeah, this is a bit dated, but the last I was aware I believe we had 53 persons in sex two offenders units at Norfolk Regional Center. []

MARIO SCALORA: So the behavioral health beds that we have now covered at Norfolk are roughly, best of your knowledge? []

SCOT ADAMS: They numbered on that same day, 36 persons, though there were a couple of discharges planned. The number had been as low as 28 in recent days. []

MARIO SCALORA: Right. With the shift. []

SCOT ADAMS: Yes, sir. []

MARIO SCALORA: Right. So we have two units covering behavioral health at the moment, is that correct? []

SCOT ADAMS: That's correct. []

MARIO SCALORA: Are those units coed currently? []

SCOT ADAMS: They are coed currently. []

MARIO SCALORA: The sex offender units, though, are all men. []

SCOT ADAMS: They are. []

MARIO SCALORA: If there was a move to one behavioral health unit, and I understand

in the past you had just one, and would be moving to one, is the intention to maintain that as coed given what you described as the potential population there? []

SCOT ADAMS: You know, very frankly, Dr. Scalora, that's one of the questions that has arisen in terms of the dynamics. A firm, clear, and final answer hasn't been reached at this point, but there is a tendency toward an all-male Norfolk Regional Center for a variety of sort of clinical reasons and expertise in facility design issues, as well. []

MARIO SCALORA: So if I hear you, Dr. Adams, your preference would be theoretically to move toward all-male but that hasn't been decided yet. []

SCOT ADAMS: That's correct. []

MARIO SCALORA: Not to put words in your mouth, but make sure I hear that (inaudible). When I hear about people with sexual offending tendencies moving somewhere, I like to know what the zoning looks like, and apparently you thought of that. []

SCOT ADAMS: Yes. []

MARIO SCALORA: Thank you very much. []

JIM JENSEN: Yes, Dr. Wilson. []

DANIEL WILSON: Scot, I appreciate your optimistic, forward-looking summary. The idea of closing the chapter on LB1083 entails, I think, the core responsibility of this commission, which was to advise the Governor and the Legislature, if remember correctly, when the behavioral health populations within the state hospitals reached 20 percent, for the purposes of closing those to future behavioral health civil services. And we're at or very near that point, certainly past it with Hastings, and at it or very nearly at

it with Norfolk. So do you have any thoughts on the feasibility of not merely reporting that but actually finishing LB1083 by those closures? []

SCOT ADAMS: You know, there are, I think, two or three or four different ways to be able to look at this, and I know that there was a great deal of sort iconic interest and focus on both the Hastings and the Norfolk regional centers. Of course, the specific legal focus on that was taken out of the bill at the time. They both were named, they were in there, and that's not what passed. And so we're left with sort of other ways of thinking about this at this point in time, so that's one response. All I mean by that is to say that a number of things changed on the way to where we got to today, including the presence of sex offenders that nobody envisioned during the conversation around LB1083, so that when closure was discussed, it really meant close the doors, lock it up, turn the lights off kind of thing. Well, I don't know that many people really think of that in the same way today. I think that there were a number of folks who, and I suspect this is yet to come in terms of the disagreement over what the money meant originally, and so there are different points of view about that. To your point though, I would say this, Doctor, and that is we have closed a significant number of behavioral health beds. The proportion of folks who fill both Lincoln and Norfolk regional centers of sex offenders has increased, and so the ability to sort of say that beds have transitioned or changed or this or that over time, becomes a very, very difficult question when you have some of the sex offenders at the Lincoln Regional Center, for example, versus the Norfolk Regional Center, here and there. All of this is to say that I think this is a time to continue renewed efforts on the special populations that remain at the Lincoln and Norfolk Regional Center system hospitals, to move as many people as rapidly to the community as possible, but that there may need to be a unit, if you will, in Norfolk, for particular reasons of expertise, of timing, of location, that may be a useful addition to the system overall. And so I'm sort of less concerned about the particular Norfolk unit, if you will, because I think more than enough beds have been changed around in other parts, in Lincoln, for example, to sort of claim an important victory at that level. Now, the bottom line level is that people in need get the services they need. We're putting in $17 million

here in the next couple of weeks, and an additional $3.5 million permanently, beyond what had been planned for, that I think can help bring the system to the right size and the right balance in the right integration of services. []

CAROLE BOYE: In follow-up to Dan's question, my recollection of LB1083 language, the statutory language, is that this commission was to report to the Legislature when beds have been reduced to 20 percent or less; that that was an actual requirement (inaudible). []

JEFF SANTEMA: It's HHS's responsibility to report that. []

CAROLE BOYE: Okay. And that therefore it could...help me with the language, Jeff, but what I'm trying to speak to, Scot, is not argue it, but to clarify when we talk about what was the intent or the mandate of LB1083 in terms of reporting to the Legislature when it was at 20 percent or less (inaudible), and "Upon such notification the division, with the approval of the majority of members of the Executive Board of the Legislative Council, may provide for the transfer of all remaining patients at such center to appropriate community-based services." So it may a distinction without a cause, but I do think even when dates were taken out of LB1083, that the focus on closure remained in the language by virtue of that notification requirement, okay? My math says, at Norfolk, 179 beds. Twenty percent of 179 is actually 35.9. So if we have 36 patients at Norfolk we're not at 20 percent. If we have 35 patients at Norfolk we are under 20 percent. And LB1083 does, in fact, mandate the division or the department to notify the Legislature of that. That's what the law says. Again, it may be a distinction of the cause because the language goes on to say, then the Legislature may close. And the department and the Legislature and I am acutely aware that our Governor just walked in, and our Governor may decide that's not what's going to happen, but I do think, from the commission's standpoint, if we hit 35 at Norfolk we're required to do this process. []

SCOT ADAMS: You know, a couple things, I'd say, Carole, especially in light of the last

couple of weeks where, because of the number of people sitting in jails became an issue of concern of humanity and the rightness of people sitting in jail as opposed as coming to a hospital for treatment, a decision was made to increase the capacity at Norfolk. That kind of dynamic, which I suspect most folks would, I would think would perhaps agree with, it's better to have people in hospitals than in jails if they've been...if that' where they should be, I think sort of indicates the need for some flexibility and the integration of the Lincoln and the Norfolk regional centers, one to complement the other. Secondly and moreover, because you are focusing a little bit on particular points, all of the beds at the Norfolk Regional Center remain licensed hospital beds. []

CAROLE BOYE: Okay. All right. []

SCOT ADAMS: And so that was...because we had thought about this and whether or not one wants to think more deeply about sex offenders versus this or that and whether or not this particular sex offender has a psychiatric condition also...uh-h-h, you know...but I would just simply say that, that those beds are, in fact, filled with live bodies. And thirdly, what I would hope that we can all grip and agree to and move with is, whatever has been, has been. And the money to develop the services in the community-based, the promise of LB1083 is here, the moment is now, and that we can agree to look forward to the next great chapter in Nebraska's recovery. []

JIM JENSEN: Thank you, Scot, and I appreciate your responding to that question about when is behavioral health finished. There was one driving factor implied. I don't know if in LB1083 we actually said that, but I certainly heard it from the consumers as we began behavioral health reform, and that was to place as many consumers who are in the institution into community-based services. And myself, personally, I feel that we still have some individuals at the institutions that I think are capable of being in community-based services. And in response to that, I certainly hope that we will continue to do that. Many states have deinstitutionalized services for those people with mental illness, and I hope that in the new vision that we will continue on with that. []

SCOT ADAMS: Senator, I couldn't agree with you more with regard to that. And, in fact, I am happy...and I don't know if C.J. knew this yesterday or not, but I had mentioned in another setting in group the case of a woman, a young person who has been with us at the Lincoln Regional Center for more than 13 months. For the last 8 months she has been picked up by the Lincoln Public School bus. She has a part-time job but she sleeps at the regional center. That's just wrong. And the reason was, there was no provider who would come and accept her. She's moved, by the way. So I agree with you, there are people at the regional centers who can move. This is a good story, though getting there was a lot longer than we thought. And our goal in the next chapter of behavioral health reform is to make sure that those folks get out. []

JIM JENSEN: Okay, thank you. Certainly we do have the Governor present with us and I would certainly allow...like to, if he would desire, to say a few words to the commission or... []

GOVERNOR HEINEMAN: I just came to listen, Jim. []

JIM JENSEN: Okay. []

SCOT ADAMS: No, really. You can take my spot, Governor. (Laughter) []

JIM JENSEN: Yes, Dr. Boust. []

SUSAN BOUST: Thank you, Scot. Nice presentation and overview. It always feels, at the end of such a long ride, like it's hard to pull it all back together and remember where we started and what we were doing. One of the statistics you gave us was that we've served 9,000 new consumers, and that's not surprising to me and wonderful with very minimal resources. But my understanding of LB1083 is that the money...if I understood our plan, and we have people in here who are expert in (inaudible)...that the intention

was to take the money that we were currently spending on the regional centers and move it to the community, and serve those same people in a more efficient and healthier way. And I believe at the start of LB1083 one of the discussions we had at length was how do you handle the unmet need. If you build community services, you can't just say, well, you can't come to this community service if you haven't been to the regional center, although I guess my own program is a case in point where they've done that. Nine thousand new people on money that was really not intended to go to new people, but rather to people who were currently using the regional center, do you see that as having a...what kind of impact do you see that as having on our community services as well as our regional centers' services right now? []

SCOT ADAMS: Well, you know, I think there's a number of things. Certainly with regard to the regional centers, I think we are at a bit of a transitional moment between the two, the...all three regional centers. There is a particular task force attending to the Hastings Regional Center with regard to the remaining services for children, and plans are afoot there to perhaps move to a new facility for young people with regard to behavioral health disorders there. And so there's a task force there, LB542 task force continues afoot. With regard to Norfolk and the Lincoln Regional Center, there continues to be a rebalancing, if you will. A year ago when I came here, probably about...this is May...maybe around this time I think Mr. Gibson was appointed as the CEO of the Norfolk Regional Center, making him CEO of all three. This really was the first time that we've had opportunity administratively to have an interlocking system of care. There really were three independent hospitals prior to Bill's arrival in that regard. And so the work of transition of fiefdoms into a system is no small task. I don't know if you were there for the Clarkson-UNMC merger, but, whew, boy, that was no small fete either. In any event, that process is not finished yet and we're still continuing to work with regard to how to account for that and what resources make best sense, that kind of thing. But I think the exciting thing in that regard is to be able to pool the resources, to have maximum efficiency, rather than two silos working hundreds of miles apart. I see that more and more in the leadership team, in the management styles, and the cooperation

and the training. This recent situation with the NOORIs (phonetic) and the restorations in jails is another example, I think, of a cooperative, positive environment. Now, moving to the community side, when I was at Catholic Charities I know that it was a lot of people coming at us and a lot of new situations coming at us as a provider well beyond what we had been accustomed to. I know that Catholic Charities probably better since I left, would rise to the occasion and adapt and become better. I suspect that's true of many providers who have both expanded quality as well as capacity over the last several years. I don't think of that job as done. Behavioral health reform is an ongoing process. We're about to infuse another $17 million into the system to help those services expand both capacity and quality again in a way that I think will really be significant for Nebraska. In addition to that $17 million going out by May 30, there is, again, the additional $3.5 million in the next fiscal year to help those systems. That's why I wanted to focus in my presentation a little bit on some of the special populations. Bottom line, short version, I suspect that the system is pretty well stressed but I think there are additional resources coming in at a time, at the right time, to be able to develop this to the next level, to the new chapter. []

JIM JENSEN: Mario, did you have a comment? []

MARIO SCALORA: To quote the Department of Defense, when you start talking eight figures, you start talking real money. And $17 million is a nice infusion to come in at a key time. It strikes me we're at an interesting crossroads with crisis and opportunity, in that you had the communities working hard to deal with a lot of folks in the community they have not dealt with before at the same level. You've had the regional centers working very hard to downsize, and now we have communities. But you have development more at a community level in terms of services. So you have more localized service development responsibility going on as opposed to when this state was practically in charge and handing out money from a more centralized place. So now that we have...and we have maybe 36 people, you said, at Norfolk? []

SCOT ADAMS: That was the last count that I knew of. []

MARIO SCALORA: Give or take. []

SCOT ADAMS: It could be down a couple. []

MARIO SCALORA: Understood. We have 36 people in Norfolk. We have some jam ups in the system now. Laws of physics are such that you can't move people to where there's not a spot. []

SCOT ADAMS: Unless you're in Sarpy County. (Laugh) []

MARIO SCALORA: We won't go there out of personal...I don't want to be quoted unless I'm in court, and I'm more than happy to be if I'm invited. []

SCOT ADAMS: You are probably wiser than I am; I'm sorry. []

MARIO SCALORA: That's okay. I'll do it under oath. We...it speaks to where does the buck stop or who's responsible for when there's a logjam or when there is a situation where there is a gumming up of the system, so to speak. Who takes responsibility? Who...where is the state going to be able to step in or how is this going to work when we hit these logjams or the community says, we can't take any more or we can't take X, Y, and Z certain populations, and the state is saying, yes, you should? []

SCOT ADAMS: Yeah. You know, Dr. Scalora, I think that's an excellent question in a system in which it is as decentralized as Nebraska is. Again, going back to LB1083, originally the regions were written out of behavioral health reform, or through behavioral health reform were written out of the equation. That didn't pass. That was specifically included and specifically taken out. And so the political moment of one way of resolving that is over; it has been addressed and is over in that regard. And so what I think you

see at this point in time is the strengthening of the regional system of care. There are strengths with that; I don't deny that. The regions know better what's going on in their location in terms of the needs. I think you can see that with regard to the particular identified kinds of resources, needs, and questions that come up in the emergency system. A very different situation in Omaha and in, literally, in Sarpy County than it is with regard to, say, in a Region IV area where distance becomes a very different kind of barrier and factor at play. And so different plans need to be developed, and I think regions are in a better spot to do that kind of thing. However, this really sort of goes back to the old Aristotle-Plato thing of the one and the many, and how do you have a singular system of care that is uniform, fair, and equal access across the state, and yet very many different conditions, and in this case, very many regions. Well, Nebraska's answer to that is to work through the regions. I think it will be the responsibility of the Division of Behavioral Health to work with the regions collectively to convene them and to ensure that there are even standards of care. But how that will look, will look very differently from regions to region. That's one of the dynamics we want to see as we move forward with the infusion of these funds, how they're used, and what one region from the other might learn from one another. Overall, hopefully, Nebraska will be the stronger for it. []

MARIO SCALORA: But maybe to get more concrete, because I have to be at times, would there be, for example, a focus with part of this $17 million, to look at, let's say, hypothetically, 36 people who have been institutionalized a long time, who we think may be able to live very reasonable, fruitful lives in the community with proper care, is there a way of or any thought of focusing how we can look at managing funds to facilitate their transition to be able to shut the lights off at part of Norfolk Regional Center, and potentially even leverage more money because we closed another part of a hospital that we don't need anymore. Where is the focus on that service? []

SCOT ADAMS: Yeah. As a matter of fact, recently in our conversations with the regions we have taken two steps right along those lines. One is we've changed the nature and

the structure of our Tuesday morning calls. The regions and the emergency system coordinators come together in a conference call every Tuesday and talk through discharge-ready folks and beds waiting and this and that at the regional centers in the hopes of doing exactly what you're saying, of moving people through the system. We have recently changed that so that we have added the social workers from the Lincoln Regional Center to make sure that they're part of the calls all the time so we can identify the particular, specific, unique barriers for that person, as opposed to that person, to that person, so that we are very much focused on getting people out of regional centers as best we can. And when barriers are identified with you, as opposed you, then to be able to problem solve around the specific cases involving Linda as opposed to Jeff. So we have changed that in our convening activities to move exactly in the direction that you're talking about. Secondly, the second change with regard to that then, is when we identify systematic kinds of problems with regard to cases, for instance it might be housing, housing, housing, then we can systematically begin to address that as a total system. Now, we continue to work on the particular letter that will go to each region that will accompany their share of the money, if you will, and we intend to identify particular priorities that we see from the state's perspective that are unmet needs or needs for development. Among those kinds of things are consumer-led services. Among that is attention to the emergency system (inaudible). And so the directions, if you will, and the expectations that will accompany this infusion of $17 million we think will be pretty concrete and specific, region to region to region. []

JIM JENSEN: And I'd just like to follow up on that. I think that's very important as I also talked to some people on a commission, and others, that said, well, the jam up in Lincoln because this individual...there was a waiting list supposedly. Well, there's a waiting list because we don't have services to take the people in the regional center in Lincoln and put those into a lesser significant area, be that a long-term secure facility like Telecare now in Region VI. Perhaps if there was a long-term secure facility, 16-bed in Region V, we could move some of those individuals that are...if you're going to have a continuum of care, it has to be...you've got to have space throughout that entire thing for

it to work. And certainly the less restrictive care seems to usually be the better care, but just... []

SCOT ADAMS: And that's what we think is exciting about this next chapter in behavioral health. With the infusion of $17 million in the current year and an additional permanent $3.5 million on top of what's going into '08-09, those services ought to be able to be developed. []

JIM JENSEN: Sure. []

SCOT ADAMS: And so that's the exciting part of right now. []

JIM JENSEN: Dr. Wilson. []

DANIEL WILSON: Scot, I'd like to again just reiterate the fundamental task of this commission as I remember it, and (inaudible) Jeff could reiterate, was to advise the Legislature and the Governor when services were drawn down sufficiently for the Legislature to consider moving more money. As I recall, that was one of the main purposes of this commission. It's also, I think incidentally, served as a place to exchange information, stakeholder expression of concerns, public comments, and a very healthy process, but that wasn't the driving purpose of it. I think that was a by-product, which incidentally will stop. The successor commission is not really a stakeholder-based commission at all. It's a geographic and political entity which will serve another purpose but it won't exchange information across the system in the way this has, nor will it, to my knowledge, advise the Governor or Legislature about this very important point at which funds can be moved from state institutions into community services, expanded community services, expanded Medicaid match money. We're talking actually about a lot of money here, if we don't finish LB1083, remaining in state institutions that are not state of the art by any means, and not Medicaid eligible. And this is really not a question for you; it's just a reiteration of our primary responsibility, which

is to advise the Governor and Legislature of that. I am surprised that HHS appears to be stepping back from that, and that we have one more meeting, I think, of this commission, but it would be my inclination to point out repeatedly that we are at the proportion at which we should be advising the Legislature and Governor that there are more monies to be brought out and more services to be extended into the community. Clearly, they should involve the interface of the legal system, through the regional system. But if HHS and the executive want to sustain direct-funded services in decrepit state hospitals...I guess that's a question for you. Why would we want to do that? []

SCOT ADAMS: I appreciate your reiteration and then your subsequent question, and I would simply say again that with the movement of the $3.5 million in the '08-09 fiscal year, that completes all the money. I mean, we ought to stop there for a moment, and in that...that is the end of the money. Norfolk is funded by 1199 funds in its entirety. []

DANIEL WILSON: In its entirety... []

SCOT ADAMS: Yes. []

DANIEL WILSON: ...after that. []

SCOT ADAMS: And so if... []

DANIEL WILSON: Well, that's a helpful point. []

SCOT ADAMS: ...so regardless of that unit being full-fledged behavioral health or some kind of a hybrid or turning into sex offenders, really in that sense it does matter by virtue of monies going to the community at that point. []

DANIEL WILSON: Well, that's helpful because I think it would strengthen the purpose of the commission here today or next month, to actually say that LB1083 has been fully

implemented and that all of the monies will be pulled out, if indeed that is what turns out to be the case. []

JIM JENSEN: Thank you. Let's take another comment if we may, and then I think it's...that we should move on. []

CAROLE BOYE: I do not want it to go unnoticed the significance of what you have announced today, which is the last $3.5 million of ongoing funds will come out next fiscal year. I would like to know how that's going work because that's going to take some legislative action and that kind of thing. But I also want to be (inaudible). I also though would like to not have it go unnoticed that it would appear that HHS, the department, has said that LB1083 is completed, has defined LB1083 as being completed by the transfer of money. You know, all the money has been transferred, so this chapter, chapter LB1083, is completed. As an advocate for people with mental illness, as a strong supporter of the Olmstead decision, which has come to haunt Nebraska in a different arena and all of those kinds of things, LB1083 was about so much more than money. That is a significant milestone, and I applaud you and the Governor and the department and everyone else for figuring out a way that we could finish this money thing, because...but I think we're too narrowly defining what LB1083 was about if it's only about transferring money. That's one point I'd like to make. I don't think there's a question up here, Scot. []

SCOT ADAMS: Okay. []

CAROLE BOYE: But you're certainly...I would certainly invite you to comment. The second thing is, as I've heard you say several times, $17.1 million is a significant infusion of money. It's got to be really clear that about half of that is one-time money. It needs to be really clear that we knew that money was there in October already, and now it's May and we still haven't seen it, so it hasn't served people for 8-9 months. And that going back to what Dr. Boust referred to, there's 9,000 new people that have been

served in this system, and that $17 million was meant to serve people who were going to go to the regional center. And so that $17 million though is going to go to serve the remaining people in the regional center, I hope, but it's also serving 9,000 more people than it ever was intended to. So it may sound like a lot of money, I mean it's real money, lots of zeros, but on a per capita basis, on the number of people that are being served in the community, we don't want to make it sound like a panacea, because it's not. Okay? There's three different (inaudible). []

SCOT ADAMS: I appreciate what you're saying. I agree that the system has done heroic things above and beyond the original intentions and in a number of ways. I suspect that some of the 9,000 who were served could have had...I...well, let's put it positively. I hope some of the 9,000 who were served had a deterioration forestalled as a result of receiving services earlier. I...you know, it's got to have happened. []

CAROLE BOYE: We know that. []

SCOT ADAMS: I think that's good news. And so, yes, you're right. And that's another chapter to be...still to be worked on. []

CAROLE BOYE: Let's not forget the vision of LB1083. It wasn't just money. It really was let's serve people closer to homes, families, and community. The next chapter can't forget that. []

JIM JENSEN: Linda. []

LINDA JENSEN: (Exhibit 2) Thank you, Carole, for your comments, and that kind of leads into some of us who are consumers and family members have been looking at the problem. We want to congratulate you for saying that we've had greater consumer participation than ever before, but we do want to remember that Nebraska has been kind of behind in this area. And we have prepared a list of things that we feel that should

be included in a final report or a report because most of the...we have...feel like LB1083 really addressed consumer inclusion, consumer and family inclusion in the process, a lot, strictly in all aspects of planning and provision of behavioral health services. And I guess we have here a list of...and we'll just circulate that, I suppose. And this certainly can't be done overnight or today, but we would hope that it could be done with the final report. []

JIM JENSEN: And it's certainly my desire and I think that the commission, at the next meeting, hopefully we can bring together these comments, and then review them and have one final last report. Anything else? Oh, excuse me. []

TOPHER HANSEN: I'd like to follow up a little on what Carole said, and I think that we often have heard, or at least on a couple of occasions have heard our system's quality defined in terms of dollars. And, of course, that's not a judge of the quality of the system or when a task is completed, this task in particular is completed. And I guess I'm curious, it will be rhetorical as to why LB1083 needs to be closed down, why it's complete, why this chapter is over, and letters you've written and words you've said, including these, say it's complete and final, but it's just a chapter. And so I'm curious why all the language around completion and then final and so. This is a process, and the process continues on, and there isn't necessarily a moment that it's complete. We can certainly look back and see our milestones. We have plenty of things to say about how the system has changed in a positive way, but we can also look at challenges we have in the system that would suggest that reform is in progress; not that it's done. And then I'm curious to why there's an inclination to change this board or this oversight commission, and why this relationship has been so trying. Really, it's been difficult to get information to really understand these numbers. It's taken quite a lot of effort on the part of commissioners to track the numbers and to try and understand what we've really been asking for since Day One, which is the numbers. We need to see the numbers in order to understand what the term is, how this thing is shaping up. And we get some of the numbers but it's been only of the last year that we've really gotten some of the

financial numbers, and that has continued to be difficult. So in my community-based situation, I would love to have a board of invested people like this who are asking questions and pointed in the same direction as I am, and showing up to all of these meetings, and digging in, in the ways. And I have a great committed board, but at the level that this group has committed its time is really quite a fete and shows a lot of dedication by the members, and I think that's a positive. And I keep hearing things about this, about completing it and finalizing it and it's over, and so on, that make it seem like we have to end it, and I don't understand that. I think what the measure of success is, is getting all the corners turned and bringing this to a level of maintenance. And you raised some of the issues ahead that need to be addressed, and I think there are others, and their performance at the regional center and other places that we need to begin to address, how do we deliver a quality system of care? I hear you say that. I don't see it. And I think that's part of what we could do together. So again it's probably more of a comment than a question put to you, but it's curious behavior from someone who manages programs and works with community volunteers. I cherish this relationship and look forward to it, and I get the impression that that's not the case here and that there's an effort to close it down. []

SCOT ADAMS: You know, I think that's soup, nuts, kitchen sink, and waterfront in there, in the thing, so I probably won't respond to everything, but let me make just a... []

TOPHER HANSEN: It's my second to the last meeting. I've got to (inaudible) it up. []

SCOT ADAMS: Let me just maybe respond to a couple things. The law before my presence, of course, brought 6-30-08 is the termination date for this. That was part of LB1083 that I think probably everybody on the commission worked for, and so I presume everybody was aware of that and agreed to that at the time. The development of a new group of people, I think, is really sort of the basis for the energy, if you will, for the sense of the chapter that we're at. LB1083, four years out, wasn't supposed to have another oversight commission; now we do. Represents a fresh start. And so it really is, I

suppose more than anything, Topher, the seizing of the opportunity of the new. As you know, and as I know from my experience with private nonprofit boards, people come and go on the commission, in committees and boards, all the time. In fact, it's typically an annual affair in which fresh blood comes on to a board and people are thanked for their service and they move on. Well, that has been different here because you've all been here, you know, and so in many ways it just represents, I think, an opportunity for that freshness that you enjoy, year to year to year, to come in. Nothing wrong with...I'm not...I don't mean to cast dispersions in any way by saying that. It's just that there needs to be a time for the new. And I think that this represents that time for a new chapter in terms of things. With...I also want to thank you for, I think, a compliment in which you said with regard to, in the last year there has been greater access to numbers, but I think you did say it was somewhat still difficult to get, but at least I think you made a distinction about the last year, so thank you for that. And finally, as the presentation noted, we intend, over the course of the next several months, to engage in a strategic planning process in which a variety of consumers and other colleagues are involved to sort of write the next chapter, to sort of start with the end of the chapter and to fill in the heros and the heroines and the protagonists and all the verbs and things that need to go into that. And so we look forward to that next vision in process for what we can be. I think that's a healthy thing, frankly. To simply say and sort of repeat the same old mantra, mantra, mantra, misses the evolution of things as it changes over the course of time. That's why freshness and rebirth is a necessary element to life, and I see this next chapter as reflecting that. []

JIM JENSEN: Let's take one more comment from J. Rock, and then we'll go into the second phase of your presentation. []

J.ROCK JOHNSON: Yes, I think that the housing that's come forth from LB1083 has been critical, and we need to continue to focus on that, because without a place to live you cannot recover. And looking at LB1083 as a whole, I reminded of The Merchant of Venice and Shylock who lost his bet with a pound of flesh, and he said, you can take my

pound of flesh but don't take one drop of blood. And I think that that's the distinction that you're attempting to draw here. Now I know that clip art being what it is, as I look at what you've shown us, I see a book that's already been written. I don't see one with new chapter and inclusion. I do have a couple points here that I think are important to make, and one is the morbidity and mortality. We've talked about that and talked about it. I hear nothing from the division. People die 25 years earlier; it's now going to 30. I've been to too many funerals this year. As I look at the documents that were a part of the RFP for the administrative services organization, it says there's an increased focus on behavioral health consumer involvement, and planning, service, development and delivery. We've had an individual as a consumer liaison for 17 years; one for 16 years, about whom we heard little or nothing, and no accountability. And with all due respect, we've had that same experience, in my opinion, and that's shared by others, in the last two years with our Office of Consumer Affairs. In this RFP, the way that the division presents itself, objective of the behavioral health system: to provide a public behavioral health system for the people of Nebraska. Well, I guess you can either argue with that nor hold you accountable for that. Intent: to work together as partners for a complete and thorough system driven by the people who need it. That's something that's never really been explored or defined or had a focus upon. And the last I want to mention here is the values: the Division of Behavioral Health provides a comprehensive system of care that is person-centered and recovery oriented, accessible, focused on positive outcomes, and cost effective. Not what we strive for or what we measure ourselves against, but a simple pronouncement that that is what is. We need system transformation. It's a concept that's in play all over the country. We have to move from institutional mentalities, as so many people are aware, the first thing the division did was to enter into contracts with community hospitals, not create new serves in the community. Not just more of the same, but new services, expanded services that are based on the consumer-driven, consumer-need. Consumer-led is a...I'm very concerned about the use of that word. But I'd read from LB1083 relative to the advisory group, that part of their work is to provide advice and assistance to the division relating to the provision of mental health services and the state of Nebraska, including but not limited

to the development, implementation, provision, and funding of organized peer support services. That's not an avenue that I have seen taken. Also consumer involvement is a priority in all aspects of service planning and delivery. We've talked about this from Day One, and what we get is input. We'll listen to what you say and then we'll make the decision; not that we will work together. That's what involvement is. And it also requires education for people, supports. I understand that you have a question about why it is that people with mental illnesses want and believe we should have jobs helping one another, when substance abuse and AA does not have that? Actually it does, in the (inaudible), but I've heard this coming back to me, when actually employing consumers is the core of the change of the system of people getting well. When we start talking about a career path, when we reframe this from patients and sick people to looking at it from an economic development, businesses, co-ops, marketing, that kind of thing, we haven't even begun to talk about that because we don't have a vision. We're already telling folks that we're recovery oriented, etcetera, so forth. And I have some concerns about your statement that in a few months they'll be a variety of consumers. Well, so many of us have had the experience of watching how these things get done, and we have not had a commitment to people learning how to participate in various processes, being educated. And this is exemplified by the fact that we have a consumer conference every single year, and every single year the priority...in fact, the only people who attend are people who have never gone to a conference before. So we have been dedicated to assuring that people don't get together, don't talk, don't have an investment in those opportunities of learning from one another. I do applaud the supported employment. That's something that has happened, along with the housing. I'd be looking for supported education, but mostly I'd be looking for us to treat the people with respect and as people who can and do recover. That's what's in the New Freedom Commission. And as I look at what you've...the information you've made available today, I'm not finding that. I'm also not finding another aspect that was specifically in LB1083, which is about data and data improvement and data sharing. We have a real hard time, frankly, in this state and with our Web sites, although we have award-winning people. But there's information that's not up there, and if it's not there, you can't find it. And it if not

data...we talk about being data-driven; if we're not collecting the data, then we cannot use that to make decisions. So while that mean seem a tall order, it actually starts with having the respect for the potential of each person. It includes integrated treatment; not mental health, not substance abuse, not co-occurring, not dual diagnosis, but integrated treatment. And changing the way we think about people. So that's my hope and prayer for where we can go so that we can be proud of the processes that include consumers, and the education that helps them participate in the world of government and that kind of decision making, as well as in the world of the community. But I don't hear any commitment to putting money that will be forthcoming into organized peer support services. And that's what I'd like to hear and I don't want to hear, with all due respect, go to the regions. I've seen the guidelines that were sent out to the regions; they're fairly restrictive. And I think that the state has a responsibility to be a leader and to be a visionary here, not just say, well, it's up to them, it's not our responsibility. And on that note, thank you, Senator Jensen. I appreciate the time. []

JIM JENSEN: Thank you. Unless you want to respond to that, we'll move on to the second section. []

SCOT ADAMS: That's fine. []

JIM JENSEN: And certainly that doesn't mean that questions on this first section can't be entered into, but the purpose of this meeting, like I said, was to look at finances of where we've come from and where we are today, and, boy, I can distinctly remember when we first started in this quest of LB1083, trying to find out what that dollar was that was in the regions. And it was finally determined, yes, it was $28.5 million, and how we worked on through that. And it has been a task for this commission to come up with those figures. I'll be honest, I think that perhaps the department has even profited by some of this digging and working through, because I think they even have a better idea themselves of what has been done. With that, go ahead. []

SCOT ADAMS: Well, I might certainly lay claim to that because having come from a place closer to my home about 13 or 14 months ago, I've come a long way on understanding the numbers. And it is complex and complicated. I would really just, I think, have a couple of quick points...is this thing coming back alive?...that I might make, and then while that's coming back from its nap, will simply say that this will be a very brief presentation. Elton Larson and Sandy Sostad are also here to respond to questions regarding financial information that you may have. Additionally, we hope that the information that we have provided to you ahead of time, we thought responded to the questions that were provided to us. But of course, questions lead to more questions, so I expected that could be the case. In any event, I want to just be very brief with regard to a couple of things. This is sort of the infamous page, and just wanted to draw your attention back to this. Many of you have this in one way or another, or in multiple ways, but this was the document used to sort of kick off LB1083, that spoke about how much money was going to be transferred to the community. And this is where the original $25.89 million or $25.889 million comes from. And it came from originally, in the original discussion and premise, the inpatient services at the Hastings Regional...the Hastings and Norfolk regional centers...for a total of $25.8 million. I'm going to switch back to this page which is simply a page that documents briefly how we have gotten to a number of about $30 million transferred rather than the $25.8 million, and that is the numbers from the inpatient services that were developed...excuse me, that were closed at Norfolk and Hastings in units so far, and the decision to fund Norfolk with LB1199, so that allowed all of that money to go into the mix. That transfer of the ACT program, the general fund transfer of the ACT program to the community, all outpatient services, and the annual appropriation granted by the Unicameral to those services still in effect over the course of years. So you add all that together and it's about $30 million of real dollars into the community over...and that's over the original idea of the $25.8 million. And that was a process that we...with providers and a subset of this group, and with the Legislative Fiscal Office, came to agreement upon earlier in this fiscal year. The other issue that I think remains something of a...that I hear is a bone of some contention on the financial side is the word "encumbrance" and the use of that in terms of state

funding of dollars. And this is simply to show that before behavioral health reform occurred in the '03-04 fiscal year, there was carryover of about $4.6 million into the next fiscal year, the first year of behavioral health reform, in that this is simply a typical and normal part of how state government pays its bills and does accounting. And again, this is about as deep as I'd go with regard to the topic of encumbrances, but Sandy and Elton are both here, and would encourage any questions you might have on that topic to them about this point, if you would. With that then, I think I'll respond to questions, or the others can do that, as well. []

CAROLE BOYE: Scot, I know Sandy. Who else is here? []

SCOT ADAMS: Elton Larson is with the state Budget Office. []

CAROLE BOYE: Okay. []

SCOT ADAMS: And the state Budget Office is an executive branch function that approves the HHS budget, as it does the other budgets for the different agencies of state government. So it's not HHS but we work in cahoots, (laugh) so maybe they're suspect; I don't know. []

MARIO SCALORA: My accounting knowledge probably is dwarfed by yours, so I apologize if this comes off as a question, but it strikes me that over the course of four fiscal years the percentage of funds out of the total budget that had to be carried over increased rather significantly. Is this an accounting issue? []

SCOT ADAMS: No. No, some of that is the one-time money then that's being put into the system this year, so at the end of the '07 fiscal year it was 11.7; grew during the course of the current fiscal year to 12.1 maybe, or some number. And how that number grew, Doctor, was as the result of really two major factors. One, services began midyear, but there was, if you will, a budget expectation for the total year, so it wasn't all

used. In other cases there are a couple of situations where some services, new services, were begun, and then closed midyear. And so again the dollars may not have been expended fully. The department had asked for...typically, when that happens, by the way, in state government, the Legislature reaches out...the Legislature and my boss reach out and grab those funds back in terms of the next biennium planning process so that all state funds come back and are accounted for. It's not just money left out there. In the case of behavioral health reform dollars, the department had asked the Appropriations Committee to renew those, if you will, and to allow for spending authority. And so that was granted through the appropriations process over the course of the last couple of years in terms of things, so that's how those funds have grown. Services have either started up midyear or didn't start up, didn't continue, so there is an accumulation of funds. And that's the money that we're putting into this system by May 30 of this year, so that at the end of this fiscal year, on June 30, we would expect that the number be back down around $4.5 million. []

MARIO SCALORA: And the fact that it's carrying over is a good thing and not a (inaudible), which... []

SCOT ADAMS: Yes, yes, and very wise in point of system transformation and change like this. c []

MARIO SCALORA: Are there things going on in terms of how we are contracting for services or setting them up that is becoming an impediment in itself, if we're having more and more money having to be carried over? Or...and I understand certain things don't fit calendars very nicely, understood, and we're adding more one-time monies in, which increases it. Are there some bureaucratic issues that are playing a role here that need to be addressed that may be interfering with getting out the money sooner? []

SCOT ADAMS: Well, the process this year where the Unicameral stepped in and spoke about distribution of funds occurred after the beginning of the initiation of distribution of

funds to the community. Contracts had already been out, if you will. That's a minor blurb. You know, that's...we're going to get past all this stuff. It's not a permanent, ongoing issue of any substance, in my opinion. []

JIM JENSEN: Yes, Carole. []

CAROLE BOYE: I have the dubious honor of the number of...of all the information that you were good enough to provide us, and again on the behalf of all of us that have been trying to look at the numbers, we thank you for your cooperation in sending us wonderful reading. (Laughter) []

SCOT ADAMS: I bet it put you to sleep more than once. []

CAROLE BOYE: My only request would be, next time could you blow it up just a little bit? []

SCOT ADAMS: We thought of blowing it up more than once. (Laughter) []

CAROLE BOYE : (Exhibit 3) I don't have a PowerPoint but I do have some overheads that I would like to share with the commission and ask you a few questions as we try to reconcile these last dollars? With your permission? []

JIM JENSEN: Go ahead. []

CAROLE BOYE: Okay. Scot, with all the papers you gave me, we've got it down to five sheets and that's pretty good. (Inaudible.) This is decidedly low-tech here, so bear with me for a second. (Inaudible.) []

MARIO SCALORA: Carole, if I may, (inaudible) hear you, we're going to move a microphone over closer to you from the table so it would be easier for everyone to hear

you. Thank you. []

CAROLE BOYE: Does that work? (Inaudible.) Is that better? Can people hear better? I'll try to speak up here. Okay. Our sole intent here...a couple things I want to acknowledge (inaudible). One is the numbers that you just reviewed, the $25.9 million, and then it grew to X, X, Z, and then 9.3 that we worked on last October, all of those numbers, it seems are...the 9.3, I think it is, a sustaining number, everyone is in agreement on that as part of that last $3.5 million (inaudible) coming out, and I don't think there's any disagreement. Everyone agrees on those numbers. What the question is in terms of trying to do a final reconciliation, that remains on this carryover piece, the encumbrance piece that you referred to (inaudible). The second thing to acknowledge is that last month's discussion really ended up landing on the issue of encumbrances and how this money is going to be spent this year, then how much was left of that pot, all right? And that was the focus of the questions that were put to you and the information. You're going to take care of the (inaudible). Okay. So in terms of your handout, our purpose today and the purpose of this kind of work group that's been working through this, is we really want to, today, reconcile and determine the amount of money that's to be distributed under LB959: the 3.5 is a given; the 5.4 is a given; the estimate of 11.6 which you have estimated now as really 8.1, 8.2; and we have estimated 11.6 at the time that the Legislature met. Okay? Your handout last month dated 4-24 said that there was going to be a total of $17 million distributed. That's $17 million minus the 3.5, minus the 5.4. The balance (inaudible) one-time carryover (inaudible). Based upon eliminating the encumbrance, based upon our analysis from the data you gave, we believe the number is $21,797,820. Let me walk through how we got to that number, and our hope is that we can come to some agreement today. If we can't, then the follow-up questions to the commission that our work group (inaudible) that we see is will HHS agree that this is an accurate number? If not, what should the committee's reaction be? You know, where do we go from here? Because the deadline is ten days from now to comply with the Legislature. Okay. And I apologize. You keep track of me because I'm not very good at (inaudible). (Inaudible), it's not going to work. Okay. Let's start, and I'll refer you more

to your papers then, but let's start with an example, because what we really have to try to do here is, as simply as possible, understand this encumbrance issue. We've talked about accrual versus cash; we've talked about 12 months versus 13 months; all of those kinds of things. But the fundamental issue is this, and probably the best way to understand it is to use an example. Here's the example, is I set an annual budget for myself of $1,200 a year to pay for my electric bill. All right? My budget plan is July through June. Through April of this year I've written checks to total $1,000 for electricity this year. That's ten months of my fiscal year. Divide $1,000 by ten and that means I have an average of $100 a month. So $100 a month times 12 months, $1,200. That's my budget. Hey, I'm on budget. I'm doing pretty good this year with utilities. Okay? What we see on this graph or on this illustration is that if I calculate my electric bills based upon, in the green, the month that I received the electricity, here's the bills that I would pay. I received $125 worth of electricity in July. I paid $125. Or I received, in August, $150, and I go July through June; I have 12 months; that equals $1,200 and I've been budgeting. There's another way that I could approach my budget. What I could do is I could say, no, I'm going to county my electrical bills based upon the month I pay it. I received electricity in July but I don't pay my July bill until August. So then I take those bills August through July, and I have 12 months, and (inaudible) dollars. But if I try to do both, I end up with 13 months and $1,300, and I'm over budget. Fundamentally, that illustrates the difference between a cash and an accrual system, an encumbrance system, pay as you go system, that kind of thing. So now let's apply that same kind of example to the real numbers of HHS, which we've derived from the material that the division provided us. Here's what we know. We know that Program 38 general fund budget for fiscal year 2008, Program 38 is community-based services, was $60 million. Can you fix that? Do you give up? I give up. You can stand here and keep them straight. Okay. I can't even read it from here. Okay, we know that Program 38's budget was $60 million. We know that actual behavioral health Program 38 costs through April, ten months of the budget year, was $50 million. We know therefore that the average monthly cost, divide that by ten, is roughly $5 million per month. That's the actual cost. We take $5 million times 12 months and we get 60...$60 million. We're in budget. That's

good. That all works. So if we do that, based upon when we pay the bill, or when we receive the goods and services, the green, July through June, we end with $5 million, (inaudible) $60 million, 12 months. If we do it in the purple, based upon when we actually paid those services, the accrual method, the encumbrance method, we end up with 12 months and $60 million. But if we do both, we end up with 13 months worth of bills and we end up with $65 million. In essence, the numbers that we have received and the estimates that we've received based on the sheet of last month, showed $65 million; not $60 million. That's where the questions started coming in. So the next thing we need is said, well, wait a minute, we all took math back in elementary school. We were told to check your work. So we said, how can we check this? How can we check our assumptions? What we did was, we also had been given the information on the regional center budgets and on the sex offender budgets. We did it with the encumbrance and without the encumbrance. We did the same...we used the exact same methodology on all of these. What we found was that if we do it with the encumbrance, the regional center and the Norfolk sex offender program, whether you look at general funds only or you look at all funds, all within striking distance of their budget. If we use the encumbrance, the method that was applied to Program 38, what we found is there were $4 million over budget on the regional center budget; we're $3 million when you add all of them; we're $1.2 million over on the sex offender budget. So in terms of trying to find an objective way to check our work, this seemed to say the way we were calculating this is that somehow we've got 13 months in here. Once we ascertain that, because we are assuming the regional center and the sex offenders aren't going over budget, that's...they aren't, are they?...they're not projected to be over budget this year...okay. Okay. So based on all that, we went back to the sheet...we went back to the sheet that you handed out at last month's meeting, the one that (inaudible) on 4-15. In this column, that first column, you will see all the numbers that (inaudible) put together that came down to that first number, that was $17 million to be distributed. Of that, the 5.4, everyone agrees on that, that's LB959. The 3.4, everyone agrees on that. That's LB959. $8.2 million to carryover is what HHS came up with last month. We're coming up with $12.9, roughly, in carryover. The difference being all these

calculations put together by the finance people of the state, there is an encumbrance here of $4.7 million. We think that's the 13 months or we're convinced of it, that that's the 13 months. That comes out...that changes this number to 5.7. Comes down here and makes this 12.9. The bottom of that sheet, having gone through all those numbers, is a few, what I would consider minor, (inaudible). There are some contracts that were posted Program 38 that should have been posted Program 33, which would have a minor impact on that number, as well. That's added on. But that is where we have landed, and we would respectfully but rather adamantly suggest that the real number here--that the real number here is 21.8, plus the additions. That's what we know. []

JIM JENSEN: Okay. Any questions from the commission as to Carole's presentation? Everybody understand that? Scot, would you wish to reply? []

CAROLE BOYE: You don't want to try this, do you? []

SCOT ADAMS: No, I don't. Just making sure the team is here. Really, I would have two comments to make, using those materials, and the first I'll use is just simply the metaphor to try to explain encumbrance. And that is, if you go back to page 2 with the green and the purple, it's 12-month picture. And she's right, this is, in essence, the thirteenth month. If the Unicameral decides at a future date, sorry, we aren't going to do behavioral health no more, that at the end of this fiscal year we still got to pay that next month. Or in Carole's metaphor, if you sell your house in June you still got the electric bill in July even though you're not even going to be there. And that's what the money is. Now then, with regard to one other item, and then I will turn it over to others. But that's the metaphor. That's the encumbrance, and that has gone on before, and that is what that number in the fiscal year '04 is. You had $4 million coming in to this in the beginning that has just sort of been part of that number all the time. Hold on just a second. The second thing that I would draw your attention to is the last number, and you talk about Norfolk Regional...the last page of your handout...Norfolk Regional Center expenditures charged to Program 365 rather than Program 870. That's the

encumbrance for Norfolk from the prior year. And so it's the tail over kind of thing, so it was appropriately charged for one month's expenditures, and that's how that made sense. []

CAROLE BOYE: Scot, there's a lot of people around here that truly do understand accrual of cash, encumbrances, selling your house, property taxes--you know, all of that stuff. The defining principle here though is the same application when applied to other programs, puts them in a deficit situation. Why is Program 38 being treated differently for purposes of determining the amount of money under LB959 that has been mandated to go out to the regions in ten days...why is there a different financial framework used for Program 38 than for Program 870 or Program 365? []

SCOT ADAMS: The answer is, there is not. We agree with you. It's the same principle. And to demonstrate that I'd like to have people from other branches of government, other parts of things not associated with Health and Human Services directly, to try to explain further this general systemwide principle of government. []

CAROLE BOYE: The numbers don't add up. []

SCOT ADAMS: I don't know (inaudible). []

SANDY SOSTAD: I guess we haven't seen the numbers. Maybe if we sat down and met with you guys and talked about them. The major difference I would see with the other programs and HHS, the only thing they pretty much encumbered there is the salaries for one month. So it wouldn't be a marginal amount that you, what Scot pointed out, (inaudible) that last transfer there. They're only encumbering the salaries. They're not encumbering a whole month of services (inaudible) like that. I don't know. But we can sit down and talk about it. []

JIM JENSEN : Sandy, could you come up and just sit there on that one mike for a

minute. (Inaudible). I know you want to do that. And the only thing, being in real estate for some 50 years, I've dealt with a lot of closing statements, (laughter) and I really look at this as kind of the same thing. This is a closing statement. On top of that, also in the Legislature for 12 years and looking at those wonderful budgets that always come out at the last and trying to go through those, I can't ever remember a budget that had a line item for encumbrances. []

SANDY SOSTAD: I mean, I could bring...I brought it with me actually...I could bring up the budget request of the department, HHS, from prior to LB1083 which was on Scot's handout there, '03-04, and I can show you in the encumbrance column, that $4.6 million, so that was the carryover, that was the encumbrance to pay June's services after '03-04. I mean, you know...so basically we see that in the budget request, so it's something that Elton and I look at when they (inaudible) their budget. []

CAROLE BOYE: So do you really think these numbers are right? []

SANDY SOSTAD: I guess I really do, and I would have to sit down and talk to you about them further. []

CAROLE BOYE: Okay. Because it's...the math says if you use the same formula across the board you should get the same results (inaudible) the same results. []

SANDY SOSTAD: And I'm not totally following your logic. I mean, we could sit down and talk about it. I mean, a few of us, if you wanted to, (inaudible) the Budget Office, and go through it in more detail if you want. But right now I'm not following what you're saying, so. []

CAROLE BOYE: Do you have a copy of this? []

SANDY SOSTAD: Yes. []

JIM JENSEN: Well, it would seem to me, and Dr. Adams, respond immediately after I get done making a statement here, that perhaps that might be the better way, is to, Carole, Topher, any other interested parties, sit down with Sandy and Willard would be available also, or Elton, and to see if we can come to a conclusion rather than try to do that in this scenario. Let's hear from Dr. Adams. []

GORDON ADAMS: In the beginning, there was a major emphasis on the fact that we could get more Medicaid dollars if we did this reform. What part of that expenditure of $52 million is Medicaid dollars, or do we know that? []

SCOT ADAMS: The Medicaid expenditures are covered in the Medicaid program, and the match money for that is taken at the point of the payment of the billing. So that...this represents payments to the regions, in essence, and other contracts that the division has. []

GORDON ADAMS: So you're telling me there are no Medicaid dollars in that $52 million. []

SCOT ADAMS: Yeah. That's right. It would be money on top of that. []

GORDON ADAMS: So, basically, the expenditures of the state almost doubled in this period of time since fiscal year '04, is that right? []

SCOT ADAMS: Largely through the development LB1199 was the major source of new revenue, state revenue for services. And the decision to fund Norfolk sex offenders, that whole program if you will, through that source. []

JIM JENSEN: Yes, Topher. []

TOPHER HANSEN: Sandy, I have a question. I still don't understand from the accrual system, if you're accruing and then paying, if in June your accrue bills but you're paying in July, and we follow this little example, then you're budgeting money in July to cover June, right? You're not budgeting a double amount in July because you have a new fiscal year and an old fiscal year all doubled up into one. You're just staying in the same system. And so if that's the case, why do we have...? I'm not understanding why we have to have another $4.6 million aside, set aside as kind of a reserve to cover the first month of the fiscal year. Wouldn't that be included in the fiscal request? []

SANDY SOSTAD: I think in my mind, and I'm not sure I can explain it here, but I'm thinking that you're getting the reappropriated amount mixed up with the ongoing appropriation amount. []

TOPHER HANSEN: Yes. []

SANDY SOSTAD: I could get... []

CAROLE BOYE: Could I jump in just a second? []

TOPHER HANSEN: Sure. []

CAROLE BOYE: However, there are $65 million. When you do it this way, there's $65 million, and there's only $60 million in the base allocation. So that 2...I mean, these are recurring expenses, so that 2 would indicate that there is an extra posting going on here. []

SANDY SOSTAD: And that's (inaudible). []

CAROLE BOYE: Because again, I can't believe that the department would be going over budget by one-twelfth of their budget. That... []

SANDY SOSTAD: And they're going over their appropriation... []

CAROLE BOYE: Their continuation appropriation, which...(inaudible)...I mean, that isn't how...that's not how government or any business runs. You...okay? And again, even if you took half of a month for salaries or those salaries are a great extent of virtually anyone's budget, 75 percent, the other two programs would also be going over budget. This just defies some logic. It just defies logic. []

SANDY SOSTAD: And if you look at the other programs, they are encumbering the salaries, or at least the first pay period in the next (inaudible) year. []

CAROLE BOYE: Our specific question was, were the encumbrance...you know, how do we derive the budget of the others, and we were told, take year-to-date, and divide by 12. That was the response we were given on those. []

SANDY SOSTAD: Well, if you look at the budget documents, you would actually see that they do encumber the first (inaudible) salaries for all of these programs in HHS. []

CAROLE BOYE: Okay. All right. []

JIM JENSEN: And you also say that that's the same as we're doing in Program 38 as we do in many other programs that the state has? It's the same. We're not changing anything here. Okay. Dr. Boust. []

SUSAN BOUST: Well, I get to the other end of Carole Boye on numbers, a lot of times--not my skill. And so I want to make sure that we as a commission don't leave...looking like Carole...I mean, I think Carole has done yeoman's work at trying to help all of us understand these budgets and understand the money, and we believe that that's part of our responsibility to all of the people who aren't at this table and in such

great need. So I get to play stupid and see if you can help me understand this. In fiscal year '04, with appropriations and expenditures, I have a checkbook and a billfold, and I kind of understand money in and money out. Is the carryover, money in or money out? []

SCOT ADAMS: (Laugh) I'm sorry, but I'm flashing on my wife right now. The carryover is money that would be reappropriated into the '04-05 fiscal year, and made available... []

SUSAN BOUST: So the carryover in '04-05 would be money in. []

SCOT ADAMS: Yes. Yes. And for '02-03 had some number that carried over into the $33 million appropriation, and so life goes on until there finally really is a thirteenth month. I mean, somebody says is all done. []

SUSAN BOUST: My church has that all the time. I don't know. []

JIM JENSEN: And we're saying contracted for but not spent, is that...(inaudible)? []

SCOT ADAMS: Yeah, yeah. And in the packet of information it gave you an example--I believe it was March--of what the encumbrances typically are, and it's an estimate at this point because we don't know what the number really will be in June of '08, but it's going to be real close. []

JIM JENSEN: Yeah, I will say, I've heard from some regions, and they're also having the same problem in that they feel like somewhere in there we're missing a month. But hopefully we can determine that. Any other...? Yes, Mary. []

MARY ANGUS: I just thank you, Carole. I know we talked very briefly about this a couple weeks ago, and I really appreciate...actually I think I understand. []

CAROLE BOYE: Well, several of us worked (inaudible). []

MARY ANGUS: And I really think that this helped me to understand, and I really appreciate that. I've got to--I think it's related--where do the Medicaid match funds come from? []

SCOT ADAMS: Medicaid match funds will come out of the Program 38 dollars, the community-based services, and they will go to providers as they draw down the particular bill. []

MARY ANGUS: So those will come out of the money that would ordinarily go to the regions? []

SCOT ADAMS: It goes to that program, to the aid budget. Yes. []

CAROLE BOYE: Mary, I think you're going to start going down...there's a whole other series of questions that people have. Can I just try to finish this up for a second? []

MARY ANGUS: Oh, yes, please. []

CAROLE BOYE: We have ten days to comply with the legislative mandate, and I assume it is the department's intention to comply with LB959 that says money should be distributed. Is that correct? []

SCOT ADAMS: Yes. Oh, absolutely. []

CAROLE BOYE: So is there...? Where is this commission at, if we need to meet, is it incumbent upon...does it matter whether this commission agrees or not with the numbers? You know, is this the forum to do that? Does that need to happen before May

10? I just want to close out this...? If we're leaving it with, we've got to meet, then what happens? So what happens next and by when? []

JIM JENSEN: Well, I would hope that you could meet in the next week, and I recognize what Monday is, but...and that we could get some kind of a calculation from the group that meets with Sandy and Elton and so on and so forth, to then submit to the rest of the commission. Okay? Does that work? []

SCOT ADAMS: And from my point of view, to the question at hand... []

CAROLE BOYE: I want to close the book on that chapter, Scot. []

SCOT ADAMS: (Laugh) It won't close. (Laugh) My take on this is, is we have agreement from the Legislative Fiscal Office, from the Governor and from the state Budget Office, and from the HHS Office on the numbers. The ones that don't agree are you. []

CAROLE BOYE: I have two responses to that. Number one, the Legislature agreed with us that there was $11.6 million estimated funds to be transferred. So...I mean, if we want to start stacking up with who agreed with who. The second is, you have been using the word over and over again about accountability and transparency. So let's be accountable and let's be transparent about this. I hope you're right. I would really rather not keep looking at these very small numbers page after page. I hope you're right, but it doesn't add up right now to any number of us who work with budgets a lot. So help us understand it. []

TOPHER HANSEN: I need to clarify, and maybe...if I understand this, and Sandy or whoever can give me guidance, but a '04 appropriation, $33 million; $4.6 remained at the end of the year. And then what happens is, does that go into the '05, $35 million? Is that part...? Does it go right up to the top as money in? []

SANDY SOSTAD: It's on top. []

TOPHER HANSEN: It's on top of that. Okay, then I don't understand. []

CAROLE BOYE: So there's $40 million there, correct? []

SUSAN BOUST: No, no, no, no. No, no. I mean, if you're taking the 4.6 out of the $33 million appropriation, you didn't have $33 million...I mean, I'm back to my very concrete wallet example. So I would love to make a motion that we get a group of people to work with the Governor's Budget Office, is that...? And try and...and help ourselves understand what this look like from each other's point of view. I think the piece of the motion I don't know how to finish though is Carole's point in this very short period of time, is this reported by an e-mail to the commission? Is there any other action this group wants? []

CAROLE BOYE: Well, based on Scot's question, maybe there's not (inaudible) doesn't matter. You know, if you're saying what's it matter whether we agree or disagree. You all agree. Is that what you're saying, it doesn't matter? Because we all have better things to do. []

SCOT ADAMS: Well, you know what I might propose is why don't we work with Senator Johnson's office as a sitting senator, a member of the commission here, and try to work through this in a rapid fashion. I also want all of us to come to an agreement eventually on this one. To be real honest with you, I'm not sure what else to show you. We don't have any more documents to produce. There's...I'm not quite sure how to go about that, and so I might just suggest working with Senator Johnson's office as Chair of Health and Human Services, if that makes sense, in a way to move forward here. []

JIM JENSEN: I don't have a problem with that, but I think we certainly need Carole, Topher, Susan, whoever else might want to... []

SCOT ADAMS: Whoever else wants to come is absolutely fine. I just want to give it sort of an air of formality and clarity about that. []

MARIO SCALORA: Do we need to have a motion or some official action or keep it informal? []

JIM JENSEN: I don't know that we need a motion. I think the minutes will reflect what we're talking about. []

MARIO SCALORA: Okay. That's fine. []

JIM JENSEN: I think we can go from there unless somebody says something otherwise. []

TOPHER HANSEN: I would then request that the minutes do call out specifically, because we have abbreviated minutes, so if the minutes can call out specifically what the intent here is so when we get, next month, the minutes, we can see on that document that this was to happen. []

JIM JENSEN: Fine. We'll do that. Any other comments, questions? Yes, Chief. []

BILL MIZNER: Just for a point of clarification and just a question on the budget there. We keep referring to the carryover as encumbrance, which, as I understand that, is money that's committed to pay something, an obligation. But as I look through the fiscal years, I see that what's appropriated and what the expenditures are, and you combine the carryover with whatever else is left over as total carryover, and then it goes into the next year, that would seem to assume that there is never any savings, any unobligated funds that does not get carried forward. So is this everything that's identified there as carryover, is that all encumbered, committed funds that's being spent, or is there

unencumbered cash carried forward that's not committed to any expenditure? And then if you appropriate for your anticipated expenditures in the following year, are you actually carrying a cash-positive balance in your total appropriation between what's appropriated and the carryover, as opposed to it being totally encumbered, and so it's all being spent the next month? I mean, that's the one question I guess I have. Is it all encumbered or is there uncommitted cash carried forward? []

SANDY SOSTAD: Part is encumbered...the first one, you see the carryover, that's an encumbrance. From then on it's split between what we would categorize maybe as encumbrances and (inaudible) appropriations. []

SCOT ADAMS: And typically when that number goes from $4 million to $10 million, it's roughly the $6 million that was probably unencumbered, and therefore...and usually is grabbed back by the Unicameral. []

BILL MIZNER: Yes, that would be my assumption. []

SCOT ADAMS: Yes. And in the case of behavioral health reform, there is a specific decision to reappropriate those funds for behavioral health reform purposes, and then that's the one-time money going out May 30. []

BILL MIZNER: Okay. []

JIM JENSEN: Carole. []

CAROLE BOYE: One more question. What's the position of the department? There's the May 30 deadline. There is...these are all estimates. Then there's real bills, real encumbrances, real reconciliation that presumably happens in July, August, something like that? LB959 states that all reappropriated money should go...I'm paraphrasing...but it says...but it says all...it doesn't...estimated at $11.6 million. So we estimate all this.

And the real reconciliation happens in July. What's the department's position if there is additional money left over if the estimates are too high, let's say of encumbrances, and there's additional money then under LB959 could have, should have, would have gone to the regions under that provision? []

SCOT ADAMS: We expect to be close, but of course we're not going to be spot-on the dollar with regard to that. If it is...our intention, because this has been such an electric dynamic or variable in the whole question, we want to make sure that every dollar that is supposed to get out, will get out. And so we will probably make contract amendment changes with the regions to make sure that that dollar gets out. []

CAROLE BOYE: When would you expect to do that final reconciliation? []

SCOT ADAMS: We usually are able to find out rapidly after the month is over, so early August would be the time frame in terms of bills coming in June, paying them in July. Books are run. And so it would be in that time frame that we would do that. []

CAROLE BOYE: Forgive me for saying this, but I think we do have more questions for you. Like you say, questions beget questions on some of this, for some data, and that's maybe something that we'll ask you to put in writing, primarily because, you know, we heard some of these dollars are going to be out in January, some of these dollars are going to be out in October. And here we're sitting in May. So if...I think it will lower some of the concerns if we know that there will, in fact, be a final reconciliation and transparency of that, and if we can get a commitment for that, that probably would be helpful in terms of hitting this 5-30 deadline. []

SCOT ADAMS: Did you want more than the written transcript of this conversation? []

CAROLE BOYE: I don't know. I'm just...I'm trying to figure out how we get to 5-30 and how we get to reconciliation on this. []

SCOT ADAMS: I really don't think it's going to be a lot, because the month-to-month really doesn't vary that much. And the example you were giving in your materials, I...you know, it's pretty close. It's pretty close. But, yes, we will absolutely make sure that...and that may go both ways. If we have overestimated the encumbrance or underestimated the encumbrance and been giving out too much money, we may need to retract some of that from regions. []

JIM JENSEN: Scot, was there some slides that we don't have? []

MARIO SCALORA: You were kind enough to provide the first presentation slides. If you would kindly shoot over to the commission the last set of slides that have the numbers, that would be very helpful to have. []

SCOT ADAMS: You bet. Happy to do that. []

MARIO SCALORA: Thank you. []

JIM JENSEN: Thank you. I have...I visited with Scot and I, for this commission, would very much like to have an update or talk about what happened at the Lincoln Regional Center when the Sarpy County judge directed, even at the point of contempt of court, to his individuals to leave an individual there, both handcuffed and shackled, which really pains me. So I would love to hear any comments that you might have, and what's the follow-up, what's the direction from here. []

SCOT ADAMS: A brief summary of the situation perhaps is in order so that we're there, but on the day in question we had a...I was at...on a site visit to a provider in the Lincoln area, and received a call from Mr. Gibson, the CEO of the regional center, indicating that sheriffs had arrived with a person, in shackles, and that they had gone to Building 5. That's sort of significant but at the Lincoln Regional Center, as you know, Building 5

is sort of tucked away and you have to know what you're doing to get there in the first place. And so this is...that's where they went to. They were informed that we did not have a bed at the time, and that therefore we should...they should return. They said that they would not do that, in that they were under a court order to deliver the person. We did not see that particular court order at that time, and still have not seen that one that ordered the sheriffs. It would be none of our business, and so we wouldn't see it and haven't pursued that. We assumed that to be true. There was a period of time where I contacted the sheriffs who had drive, the two sheriffs who have driven the man to the Lincoln Regional Center, and spoke with their supervisor about this, and attempted to be in touch with the judge to see if we could back out of this in some orderly fashion. You can imagine the difficulty if everybody sort of court-ordered the person right now, today, to go. This was a person who had not been on the waiting list but who had been adjudged to be not responsible by reason of insanity that day, and then so the transfer is taking place immediately. At the time, there were four other people ahead of this person in terms of the wait list. That is not an unusual situation and it could be described as normal in the sense of it ranges from 0 to 4 over the course of time and our experience, and years. That means that anywhere from a few days to perhaps a couple weeks, sometimes three, maybe as long as four weeks, that all four of those folks would (inaudible) get in, all five of those folks would get in. Today, by the way, we're at three in terms of that list. I think the next significant point was that while I made a follow-up call at about an hour after the first call to see if we could back out of this in some reasonable fashion, I made a follow-up call to Lieutenant Grabowski to discuss further and assure him that we were working on the situation and that we would...or we're still trying to find ways to make sense of this and to move on. About 45 minutes after that, Mr. Gibson called me and let me know that the sheriffs had left and that the person was in the waiting room at the Lincoln Regional Center. We, of course, had a person with the patient, and stayed with the person. Not quite sure what to do at this point. It's an unusual situation. Cared for the person. Gave water and some food and things like that. Continued conversation. He was in a calm state, not agitated at the time. They left the key, and so at a point where we decided we had to do something, we

moved to a more secure area and took the shackles and handcuffs off. Beyond that, I would not be able to speak about particular clinical admissions or things like that with regard to the person because of confidentiality restrictions related to his care. But that would be a brief summary. Now, subsequently, of course, Senator Chambers has issued a formal complaint with the Judicial Commission. We have reviewed our procedures to see if we can encourage and more rapidly admit folks. We intend to consider additional kinds of things. And, in fact, part of the conversation today involving the balanced system of regional center care really is premised on the desire that people not stay in the jail. I mean, we think we all sort of agree with that point and direction. And so our intention is to be able to better serve people, but I don't think at any point will we ever be able to get to a zero waiting list, for a couple of reasons, some of which are outside the control of the Department of Health and Human Services. For example, Douglas County has a policy whereby they only transport on Thursdays, so even if there were a person who were to be sent on, and the court came up on Friday, they're not going to leave, although they could be on our waiting list, that day. They're simply not going to move for a week, and so we would have at least a week wait...a waiting list of a week in that particular situation. So I think there will always be some time, and I think that as you try to make maximum use and efficiency of a resource such as a regional center bed, but as little as possible because of other demands, then there will be some moment of wait between bed availability and a person coming in. I think that one of the questions I'd like to perhaps encourage in the next chapter of behavioral health reform with the new oversight commission will be something along the lines of what is a reasonable there? Is it...? In a perfect world, of course, zero is that number. In our world, what's a reasonable number? And some encouragement and thoughtfulness around that would be, I think, a useful kind of conversation. That's part of our sense of the strategic planning, by the way, sir. []

JIM JENSEN: Mario, and then Dr. Wilson. []

MARIO SCALORA: I maybe take off...well, as a commission member, someone who's

worked for 15 years serving courts in the 93 counties of our state, coordinating and performing evaluations, I have a personal interest in this situation. And I think one of the things that has to be explained in this, and I appreciate and applaud Dr. Adams' description and restraint in giving it. And by the way, I think, frankly, I've rarely ever seen a judge who is nothing but compassionate in dealing with these situations, and I don't know what the judge's motivation was. I'm not going to speak to that. My general encounters with the members of the judiciary has been nothing but trying to be flexible and compassionate in dealing with people with serious mental illness. And this was the first time in 15 years, having witnessed or dealt with a murderer in a facility, some very horrendous situations, and this was the first time I've ever encountered such a thing, and pray we don't have to again. There are reasons why we don't run forensic mental health hospitals like jails, and just drop people off. First of all, I have 43 beds that I and my colleagues work with to deal with some of rather violent individuals or individuals who were rather violent at one time. And we have an obligation to provide a therapeutic and safe environment. We cannot do that when we do not know who is coming in. We literally do not have any information when someone is literally dropped off like that. We do not know what the legal situation is, what medication they're on, what crimes were, whether their alleged victim is related to someone else in the facility which has happened quite frequently and we have obligations to keep people separate. There are significant challenges in being able to manage a facility like that without having surprises of that nature. And behavior of that nature does put not only the staff, but that patient at risk, but other patients in the facility at risk. And which is why we do not run the facility that way for obvious reason. We have taken emergency admissions into the forensic unit in frequent situations, but even in those cases we knew who they were coming in, and we worked very hard to try to accommodate those counties, and they were rather dramatic, intense situations that precipitated that. And we've been able to work that out. I can't speak about this current situation, but I don't know anything that's been said publicly to suggest that there was anything that would have warranted such an intensity of effort to mandate that at an emergency level. I think the other thing to think about, too, is there are some systemic problems. One of the...what (inaudible)

systemic problem is we have had very aggressive outreach as a forensic service to all the communities across the state to do evaluations as much in the community as possible to minimize the need for hospitalization. As I mentioned before, we rarely use forensic beds for anything but care, now, and for...so when people come in, they are in desperate need of care, they are more...these are individual who can't be managed elsewhere. And we've done some things to manage that. Where we do have a bottle neck and where the judge's frustration may have been, has been that we do have a larger number of people now in the system who for whatever reason aren't manageable in the civil mental health system, the nonlegal part of the system, and as a result instead of having four or five people who fit that criteria, who are too violent to manage, we now have 20...or until there was a transfer to Norfolk, 10-12. When you have that many of your forensic beds taken up by that part of the population, there is going to be more pressure on that. But those aren't the legally involved, and so if there is a problem systemically, that's where it is. I don't necessarily have a solution because many of these are very complex situations to say, well, the communities aren't coming forward. In many of these cases, individuals burned a lot of bridges on the communities, and the providers made multiple efforts and it didn't work out. I don't know what the answer is in those cases, but I think it was worth sharing some added context with regard to that situation. Thank you. []

JIM JENSEN : Thank you, Mario. Dr. Wilson. []

DANIEL WILSON: Well, I think it's clearly an anomalous development, Scot, and I...you know, but nationally, as state and public mental health systems reconfigure themselves, this interface with the legal and criminal justice system is very fractious and not attended to particularly well. I think the lesson here is probably that we as a state need to pay more attention to this interface, and develop...the regions, in particular, need to develop a better conceptualization of how they can facilitate the courts. There is an underlying issue though, too, that the state hospitals still are the de facto treatment center of choice for the legal system. They're free to the respective regions, so there is

an ongoing incentive to not really pay much attention on the community interface. I don't mean to call anybody out, it's just a national problem, and this state could do a better job with that. []

SCOT ADAMS: I would agree with you in terms of the duality of the system and the anomalies within that. I would also like to point out, on an optimistic note, that we have been the recipient in the last year of a state mental health justice grant, and we are in the process of renewing that for a three-year process that we think can begin to address that, as well as other interface issues between the justice system and the behavioral health system. []

JIM JENSEN : Thank you. Any other comments? Thank you, Scot, for that. Oh, excuse me, Mary. []

MARY ANGUS: Senator, I just have one. I am concerned...there are so many important things being said today, but I am also very concerned about moving eight people from Lincoln Regional Center to Norfolk. And I see it that it's been happening with some regularity over quite some time now. And I can tell you that it is highly unlikely that that is therapeutic. There may be reasons on the behalf of one of the persons involved, but it's generally not the person that's being transferred, and I have some real concerns over transferring people from one facility to another, and especially given the length...the number of miles, etcetera, that that removes them from whatever support that they had at the regional center. And in my experience, being moved has not been a therapeutic situation. []

SCOT ADAMS: Ms. Angus, I appreciate your comment and your concern, and I share that. The moves in question were not taken lightly, but in the face of folks sitting in jails and the growing tension and pressure around that. I would also note that the people who were moved were largely from Region IV, and so closer to home, (inaudible) from Region VI, who there. Another identifying characteristics were that they were further

along in the treatment process, more stable and more likely to be released relatively soon. But I absolutely concur that in an ideal world everybody would start and finish there and move on. And, heck, in an ideal world, they would never show up in the first place, and...but I certainly agree with your point that it's not the ideal situation. That's why in our next chapter we wanted to look at the greater integration of the two hospitals would still have operated somewhat independently so that we can have a singular system to avoid that kind of thing in the future. []

MARY ANGUS: Oh, I guess part of my concern is that no matter where they're from, they're in a regional center. And if they're from Norfolk in the first place and they're at...I mean, I don't want them in Norfolk at all, but I really can't...and I think you understand what I'm saying, but I just can't quite put it into words. I don't want them being transferred miles and miles, in some cases hundreds of miles away from their homes, regardless of the situation. And even if they're more stable, even if they are almost ready to be discharged, it's certainly not therapeutic. Obviously, in the case where they're moving closer to home, there is a little more value to it. But if they're that close to being ready, could they not be moved into some other form of treatment and not continue in an institutional setting? I don't know. Again, I don't know the answer to that either. []

MARIO SCALORA: From a clinical point of view, listening and hearing what some of the conversations were are the regional center, I think if they could, they would have. You know, I think in a lot of those situations they are constantly pushing to move some of those people out. Would there have been exceptions where they probably could have? Possibly. Mary, I don't know, but I know in some of the circumstances they discussed, they were trying very hard to look at options that were out in the community, and (inaudible) not available. So I know it's not for lack of effort, in some respects. I'm not minimizing your point. I just want to put for the record, I think some people, a significant number of people were trying to make very legitimate, heartfelt efforts to avoid some of that as you have suggested. []

MARY ANGUS: Thank you. []

JIM JENSEN: Any other comments? A legislative update. Senator Johnson, you had a comment on that? []

SENATOR JOHNSON: (Exhibit 4) Well, (inaudible) we'll try and make it short here. The sheet that you'll have in front of you is what we did as far as interim studies, as we put together a list of suggestions for interim studies from the various senators. What we did then is people got to vote for only six of the group, and then we added up the numbers, and then ranked them in order that way. And so as you go towards the top of the list, that was what our committee thought was the most important, and then as you go down the list sometimes they just were ones that were of interest only to the senator and not to the overall group, so. I guess the only one that I would call your attention to, and number 4, which happens to be one of mine. But we had a discussion about this last year. I think with all the discussion around the table today, we still see the need for this, and that's as we've gone from the institutional-based to the community-based, it takes more people that are caregivers of all types, rather than less, and we haven't changed those numbers. So my personal opinion is that we need to work on this and hopefully find a champion to carry this to the floor next year, and improve the situation. So if anyone has any other comments, they can visit with us afterwards, and (inaudible). []

JIM JENSEN: I did see in the paper where Iowa are having the same problem and are reaching...or are putting special emphasis on work force recruitment, and even stipends for psychiatrists that... []

SENATOR JOHNSON: I think it's pretty universal all across the country, and...but we can and will have to do better. []

JIM JENSEN: Any other comments on that? Other business? Excuse, J. Rock, we're

you going to comment on...? []

J.ROCK JOHNSON: Well, part of the comment goes to having heard "in an ideal world." I don't want to hear that. I want to hear maximum, feasible. I want to hear Deming's plan, do, act, change; plan, do, act, change. I don't want to hear "in an ideal world," as an excuse for what exists. I'm very concerned to think that the dungeon that I feel Norfolk Regional Center is, it sounds as though it might be, we've already invested a million and a half dollars in getting it accredited as a hospital, that it might become an acceptable place for moving people. And I think that people have been moved around a lot, and we haven't discussed that. We've got a census for one day. But lots of times people have been moved. If we are going to keep moving people, until we change the values, the beliefs, and the goals that we have here for prevention...for example, I see in the regional budget plan, plan of expenditures, guide lines...I've now figured out all the names I think that it has...and in there, emergency services are those that will keep a person from becoming in such a crisis that you have to call law enforcement or are after law enforcement comes and how you can minimize the number of days. We really need to flip the way that we think, or we're going to continue to have this problem that has existed from the beginning. And I just think that we cannot emphasize that enough, is we've got to look at prevention and the way that part of the work force issues have to do with consumers becoming educated and taking care of each other and being in those kind of jobs, the sorts of things that our system has yet to really take into account and work on and see where it can go. []

JIM JENSEN: Thank. Dr. Wilson. []

DANIEL WILSON: Yes, Senator. I just wanted to follow up on something from prior meetings, I think in particular the last meeting of the commission, there was a discussion about deliverables that were formulated early in this process by HHS, and I just asked some colleagues to help me dust that off. And it was July 1, 2004, that this was presented, and just to kind of memorialize where we are, a lot of things have

happened as Dr. Adams has discussed, but there are at least 15 things that remain, and I think it would be maybe useful to have those in our more current minutes. Work force development was one, Senator. A greater focus on what's happening within the institutions and the array of services and how they connect to the community. Clinical and educational telebehavioral health to reach around the state. Management information services. Rate setting mechanisms. Increased support of employment for consumers. Housing, first policy, best practices. And closure of the Hastings Regional Center for behavioral health and closure of the Norfolk Regional Center for behavioral health, and notification to the Governor and Legislature as we...I might have mentioned that earlier, Dr. Adams, just...and I'll probably mention it again, but. A lot has been accomplished. There are still some useful things that in your strategic planning I think it would be worth looking back and trying to reincorporate some of these things. And I'll just close. I have to run back to a meeting in Omaha, but as I walked in the north entrance today, it said above me, carved in the stone, "The salvation of the state is the watchfulness of the citizen." So I have very much enjoyed the watchfulness today, although it dragged on a bit here and there, but. []

JIM JENSEN: Okay. Thank you. Yes, Dr. Adams. []

GORDON ADAMS: I don't want to let the characterization of the Norfolk Regional Center as a dungeon go unchallenged. In the process, when we were having LB1083 hearings, and so forth, I had a lot of input from patients and families who had had experiences there. Norfolk Regional Center is a hospital. It is served by very dedicated and professional staff, and it is not a dungeon. I would gladly you show you what a dungeon looks like, but I don't have one on hand right now. []

J.ROCK JOHNSON: I have seen them. Thank you. []

GORDON ADAMS: I want to really be sure that doesn't go in the record as unchallenged. []

JIM JENSEN: Thank you, Dr. Adams. []

J.ROCK JOHNSON : I believe it goes in the record as my opinion of my experience, and that's valid. []

JIM JENSEN : Okay. Topher. []

TOPHER HANSEN: Scot, one more question. As I go down my budget each month, I squint, and the ones that spike high or spike low, I start paying attention to the percentages of the dollars. There was a month in this year, April, where there was a big spike in expense--almost double the monthly budget. Do you know off the top of your head what that's about? There was, like $9 million spent that month. Do you have a clue about that? []

SCOT ADAMS: I would be absolutely happy to sit down and you point it out to me, and we can work through it, but I have no idea what you're talking about. []

TOPHER HANSEN : Okay. Well,... []

JIM JENSEN: We can certainly discuss that this... []

TOPHER HANSEN: Discuss it when we meet with Sandy and so on. []

SCOT ADAMS: Yeah. []

JIM JENSEN: Yeah, sure. Public comment. []

JOHN PINKERTON: I'll go first. []

JIM JENSEN: Okay. []

JOHN PINKERTON: Hi. John Pinkerton. I'm the treasurer of NAMI-Nebraska, and we have four homes across the state in three different regions for behavioral health consumers. And I just wanted to give a thanks to the Governor for appointing Scot Adams. I think Scot has been a breath of fresh air, from what I've seen over the years, and I think he has worked for advocacy and inclusion in the way we do things. And for anybody who doesn't think inclusion is important, I wish they could have attended all of the assisted-living meetings that Scot held across the state. The different regions actually them. They went everywhere from only having government employees there, to being 90 percent consumers. And the meetings, without fail, that had consumers there, provided much more intuitive information than all the other meetings. It was very impressive. And I think it did accomplish a lot in openness, more than I've seen across the state in a long time. So anyway I want to thank Scot for those meetings. He did a good job. []

JIM JENSEN: Thank you. Any other public comment? The next meeting, June 20, I've been informed that that's the same time as the NABHO meeting. I do have 14 members who have already responded that they can make that meeting. Unless there's another date I think we'll stay with the 14th. []

_____: It's the 20th. []

JIM JENSEN: Or the 20th, excuse me. Yes. []

_____: NABHO actually changed that meeting date to the 27th to accommodate the Oversight Commission. []

JIM JENSEN: Super. Thank you very much for doing that. []

MARIO SCALORA: For the record, thanks (inaudible). []

JIM JENSEN: Yeah. []

MARIO SCALORA: Sir, I thought I saw somebody stepping up when you (inaudible) a closing comment. []

JIM JENSEN: Oh, did they? I'm sorry. []

MARIO SCALORA: I didn't know if that was just... []

JIM JENSEN: Okay. []

MARIO SCALORA: Did you want to make a comment, sir? Please. []

JIM JENSEN : Yes. Well, come on up, Alan, I'm sorry. You're such a little fellow, I missed you back there. (Laughter) []

ALAN GREEN: I've never been accused of being bashful, I guess. Just a couple points. One of the biggest benefits of this commission and one of our greatest fears is that what little oversight and accountable that is available right now will not be available as of July 1. The law that authorizes the new oversight commission, says basically that it will do what the division wants done. You know, I've said this before at other times, but anyway. One of the things I wanted to talk about kind of dovetails with the situation that occurred at LRC. And again this is...I'm not in any way picking on LRC or physicians or care providers or anything, but this is, from my point of view, the issue really at hand is the fact that we have a shortage...J.Rock mentioned this...a great shortage, if not a nonexistence of any preemptive preventative-type programming, that in an article in the Omaha World-Herald, I believe Martha Stoddard wrote it, stated that this individual first exhibited symptoms about two years ago, and wasn't able to get care. That he tried and

wasn't able to get anything. That his...then his involvement...as symptoms increased, his involvement with the judicial system increased to the point where he was put in a hospital, and what really struck me about him in the article was that evidently he was noncompliant, and a nurse threw ice water at him to get him to calm down, at which point he then reacted and attacked the nurse, and was then incarcerated for assault. To me, you know, this is our philosophy right now. This is what our system is, and this is not recovery. And so what I'm getting at is a fundamental change in how we use terminology, how we use words. It was mentioned about burning bridges, and compliance, but that's a two-way street that when I used to run a day shelter here in Lincoln, and we dealt with a lot of people who burnt bridges at agencies because they didn't comply with what those agencies were providing. They were at fault, not the fact that the services that were available were inadequate or not appropriate. It was the individual. And so we need to look at it from two ways. That it's...we need to have the continuum of services available that meet the individual where they happen to be. Not require the individual to fit into a system where we want them to fit. Again, so that's all what I would say, you know. That it's two ways. Compliance is not only the patient not taking medicine, but it's also the provider and not doing harm. So I think we need to look at the full picture. Thank you. []

JIM JENSEN: I agree. Thank you. []

J.ROCK JOHNSON: And your name? []

ALAN GREEN: Oh, I'm sorry. Alan Green, executive director of the Mental Health Association. []

JIM JENSEN : Any other public comment? Thank you. Linda, NAMI walk is coming up soon. Could you just...? []

LINDA JENSEN: Yes. Anybody (inaudible)? []

JIM JENSEN: I just think that's such a fantastic... []

LINDA JENSEN: Come and walk with us. It's actually the day after the next (inaudible). []

JIM JENSEN: Okay. And you've been raising funds. []

LINDA JENSEN: Well, I hope it to be a stigma buster, that's the idea. Big group there. []

JIM JENSEN: All right. Super. Well, I think it's fantastic. With that, any other comments, we're adjourned. Thank you. Oh, excuse me, Senator Johnson. []

SENATOR JOHNSON: If I could just for one second. I will not be able to be here next month for the last meeting of this group but I'd like the record to show that this, as I've seen over its existence, has been perhaps the best group of individuals. I guess I would call it an adversarial cooperative, (laughter) and that the way it should be, because you don't learn anything by just patting each other on the back all the time. And I think it's just been a great group, and you're all to be commended. []

JIM JENSEN: Thank you, Senator. With that, we're adjourned. []